



Samaritan Health Services

Building healthier communities together

Graduate Medical Education

Quarterly
Newsletter

Spring 2018

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A message from the DIO

By Sugat Patel, MD, DIO

The quality and professionalism of our residents and fellows are not only reflective of those traits amongst our faculty but that of all staff in the learning environment. We can no more expect our learners to reach an aspirational level of competence than that in which we expect within our faculty and staff. The clinical learning environment provides the framework from which our residents and fellows grow and build from as they progress to become competent physicians. Graduate Medical Education (GME) at Samaritan Health Services (SHS) is committed to improving the learning environment of all residents/fellows. Using the six Clinical Learning Environment Review (CLER)¹ focus areas (Patient Safety, Health Care Quality, Care Transitions, Supervision, Well-being and Professionalism) and the Pathways within each focus area as a guide, GME is performing a comprehensive review of the learning environment within SHS. With committed partners from Executive Leadership, Quality Departments, Risk, Clinical Directors, Nursing Leadership, Program Directors, Wellness Committees, faculty and residents/fellows, our hope is to

identify areas of improvement, influence beneficial change and develop programs in line with each of the Pathways within the CLER focus areas.

The GME Newsletter is one tool that will be used to improve resident, fellow and faculty education. Quality improvement is one area of focus. The goal is to improve our trainee's and faculty's familiarity with institutional priorities, review institutional data on quality metrics and show progress on these metrics. Our hope is to align quality projects performed by our residents, fellows and faculty with institutional priorities. In this addition, Pamela Aronson (Director GSR Quality Improvements) discusses the Centers for Medicare and Medicaid Services (CMS) Five-Star Quality Rating System and the efforts to improve that rating at our institution. The Resident Quality Counsel (RQC) was inaugurated in 2016 to provide a forum for residents and fellows to originate and implemented quality improvement projects within SHS. Ashely Rivera, PGY3 General Surgery and current chair of the RQC, reviews the activities of the RQC.

Other areas of focus are Wellbeing. Fatigue is a common amongst medical professionals and its effect on patient care well documented. The LIFE Curriculum, supported, in part, the Josiah mac Jr.

Foundation, is a collaborative effort from multiple partners to include Duke University Hospital to assist GME programs to prevent, identify and manage fatigue, depression, burnout and impairment. We will begin our series by presenting information on fatigue and strategies to mitigate it.

¹ <http://www.acgme.org/What-We-Do/Initiatives/Clinical-Learning-Environment-Review-CLER>

Wellness Corner: Fatigue Part 1

Anyone can experience fatigue, but those in certain professions, such as healthcare, pose a greater risk, putting themselves and patients in danger. Understanding what fatigue is and being able to recognize it within yourself and those around you can significantly improve your overall wellbeing and the care you provide.

This article will focus on the definition of fatigue; discuss the physical mental and social consequences of fatigue; and how to recognize signs of fatigue. Future articles will address the link between medical error and fatigue; identifying strategies for managing fatigue; predicting times of peak and nadir performance; and understanding how managing and recognizing fatigue is a shared responsibility among all persons in the healthcare setting.

“Sufficient sleep and sleep hygiene are critical for the practice of good medicine”

–David F. Dinges, PhD and Don K. Nakayama, MD, MBA²

What is Fatigue?

As defined by Oxford dictionary, fatigue is “extreme tiredness from mental and physical exertion or illness³”. In other words, fatigue is the result of sleep deprivation or the disruption of a normal sleep pattern which can severely impair an individual’s function.

Common physical, mental and social consequences of sleep deprivation

- Higher occurrence of traffic violations, to include accidents
- Reduced motivation
- Increased cynicism
- Increase chance of substance abuse
- Low cognitive performance (test taking, decision making)

What is a normal sleep pattern?

Most people, on average, require approximately eight hours of non-interrupted sleep every 24 hours to satisfy their physiological needs. When you get less than five hours of sleep over a 24-hour period your peak mental performance usually deteriorates.

How much is enough?

- The amount that allows the person to feel alert when rested and relaxed (e.g., during grand rounds)
- The average person requires about 8 or more hours of sleep
- One night with 2 hours fewer than the usual amount of sleep is sufficient to produce significant declines in waking performance
- After several nights of 5-hour sleep periods, most adults will not realize that they are pathologically sleepy

Recognizing the signs of fatigue

- Moodiness, depression and irritability
- Apathy, impoverished speech, flattened affect
- Impaired memory confusion
- Inflexible thinking and impaired planning skills (e.g., can’t come up with novel solutions, unable to multitask)
- Sedentary nodding off (e.g., during conferences)
- Medical errors
- Micro-sleeps (5 to 10 seconds) that cause lapses in attention and can be extremely dangerous
- Repeatedly checking work
- Difficulty focusing on tasks

If you would like to learn more about fatigue please visit our [Resident Wellness](#) page.

