Message from the DIO

By Sugat Patel, MD, DIO

Spring is a time of growth and renewal. Residents and fellows are now well entrenched in patient care and programs are humming along implementing their curriculum. Every spring each GME program begins a period of self-reflection and assessment to evaluate for opportunities for improvement. The process begins with confidential evaluation of each GME program and their faculty including the program director. These evaluations are done by residents, fellows and faculty and are administered by each individual program or by the GME department in the case of smaller programs. In addition, ACGME (the accreditor of our GME programs) annually surveys all residents, fellows and faculty. In this issue of the GME newsletter, we describe the role of the Program Evaluation Committee (PEC) and how they use these evaluations and survey to make programmatic improvement.

Growth with an eye toward improvement not only occurs at the programmatic level but also at the personal level. The success of our GME programs is due to the hard work of all of our faculty. Many of our faculty came to Samaritan Health Services to teach with teaching backgrounds. Others have come to teaching later in their career. Regardless of the background, teaching is a skill that needs constant refinement. On Friday May 31st, SHS GME will be hosting our first annual Faculty Development Conference. This all day conference will target faculty members interested in improving their teaching and evaluation skills. The free CME event is offered to all SHS educators and more information is provided in this issue (page 12).

Our Graduate Medical Education (GME) programs aim to create community-based physicians capable of thriving in a team-based environment and who are dedicated to the well-being of the patient, clinician and communities we serve.

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Teaching Faculty: Don't forget to register for our Faculty Development Day on May 31, 2019. CME provided.

REGISTER HERE

See flyer on page 12 for details

*Please note that throughout this newsletter the term “resident” may refer to both specialty residents and subspecialty fellows.
Samaritan Pediatrics on Circle Blvd opened its doors on September 4, 2018 and is located upstairs in the Johnson Teen Center building at the Boys and Girls Club of Corvallis. This new clinic is a great resource for kids who need a primary care physician, well child checks, immunizations, or just need to be seen for a cold or the flu.

The clinic is currently seeing about 14-20 patients a day and many of these patients are seen for preventative services. Some are coming in for more acute illnesses like the cold or the flu. The clinic can perform Point of Care tests such as rapid influenza testing, rapid streptococcus testing, lead levels, hemoglobin, lipids and urine dipsticks are available. Scheduling is flexible, and the clinic can almost always fit patients in same day.

Samaritan Pediatrics on Circle aims to integrate youth development and health professionals who can provide classes and information in areas including nutrition, physical activity, job readiness and making healthy lifestyle choices. A trained tobacco internationalist is available on-site. This is a wonderful resource to have within the Boys and Girls Club.

One of the great things about this clinic specifically, is that it serves as an additional training site for our family medicine residents. The residents work under the supervision of currently-practicing physicians and will spend some of their time interacting with the Boys and Girls Club members in the Johnson Teen Center and the Clubhouse.

Updates from the Research Development Office:

All about the IRB

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

Paulina Kaiser (epidemiologist) and Olivia Pipitone (biostatistician) from the Research Development Office (RDO) are always available to help you plan, conduct, summarize, and share your research and/or quality improvement projects. Most projects also need to be reviewed by Samaritan’s Institutional Review Board (IRB). The amount of scrutiny (and paperwork) your project will require depends on the level of risk to study participants. Not sure what you need to do? Contact the RDO (shsresearch@samhealth.org) or the SHS IRB Coordinator, Stephanie Mock (SHSIRB@samhealth.org) – we'll help you figure it out!

To submit a project to the IRB, email the following to SHSIRB@samhealth.org:

Note: The IRB will not review your submission until ALL required documents are received. The RDO can edit drafts of all documents!