² The information in this article is referenced out of the [LIFE Curriculum](#) created by Duke University.

³ <https://en.oxforddictionaries.com/definition/fatigue>

Alumni Spotlight

Name: Brian Hodges, DO

Program: Orthopedic Surgery

Completed Residency: 2015

Current Practice: Soddo Christian Hospital; Soddo, Ethiopia

Where has life taken you after residency?

Before I graduated orthopedic residency, we knew God was calling us to do a medical mission in Ethiopia. The Ethiopian government would not issue a medical license unless I had one year of experience outside of residency, so after graduation I worked for Synergy Surgicalist in Corvallis and Leesville Louisiana. After completing one year of work with Synergy, my family and I moved to Ethiopia. I currently do orthopedic surgery in a mission hospital in Soddo, Ethiopia. I mainly do orthopedic trauma and deformity correction surgery. My mentor is a seasoned orthopedic surgeon from the U.S. who has been on the mission field for 13 years. Our heart is to help the people of Ethiopia both physically and spiritually in the name of Jesus.

What is your greatest takeaway from residency?

Always do your best and never settle for something less, and to always be prepared for anything that might arise during your surgical case.

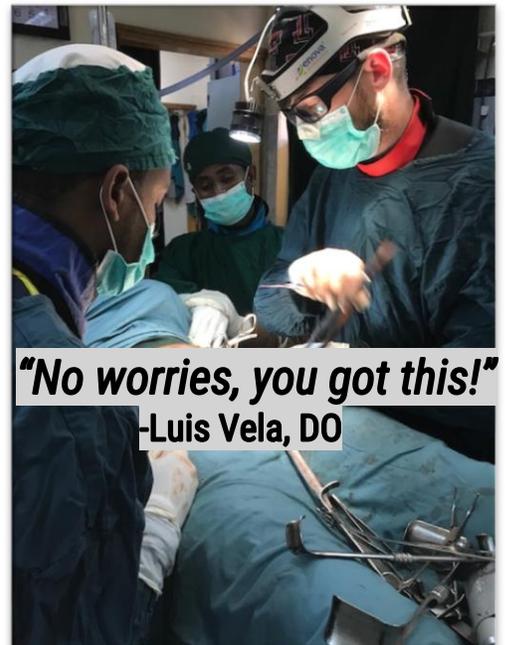
Best words of advice/wisdom from residency faculty members?

"Always be prepared for every situation in every case," Peter Tsai, MD

"The enemy of good is better," Jacque Krumrey, MD

Do you have any advice for current and/or future medical students?

Keep the course; residency is a marathon not a sprint



To follow Dr. Brian Hodges journey in Ethiopia you may follow his family's blog at: <http://www.apeaceofourlife.com/about/>

What do you miss most about the Corvallis area?

We miss the people and the beautiful landscape of Corvallis Oregon.

If you were to start all over again would you choose your same career/specialty?

Definitely, yes! I love the field of orthopedic surgery and all the challenges it offers on a daily basis.

Family Life: We are a family of six with three girls and one boy. Our girls are Elisabeth (11), Abigail (8), Lexi (2), and our boy is John (6). My wife, Autumn, homeschools our four kids. They are thoroughly enjoying Ethiopia and experiencing a different culture. They have Ethiopian friends and other missionary children which are helping them grown in learning about different cultures and diversity among the different people groups of the world.

Resident Quality Council

By Ashley Rivera, PGY₃, General Surgery Resident

The Resident Quality Council (RQC) was established in the Fall of 2016 under the direction of Dr. Sugat Patel MD, DIO. The council is represented by residents from each training program as well as representation from the resident wellness committee, research department, risk management, quality resources and GME. The focus and purpose of the council is to identify quality related issues from a resident perspective, develop quality improvement projects and help improve the overall learning environment.

During the initial year of creation, the council completed two large projects. The first project was the development of a resident specific unusual occurrence reporting system. This provided a forum for residents to anonymously report issues related to patient safety that they are exposed to on the “front lines” of patient care. In the first 9 months since the system went live, over 30 reports were generated which directly led to the improvement of quality and the development of projects throughout the hospital. The second project was the implementation of a standardized handoff system available to all hospitals and services throughout Samaritan. This tool has been essential in the improvement of transitions of care, not only between residents but for transfers between all physician teams in the inpatient setting.

Based on the resident reporting tool, many other projects have been started, including psychiatric hold policies and peri-operative insulin management. The council also identified a detailed way to view blood administration information in EPIC, improved the stocking of the chest tube carts, and took advantage of opportunities for individual and group education on patient specific encounters. The council is working closely with the resident wellness committee to introduce opportunities for physical and mental well-being in the form of fitness classes and meditation sessions to encourage work-life balance.

This coming year, the council plans to further integrate with the SHS Quality Council. The mission of this integration is to provide a resident perspective to the advancement of system quality initiatives and align projects with the vision set forth by the entire system.

Updates from the Research Development Office

By Paulina Kaiser, PhD, MPH and Olivia Pipitone, MPH

A reminder that the Research Development Office (RDO) is available to residents and staff to help plan, conduct, summarize, and share your research and/or quality improvement projects! The RDO includes Paulina Kaiser, epidemiologist, and Olivia Pipitone, biostatistician. Some of the services that we provide are:

- Refining research questions & choosing an appropriate study design
- Help preparing your study protocol
- Navigating the IRB: when IRB review is required, help preparing your submission materials
- Gathering data: getting data from Epic, or collecting new data (surveys, prospective studies)
- Data analysis, summaries, and visualization
- Disseminating your results (abstracts, posters, manuscripts, etc.)

Speaking of disseminating your results, did you know that the RDO has assisted in successfully publishing 2 scholarly activity projects so far, with 6 additional publications currently in the works? Submitting your project to a journal for publication can be time-consuming, but doesn't have to be difficult! The RDO can help you choose which type of article to write and which journal to submit to. Publishing your work is totally achievable, but planning ahead always helps.

Feel free to reach out to the RDO at shsresearch@samhealth.org with any questions or comments – we're here to help! Also, check out our SharePoint site: from the SHS Insider, go to the Physician's Page and click “Research Tools and Resources” on the lower right-hand side. Here, we have a TON of resources for you to use as you work on your scholarly activity. On the left-hand side, we have a list of all current projects going on with the RDO (“Current Projects Database”) and a list of potential project ideas (“Project Ideas Database”). (If you can think of additional resources that would be helpful on the SharePoint site, let us know!)

Osteopathic-Neuromusculoskeletal Manipulative Medicine Residency brings a unique kind of care to Corvallis

Good Samaritan Regional Medical Center began its Osteopathic-Neuromusculoskeletal Manipulative Medicine (ONMM) Residency in 2015. This June, the ONMM program will graduate their third class of residents who have spent an additional year of residency with focus on Neuromusculoskeletal Medicine and Osteopathic Manipulative Medicine. The ONMM program provides care to patients in both the inpatient and outpatient settings. Over the past three years, the ONMM inpatient service has grown to one of high demand and has quickly become a busy consultative option at GSRMC. The ONMM consultative team provides care to a broad scope of hospitalized patients including those on labor and delivery, newborns, surgical, intensive and progressive care and mental health. “We are so lucky to have the OMM service as a resource for our families on the Labor & Delivery and Postpartum units at GSRMC,” shares Emily Yeast, Clinical Nurse Midwife at GSRMC. The ONMM team provides consultation during the morning hours Monday through Friday and typically cares for an increasingly large patient volume.



Dr. Erandhi Hall, Co-Program Director, supervises ONMM Resident, Dr. Sunil Bhat as he provides OMT treatment to his young patient.

The ONMM clinic focuses on physical touch and manipulation to heal and improve health among a diverse range of patients, “Our goal is to use Osteopathic Manipulative Medicine to help promote optimal health through our knowledge of anatomy and physiology,” shares Co-Program Director, Erandhi Hall, DO. On the labor and delivery floor, ONMM is requested for mothers who are having long, difficult labors, or who are experiencing postpartum discomfort and for newborns that are having trouble feeding, “Our patients constantly report high satisfaction and relief from symptoms after OMM treatment, and we are grateful to be able to offer this service,” says Yeast.

Much like the consultative service, the outpatient clinic is a busy referral source. The clinic provides care to new mothers for prenatal and post-partum needs, children of various ages to help prevent illnesses and achieve optimal health, patients who suffer from acute and chronic disease processes. The clinicians also provide care to OSU athletes through a care collaboration with Samaritan Athletic Medicine.



Michael Watson Jr., DO, ONMM resident, visits with his young patient and her mother



Dr. Watson guides the hands of third year medical student, Cheng Liu, during an Osteopathy treatment.

UPCOMING EVENTS

Graduation Ceremony

June 15, 2018 Boulder Falls Center

2018-2019 Resident Orientation Week

June 18 – 22

First day of the 2018-2019 Academic Year

June 25, 2018

Fall Resident Education Day

September 21, 2018

GME Strategic Planning Day

September 28, 2018

RQC SNAP SHOT

Fully implemented Projects: 2

- ✓ Resident specific unusual/patient safety events reporting system
- ✓ Standardized handoff system available through all hospitals to improve patient care transitions

Projects in Process: 2

- ✓ Psychiatric hold processes
- ✓ Peri-operative insulin management

Improved Processes: 4

- ✓ Viewing blood administration information in EPIC
- ✓ Stocking of the chest tube carts
- ✓ Individual and group education on patient specific encounters
- ✓ In-house fitness classes

Quality and Patient Safety

Our future is four-stars

By Pamela Aronson, RN, MBA, CPHQ

With the arrival of every new year comes an opportunity to update and plan our work for the next year. For SHS, 2018 also brought new executive leadership and introduction to a fresh mission and vision, as well as refined values and strategic priorities. Quality and Service Excellence has always been important to SHS, but our updated goals ensure unified focus on achieving specific, measurable and relevant objectives. Specifically, we want to achieve “four star” CMS ratings in all five SHS hospitals.