IRB Submission Form

- Either Form B-1 or Form B-4 (ask RDO or IRB which one)
- These can be found from the SHS Insider > Departments > Research, Grants & IRB > Shared Documents > IRB Submission Forms > Investigator Initiated Submission Forms

Study Protocol

- A clean, final version (no tracked changes!)
- A template can be found from the SHS Insider > Departments > Research, Grants & IRB > Shared Documents > Research Tools and Resources > Study Protocol Templates and Submitting To the IRB

Any other study documents (consent form, recruitment materials, survey questions, data abstraction template, etc)

CITI training certificates for Principal Investigator and all Sub-Investigators

- CITI training is free. Contact the RDO or the IRB for instructions.

CV or resume for Principal Investigator and all Sub-Investigators

If you’re organized and have a low-risk project, getting IRB approval can take a few days. If you have a complicated project and don’t get your ducks in a row, it can take months. Please reach out to the RDO and the IRB so we can help!
The Oregon Chapter of American College of Physicians (ACP) held its Annual Scientific Meeting in Salem, Oregon from November 8—10th. This meeting brings together physicians, allied health professionals, residents and medical students, interested in internal medicine to showcase their posters and oral presentations.

Mark Day, DO (featured on page 4) was one of many residents and medical students who competed during this event, taking second place among the Resident Clinical Research category for his research topic, “HEART Score as a Risk Stratification Tool For Patients With Chest Pain at a Community Emergency Department,” (see page 10 for abstract).

Dr. Day will be traveling to Philadelphia, PA to represent Oregon and present his research topic at the National ACP Residents’ Poster Competition on April 11th, 2019.

Dr. Mark Day takes 2nd place at local ACP Chapter Competition

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Family Medicine resident, Cristina Capannolo, DO, presents at annual research conference in Chicago

The North American Primary Care Research Group (NAPCRG) held its annual research conference November 9-13, 2018 in Chicago, IL. Third year Samaritan Family Medicine Resident, Cristina Capannolo, DO, presented her research topic “Tapering Patients Off Opioids: One Clinic’s Story,” alongside research mentor and collaborator, Bharat Gopal, MD, MPH, Associate Program Director of the Family Medicine Residency. When asked the importance of attending conferences like this, Dr. Capannolo shared that “the annual conference provides researchers at all levels of experience a collaborative and nurturing environment to help receive constructive feedback regarding their work.”

This was Dr. Capannolo’s first research project and she shares how daunting the whole experience can be. Her greatest source of encouragement came from partnering with a research mentor who has years of research experience. “Dr. Gopal helped make the process of learning how to do research a fun and educational one,” shares Dr. Capannolo.

Research projects are one example of how our residents are continually improving our communities health through research and data collection. “I have come to better appreciate the significance and impact that the research we do has on patients and the communities in which we serve,” shares Dr. Capannolo.

Dr. Capannolo and Dr. Gopal conducted their research within the Corvallis Samaritan Family Medicine outpatient clinic over a 14 month period. The purpose was to see if there had been a decrease in the overall and per capita Morphine Equivalent Doses (MEDs) over the study period in response to changes among multiple factors regarding opioid prescribing.

In follow-up to their research Drs. Gopal and Capannolo presented, they wrote a “Letter to the Editor” published in the Journal of Family Practice which can be read here:

To review the full abstract and research poster see page 11.
Resident Spotlight
Mark Day, DO

Residency Program: Internal Medicine
PGY: 2
Hometown: Henderson, NV
Undergrad: University of Nevada Las Vegas
Medical School: Des Moines University, Des Moines, IA

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

What did you do prior to medical school?
I’ve always enjoyed medicine, given that my father had a private family practice in Henderson, but I was unsure if that was the path I wanted. I graduated high school planning for a business degree, which seemed too boring for me, so I considered hotel administration given that I was at UNLV in Las Vegas. This interest lasted two weeks because my Dad’s associate informed me how the current 2008 recession had taken so many of the hotel industry jobs with it. Finally, I landed back on medicine, given that this was something that I had always been around and enjoyed, and I knew that helping people was what I really wanted to do for my life.