The CMS hospital star rating system relies on 57 publicly reported quality measures, which are summarized and grouped into seven weighted categories (See table). Category scores are then aggregated to create an overall star rating. Less than 10% of hospitals nationally received the highest rating of 5-stars in 2017, while 31% received 4-stars and 32% received 3-stars. In the 4th quarter of 2017, all five SHS hospitals earned a 3-star rating overall.

Star Rating Category	Category Weight	Number of Metrics
Mortality	22%	7
Readmission	22%	8
Safety of Care	22%	8
Patient Experience	22%	11
Effectiveness of Care	4%	11
Timeliness of care	4%	7
Efficient Use of Imaging	4%	5

SHS generally performs above the national average in the categories of Readmission and Safety of Care and scores about the same as the national average in all of the remaining categories. Opportunities for SHS hospitals to improve from 3-stars to 4-stars reside within the Patient Experience category, particularly related to how patients rate quietness at night

and cleanliness of patient rooms on Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) surveys. You may have noticed a number of hospital units enforcing “quiet times” during every shift, where the lights are dimmed and voices hushed with the intention of improving patient ratings. Staff are also encouraged to narrate their efforts to reduce noise and improve cleanliness by verbally explaining how care activities support achievement of a clean and quiet environment.

Respective to Safety of Care and Readmission, SHS is addressing catheter-associated urinary tract infections (CAUTI), central line-associated blood stream infections (CLABSI), surgical site infections, patient falls, hospital-acquired pressure ulcers (HAPU), ventilator-associated pneumonia (VAP), serious adverse events and readmissions, reporting and tracking them through a new dashboard entitled “Decreasing HARM Across the Board”. These unintended outcomes are being targeted for improvement, with their contributing factors being addressed at all levels within the organization.

Finally, SHS is continuing to build staff teamwork and communication skills in 2018 through ongoing TeamSTEPPS education, building reliability into our processes through timely reporting of safety risks and hazards, and updating processes related to transitions of care and resolution of patient and/or family concerns.

Resident spotlight

Doug Blaty, DO

Name: Doug Blaty

Program: Orthopedic Surgery, PGY 5

Hometown: Coeur d'Alene, ID

Medical School: Arizona College of Osteopathic Medicine

Dr. Blaty was nominated by GME Leadership due to the dedication he exhibits among training, community, research and patient care.

Dr. Blaty has been published in World Neurosurgery and the Journal of Orthopedics, with a third publication in the submission process. Please see page 12 for details on Dr. Blaty publications.

What did you do prior to medical school?

Prior to medical school I was very active in various sports and outdoor activities. I loved to learn about the human body and how to incorporate this into training for football and track and field. Unfortunately, I was involved in a mountain biking accident prior to my senior year in high school, breaking multiple bones in my lumbar spine, and ultimately ruining my plans to continue football throughout college. However, looking back on it, this event ultimately spurred my interest in orthopedics, and specifically the spine. Previously being recruited as a running back at the University of Oregon, the team



“The choice of pursuing a medical career has to be purely based on the desire to help people”

physicians would not clear me to play due to my back injury. This lit a fire to learn more about the spine and become my own source of knowledge. I decided to continue with track and field, and to pursue the medical field. As a student-athlete at the University of Washington, I went on to become a top-ten record holder in the Men's Decathlon, Indoor Heptathlon, and a PAC-10 All-Academic Athlete. Yet, this was just a stepping stone, as I wanted to continue on to medical school in hopes to become a spine surgeon.

Though this injury seemed devastating at the time, I have to appreciate how that experience brought me to love orthopedics, and ultimately built the desire to become a spine surgeon. Many medical students, and even some younger residents, may not know exactly what they want to do in medicine; and that can be frustrating. However, given my experience, I have always wanted to be involved in spine surgery, and I am fortunate to be given that focus from very early on in this whole process.

Prior to residency, what was the most unusual or interesting job you had?

I was a CNA prior to medical school, working in a progressive care unit at Kootenai Medical Center in North Idaho. I worked with great nurses who taught me so much. As a resident now, that experience has allowed me to appreciate the work and dedication the nursing staff has, and how vital everyone is to patient care.

What is your most memorable or proudest moment during residency?

While there are so many great patient experiences I can think of during medical school and residency, my most memorable was not too long ago when a patient presented to our spine clinic in



absolute agony from a cervical disc problem. That patient had been this miserable for an entire year, to the point where he could not leave the house or even be upright for more than a few minutes. In fact, that patient's personality and entire lifestyle had been ruined due to this neck issue. A few days later, the surgery went well, and when I came to the room the next day, it was a complete transformation. He was moving around without problems, had almost no pain issues, and was full of joy and a gratitude that is hard to explain. Most importantly, his eyes were full of light, whereas before they were filled with defeat and agony. I don't know why that experience touched me the way it did, but I have to think it was due to the fact that this is my last year in residency, and thinking back to how badly I have wanted to become a spine surgeon and help people, that moment felt like a culmination of all the hard work put in over the last 10 years, all wrapped into one patient.

Favorite interest/hobby?

I enjoy snowboarding, working out and hiking.

Do you have any advice for current and/or future medical students?

With how much medicine has changed in the last 5 years, and likely where it will be headed, the choice of pursuing a medical career has to be purely based on the desire to help people. My advice is to not let student loans and politics cause stress, and to know that you have job security and that you are getting into a career that is extremely self-satisfying.

What is on your wish list for the next 10 years?

I have been accepted into a Spine Surgery Fellowship at Twin Cities Spine Center in Minneapolis, MN which is a one-year program beginning this summer. Though I am leaving all my options open, my hope is to ultimately get back to North Idaho and enjoy being around my family and giving quality spine care back to the people of the area I love. It's exciting to think about starting a family and building a practice. I look forward to settling down, getting a routine, and practicing medicine in one location. Having moved 23 times in my life and lived in 8 different states (with residency being one of the longest periods I have lived in one location during my life) the idea of settling down is honestly one of the more exciting aspects of a career right now.

Are there any interesting projects or interests you have?

I'm in the process of creating a smartphone App to help medical students and residents study. It stemmed from the flashcards I have been making since my 4th year of medical school. I always carry small flashcards around, and whenever something important comes up from reading, during conferences, after exams, or even after surgeries, I try to formulate it into a straightforward question and answer. I soon realized that I had almost 10,000 flashcards, and thought to myself "how can I share this knowledge." So, I am currently formulating these into an App that will help orthopedic residents, and even students, to test themselves using their phone, so that



they can study "on-the-go". It has even helped me score in the 95th percentile on our Orthopedic In-service Training Exam (OITE), which is a national standardized exam. My hope is that residents and students could use this whenever they find a moment in their busy day, in order to share this knowledge that I have gained over the last 5+ years.

Family Life

My wife and I have been apart for almost two years now, as she pursues her dream of becoming an Endocrinologist. It has been very hard, but is worth the sacrifice as she pursues her dream. I am so unbelievably proud of her, and feel like the luckiest guy alive to be in her life. She was previously an Internal Medicine resident here at Good Samaritan, and is finishing her Endocrinology Fellowship at the University of Wisconsin, Madison. She has developed a love for the treatment of osteoporosis and bone health and with my career in orthopedics and spine surgery, our hopes is to incorporate this into developing a Bone Clinic. Our hope is to not only treat those with

decreased bone density, but also to help prevent what is arguably one of the most under-rated silent killers; as the mortality rate from osteoporotic-related fractures is higher than that for breast cancer and cervical cancer combined.

To Nominate a Resident

Please send all resident nominations to Megan Kinane at mkinane@samhealth.org

Please include the following:
Subject line: Resident Nomination
Include reason for nomination

Did you know?

The difference between Medical Student, Intern, Resident, Fellow and Attending

By Megan Kinane, MHA

When you or your loved ones are in the care of a teaching hospital, your care team may include multiple levels of learners. These learners are at various stages in their education and require different levels of supervision and autonomy. For most, it is hard to identify the difference, especially when intern, residents and fellows are all doctors and are referred to as such. So, we are left to wonder, what do these different titles mean, what does PGY stand for and who exactly is in charge?

Let's take a few minutes to break down who's who among your care team.

The medical student: A medical student is not yet a doctor, but they are on their way to becoming one. Medical school is a four-year process that a student does after completing their undergraduate (four years of college to obtain bachelor degree). By the time they graduate from medical school they have done *at least* eight years of college. When you see a medical student in the hospital they are usually either in their third or fourth year of medical school. Medical students will always be under direct supervision by either a resident/fellow or attending.

Upon completion of the four-year medical school the Graduate officially becomes a "doctor" and is either a M.D. (graduated from an allopathic medical school) or a D.O. (graduated from an osteopathic medical school). To be able to practice medicine in the United States a medical school graduates must get *at least* one year of training in a residency program.