What is your most memorable moment or proudest moment during residency?
First is getting into residency, but since then I would have to say presenting my research at ACP and being able to be proud of something that I put so much work into.

Favorite interest/hobby?
Currently my biggest obsession is podcasts, medical and historical are my go-tos. I also enjoy taking my dog to the dog park and spending time with my wife.

Do you have any advice for current and/or future medical students?
A tip I got early in 3rd year of medical school, which still rings true to me is: “whatever specialty you choose there will be the rare diseases and ‘zebras’ out there, but there are also the common things and if you don’t love the common things in a particular specialty then it’s not for you.”

Prior to residency, what was your most unusual or interesting job you have had?
Prior to undergraduate I worked at Primm Valley Golf Course on the Nevada-California border for a summer doing maintenance. It was fun because I was with my best friend Chase, but early mornings in the desert heat were brutal. Prior to medical school I had graduated undergrad and was still doing interviews and needed some extra money so my sister got me a job as a food runner at a restaurant on the Strip called First, which closed after it was sold. It was a good experience and I was able to meet many different people.

Family Life
Married to my wonderful wife of four years, Ashley, currently living in Albany with our 1.5 year old chocolate lab, Maple, and hoping to stay in Oregon/Northwest for as long as possible.

What is on your wish list for the next 10 years?
With my career: graduate from residency, get into a Cardiology Fellowship, get a job (hopefully) within the Northwest, and maybe at some point consider going back to Las Vegas.
Personal life: my wife and I having one to two children, establishing a home and some more dogs…. the doors are open and we are ready for what is to come.

“Whatever specialty you choose there will be the rare diseases and ‘zebras’ out there, but there are also the common things and if you don’t love the common things in a particular specialty then it’s not for you.”

Find time for yourself, it is difficult, but if you can make a commitment early on to set aside specific time for you, it truly pays off later on.
Enjoy every moment of Medical School and the time you have to learn without pressure, soon it will become your job and you will get paid to do the job you love, but until then you have this freedom to explore things in a protected space of learning that you do not get anywhere else and that is the best.

Please send all resident nominations to Megan Kinane at mkinane@samhealth.org
Please include the following:
Subject Line: Resident Nomination
Email Body: Include the reason for nomination
Wellness Corner
Substance Abuse Part 2

Last issue we began our first mini-education series on substance abuse, its risk factors and its effects on professional lives. We identified the six substances most commonly abused by physicians and how to recognize common indicators, signs and symptoms of substance abuse in residents and faculty. This issue will focus on favorable treatment outcomes of substance abuse in residents and faculty, review the recovery rate and discuss strategies for creating a non-punitive, collegial culture in addressing the issues of substance abuse.

The information provided in the Wellness Corner is driven by research that has been conducted over the years regarding residents, physicians and their wellbeing. Educational content for this piece comes directly from the Learning to Address Impairment and Fatigue to Enhance Patient Safety (LIFE) curriculum developed by Duke University.

Identifying those at risk of substance abuse can be challenging for a number of reason. Denial of an addiction problem is high and it can occur on all levels of the institution, the resident, peers, and the family/significant others. If someone suspects that substance abuse is occurring they may stay silent in fear of retribution, causing legal problems, risking a friendship or alienating a person they value, but most importantly they may fear that reporting a colleague’s addiction will end his/her career. It is important that institutions, residents, peers, family members and colleagues refrain from taking a punitive approach when dealing with someone who is experiencing substance abuse.

Traditionally, substance abuse has been treated as if it were a morale or ethical failure instead of a disease. Physicians who became addicted faced extreme disciplinary measures, including loss of the medical license. Now, addiction is viewed as a disease and there are medical societies and programs in every state designed to help physicians deal with substance impairment.