The Intern Resident and Resident: (PGY1 – PGY5): The PGY 1 resident is classified as an "intern resident", but they are usually referred to as simply, "resident". They are in their first year of training after graduating from a medical school – post-graduate year one (PGY1). After completing their intern year, they can become a [general practitioner](#) and practice independently. However, today most residents complete a specialty focused residency which can be three to seven + years in a residency/fellowship program, depending on the specialty selected. Residents who are a part of a specialty program get promoted to the next post-graduate year (PGY) upon successful completion of program requirements specific to the year of training they are in. When a PGY1 resident successfully meets all requirements of that year, they will move on to their post-graduate year 2 (PGY2) and so on.

Currently, Good Samaritan Regional Medical Center (GSRMC) has the following specialty specific programs:

Family Medicine: PGY 1 – PGY 3

Internal Medicine: PGY 1 – PGY 3

Psychiatry: PGY 1 – PGY 4

Dermatology with Silver Falls: PGY 2 – PGY 4 (requires an intern year of training prior to acceptance into a dermatology residency program)

General Surgery: PGY 1 – PGY 5

Orthopedic Surgery: PGY 1 – PGY 5

ONMM+1: The ONMM+1 residency program is an additional year of training that a graduated resident can do to obtain specific training in Osteopathic Neuromuskuloskeletal Manipulative Medicine

Cardiology Fellowship: PGY 4 – PGY 6

Interventional Cardiology Fellowship: PGY 7

Child and Adolescent Fellowship: PGY 4 – PGY 5

The Fellow: Good Samaritan currently has three fellowship programs: Cardiology, Interventional Cardiology and Child and Adolescent (C&A) Psychiatry. Fellows are doctors who have chosen to complete additional training in a sub-speciality field. This requires completion of training in the core specialty. For example, a cardiology fellow has completed three years in an Internal Medicine program (the core specialty) and has chosen to do specialized training in cardiology (sub-speciality). The PGY for fellows can range from PGY 4 – 7 within Good Samaritan's fellowship programs.

The Attending Doctor: In the most basic of terms, this is the doctor in charge and is responsible for the overall care of a patient in a hospital or clinic setting. The attending physician is fully licensed to practice medicine on their own. All medical students, residents and fellows have an attending they must report to.

For more information regarding the different levels of learners we have at GSRMC you may reach out to the GME department:

medicaleducation@samhealth.org

9th Annual Commencement Ceremony to recognize 43 graduates

By Megan Kinane, MHA

The 9th Annual GME Commencement Ceremony will take place on June 15 at Boulder Falls Center in Lebanon. This is a time when we come together to recognize the interns, residents and fellows who have completed their training with Samaritan Health Services (SHS). These learners have reached a major milestone in their career and are now on to new adventures near and far. Please help us congratulate these learners on their huge achievements.

Interns

Doctoral Candidates in Psychology:

Terra Bennett-Reeves will be completing her post-doctoral psychology residency with SHS

Colleen James will be completing her post-doctoral residency position with Strong Integrated Behavioral Health in Eugene, OR

Bella Vasoya will be completing her post-doctoral fellowship in clinical health psychology at Strong Integrated Behavioral Health in Eugene, OR

Sarah Yassin will be completing her post-doctoral residency in Neuropsychology at Arizona Psychology Consortium

Residents

Traditional Rotating Resident Interns:

Lacey Roybal, DO – Dr. Roybal will be continuing her education in the Dermatology Residency Program with Silver Falls Dermatology

Kelsey Ferrell, DO – Dr. Ferrell will be continuing her education in the Dermatology Residency Program with Silver Falls Dermatology

Ryan Willen, DO – Dr. Willen will be dedicating time to pursue research

Mattie Arseneaux, DO – Dr. Arseneaux will be continuing her education in a General Surgery Residency program in Ventura, CA

Family Medicine Graduates:

Stephanie Bosch, DO – Dr. Bosch will be practicing outpatient family medicine in Waldport, OR

Justin Bruno, DO – Dr. Bruno will be working in outpatient family medicine at Kaiser at Rockwood

Rachel Elsasser, DO – Dr. Elsasser will be practicing at Geary Street Family Medicine in Albany, OR

Aaron Erez, DO – Plans not reported

Yu Matsumoto, DO – Dr. Matsumoto will be joining the OMM team at Ambassadors Health Alliance in Corvallis

Samuel Milstein, DO – Dr. Milstein will be joining Samaritan Urgent Care on Geary St. in Albany, OR

Niki Myers, DO – Plans not reported

Elena Styles, DO – Dr. Styles will be practicing Family Medicine at Providence Health Care in Sherwood, OR

Nathanael Weigel, DO – Dr. Weigel will be opening an OMT practice in Corvallis, OR

Internal Medicine Graduates:

Caleb Hedberg, DO – Dr. Hedberg will be working at New West Physicians in Denver, CO as an outpatient physician

Jennifer Maire, DO – Dr. Maire will be joining an outpatient practice with Legacy in West Linn, OR

Brittany Olson, DO – Dr. Olson will be staying on with GSRMC as a hospitalist

Katelyn Austin, DO – Dr. Austin will be heading to Minneapolis, MN to become a hospitalist with North Memorial Hospital

Shyam Bhansali, DO – Plans not reported

Jeffrey Bulkley, DO – Dr. Bulkley will be heading back home to work as an outpatient internist with Mosaic Medical in Bend, OR

Aaron Chavira, DO – Dr. Chavira will be staying on with GSRMC as a hospitalist

Anne Marie Collum, DO – Plans not reported

James Townsend, DO – Dr. Townsend will be joining the hospitalist group here at GSRMC

Adult Psychiatry Graduates:

Robert Duffy, DO – Dr. Duffy will be working as an outpatient psychiatrist with the Portland VA

Sydney Harvey, DO – Dr. Harvey will be continuing her education in a Consult-Liaison Psychiatry Fellowship at OHSU in Portland, OR

Michelle Hastings, DO – Dr. Hastings will be working at Linn County Mental Health in Albany, OR

Franklin Urion, DO – Plans not reported

William George, DO – Dr. George will be continuing his education with SHS in the Child and Adolescent Psychiatry Fellowship

Orthopedic Surgery Graduates:

Douglas Blaty, DO – Dr. Blaty will be continuing his education in a Spine Surgery Fellowship at Twin Cities Spine Center, Minneapolis, MN.

Jun Kim, DO – Dr. Kim will be continuing his education in an Adult Reconstruction Fellowship at Wake Forest School of Medicine in Winston-Salem, NC

Stefan Yakel, DO – Dr. Yakel will be continuing his education in an Orthopedic Spine Fellowship at Twin Cities Spine Center, Minneapolis, MN

General Surgery Graduates:

Melissa Greive, DO – Dr. Greive will be returning to her hometown of Grants Pass, Oregon to join a general surgery practice.

Kelsea Peterman, DO – Dr. Peterman will be practicing general surgery in Port Townsend, WA

NMM+1 Graduates:

Sunil Bhat, DO – Plans not reported

Michael Watson Jr. DO – Dr. Watson will be practicing Family Medicine and OMT at Baptist Health in Paducah, KY

Silver Falls Dermatology Graduates:

Lauren Boudreaux, DO – Dr. Boudreaux will be joining the dermatology faculty at Silver Falls Dermatology in Portland and Salem, OR. She will practice general dermatology as well as laser and aesthetic medicine.

Stephanie Howerter, DO – Dr. Howerter will begin her fellowship in Micrographic Surgery and Dermatologic Oncology with Silver Falls Dermatology

Fellows

Cardiology Fellow Graduates:

Benjamin Lee, DO – Plans not reported

Lindsay Frye, DO – Plans not reported

Silver Falls MOHS Micrographic Surgery and Dermatologic Oncology Graduate:

Benjamin Perry, DO – Dr. Perry will be joining Mountain Pine Dermatology in Meridian/Boise, ID

Featured Abstracts

Incidence of spinal epidural lipomatosis in patients with spinal stenosis

JB Malone, PJ Bevan, TJ Lewis, AD Nelson, DE Blaty, ME Kahan.

DOI: [10.1016/j.jor.2017.11.001](https://doi.org/10.1016/j.jor.2017.11.001) *Journal of Orthopedics*

Introduction

Spinal Epidural Lipomatosis (SEL) is believed to be a rare disorder. The incidence and prevalence of clinically symptomatic SEL in patients with spinal stenosis has never been reported in the literature. Our study aims to determine the prevalence, incidence, and associated risk factors of SEL in patients with the diagnosis of spinal stenosis.

Methods

This is a retrospective study. We reviewed the charts of 831 patients with the diagnosis of spinal stenosis over a 30 month period. All patients had spinal MRIs. Grading of SEL was performed using the Borré method.

Results

52 patients (21 female and 31 male) had symptomatic moderate and severe SEL. We found a prevalence of 6.26% and an annual incidence of 2.5%. SEL was most commonly seen at L5-S1 level. 27% had received corticosteroids. All SEL patients were overweight and 79% were obese.

Conclusions

SEL is not uncommon in patients with spinal stenosis. SEL should be considered as a possible diagnosis in those with symptoms of spinal stenosis especially in those with associated risk factors.

Featured Authors:

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Sporadic Intradural Extramedullary Hemangioblastoma of the Cauda Equina: Case Report and Literature Review

D Blaty, M Malos, T Palmrose, S McGirr

DOI: <https://doi.org/10.1016/j.wneu.2017.10.104>

Background

Spinal hemangioblastomas account for 1%–5% of all spinal cord tumors. Although spinal hemangioblastomas are rare, it is exceedingly rare to have a case of intradural extramedullary hemangioblastoma of the spine, especially in isolation without von Hippel-Lindau syndrome. The purpose of this report is to present a rare case of intradural extramedullary hemangioblastoma of the cauda equina and a literature review.

Case Description

An 82-year-old man presented with an intradural mass at the L4 spinal level on magnetic resonance imaging. Given the benign appearance on magnetic resonance imaging and lack of radiculopathy, the decision was made to observe the patient. Over the course of 4 years, the tumor enlarged and caused left lower extremity radicular pain. Posterior laminectomy and tumor excision was performed. Owing to intimate involvement with multiple nerve roots, subtotal resection was performed. Immunohistopathologic analysis revealed a highly vascular and cellular tumor, with findings consistent with intradural extramedullary hemangioblastoma. The patient ultimately underwent CyberKnife radiosurgery for residual tumor, with improvement in neurologic symptoms. Follow-up studies at 2 years failed to show any tumor growth.

Conclusions

Literature review revealed cauda equina intradural extramedullary spinal hemangioblastoma to be a rare diagnosis. Furthermore, this was a sporadic case without associated von Hippel-Lindau syndrome. Only 20 previous cases have been reported. Immunohistopathologic analysis was required to make the diagnosis. Radiosurgery appears to be useful in cases of residual tumor after subtotal tumor resection

Featured Authors:

Douglas Blaty, D.O – Orthopedic Resident, PGY 5

Michael Malos, M.D. – Neurosurgeon, Good Samaritan Regional Medical Center

Thomas Palmrose, M.D. – Pathologist

Prevalence of osteoporosis in the spine population: implications for patients with spine disease and significance for the spine surgeon.

D Blaty, T Blaty, T Lewis, O Pipitone, N Binkley, P Kaiser, S Swartz, S Ranzoni, A Nelson, C Noonan

Study Design: IRB-approved cross-sectional study

Objective: The purpose of this study is to assess the risk factors for, and prevalence of low bone density (LBD) as measured by dual-energy x-ray absorptiometry (DXA) in a cohort of patients with spine diagnoses in the United States (US).

Summary of Background Data: The presence of osteoporosis in patients undergoing spine surgery has been associated with higher complication rates, including failure of surgical instrumentation and poor fusion rates. Preoperative identification and treatment of osteoporosis have shown to improve outcomes in those undergoing spine surgery. However, osteoporosis is often underdiagnosed and there is no consensus approach to assessment and management of osteoporosis among spine surgery patients.

Methods: Patients at an adult spine clinic were screened, and completed a questionnaire regarding osteoporosis risk factors. ICD-9 spine diagnoses were collected. DXA scans were performed and T-scores recorded to identify patients with osteoporosis or osteopenia. The prevalence of LBD was standardized for comparison to the general US population data.

Results: 144 individuals were included. After standardizing to the US population, the prevalence of osteoporosis was 17.6% and osteopenia 40.4%. Subjects with higher BMI were significantly less likely to have LBD. Those with a family history of osteoporosis were seven times more likely to have LBD. Over one-third of our cohort had a history of low vitamin D.

Conclusions: This is the first study in the US to compare DXA results between the spine population and the general US population. Among patients with spine conditions, the prevalence of osteoporosis was over 7% higher than the general US population. Efforts should be made to screen patients with spine disorders for osteoporosis who are older than age 50, as obtaining DXA scans in this population could avoid complications in those undergoing spine surgery by allowing proper pre-operative optimization and surgical decision-making.

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GME Directory

Wellness Resources

Resources to assist those experiencing burnout, depression and substance abuse:

- ❖ Vital Work Life - [Vital Life for Physicians/Residents](#)
- ❖ Calapooia Employee Assistance Program – From the SHS Insider, search “Calapooia Employee Assistance”; click on the first option and you will be taken to the PDF version of the brochure. Please contact Megan Kinane or you HR office if you are having trouble finding this information.
- ❖ Health Professionals’ Services Program (HPSP) & Reliant Behavioral Health (offered through the State) - [HPSP](#)

If you are battling fatigue – remember that SHS has multiple RESIDENT ONLY sleep rooms available:

- ❖ GSRMC first floor: 2 surgery sleep rooms
- ❖ Ancillary Building second floor: 6 sleep rooms

Counseling Services (Family, marital, relationship):

- ❖ Vital Work Life
- ❖ Calapooia Employee Assistance Program

Financial Counseling (budget and credit counseling, debt management plan, housing counseling (pre-purchase, mortgage, and rent delinquency counseling) and credit report review):

- ❖ Vital Work Life
- ❖ Money Management International - [Money Management International](#)
- ❖ Principal Financial Group

Policies and Procedures

Resident and Faculty access: [New Innovations Portal](#)

All others: SHS Insider: [Policies and Procedures](#) : Departments: Graduate Medical Education