What do you do if substance abuse is identified?
1. Be familiar with your institutions/programs policy regarding Physician Impairment.
2. Intervention should take place with the help of a team (physician associated with employee health, a director of the physician wellness committee, or the Physician Health Program (PHP) in your state).
3. Use a trained, experienced leader for the team.
4. Select the site of the confrontation carefully (e.g., choose a quiet, non-threatening neutral space).
5. Work with the clinician to find a therapeutic pathway. These pathways consist of clinicians and/or programs in the area that can provide substance abuse treatment.

PHP: Using your state’s PHP can be of enormous help. The key components of a PHP consist of evaluation, referral for treatment, aftercare, and monitoring of the physician. Once the individual has been evaluated and referred by the PHP, treatment proceeds on an individual level of need. Some may require detoxification which requires inpatient care while others may be suitable for outpatient care.

Prognosis for addicted physicians: The prognosis for addicted physicians is good. Re-entry into the work field may offer particular challenges to the physicians in addition to resumption of duties and staying substance-free. Many experience guilt because of their absences and humiliation because of their addiction. It is important to maintain a therapeutic and non-punitive environment.

Steps programs can take to help combat substance abuse in residents and faculty:
1. Educate residents to raise awareness about stress, fatigue and other conditions that contribute to substance abuse
2. Recognize the prevalence of substance abuse. Be proactive; establish procedures to address the problem and assist in recovery
3. Educate graduate medical trainees (i.e., residents and fellows) and attending faculty about your program/institution’s substance abuse policies
4. Increase awareness of the resident’s professional and ethical responsibility to physician colleague with substance-abuse issues, including how to find assistance for a colleague they suspect is addicted
5. Differentiate myths from reality regarding substance abuse for residents, their families and attending physicians
6. Define a clear, confidential process for referral and self-referral of resident and faculty with substance problems
7. Think carefully through who needs to know the information regarding the physician. It is important to preserve the trainee’s confidentiality.

Oregon PHP Program: Reliant Behavioral Health Monitoring and the Health Professionals’ Services Program (HPSP)
The purpose of HPSP is to provide a statewide confidential monitoring program for licensed healthcare professionals who have been diagnosed with a substance use disorder and/or mental health disorder. HPSP has two important goals:
1. Supporting public safety.
2. Assisting health professionals (licensees) with substance use disorder and/or mental health issues so they may continue working in their chosen profession.

For more information on Oregon’s HPSP program call 888-802-2843

For a list of wellness resources see page 13 or contact Megan Kinane at mkinane@samhealth.org

Alumni Spotlight
David Lemons, DO

**Residency Program:** Internal Medicine
**Completed Residency:** 2012
**Fellowship Program:** Cardiology, Interventional Cardiology
**Year graduated:** 2015; 2016
**Medical School:** Kirksville College of Osteopathic Medicine
**Hometown:** Jefferson City, MO
**Current Practice:** Eureka, CA

*Where has life taken you after residency?*
After completing residency and two fellowships with Good Samaritan Regional Medical Center, I worked in Branson, MO for two years and then moved to Eureka, CA where I work as Cath Lab and STEMI Director. I have started a high risk PCI program with Impella assisted PCI and Orbital Atherectomy. My wife Lisa completed her psychiatry residency program with Good Samaritan Regional Medical Center in 2016 and we have a three-year old son, Charlie.

*What is your great takeaway from residency?*
Listening to the patient will provide a diagnosis in 80% of cases.

*Best words of advice/wisdom from residency faculty members?*
**Dr. Toggart:** His advice is continually helpful to keep my professional career in perspective. He is a mentor who provides excellent professional and life support.
**Dr. Greschner:** who provides sound advice regarding cases and work/life balance
**Dr. Marker:** always provides a practical and holistic approach to cardiology.

*Advice for current residents and/or medical students?*
Enjoy the camaraderie in residency/fellowship and cherish the academic learning and discussions as those are the things I miss the most.

*Biggest surprise when hitting the “real world”?*
I felt comfortable performing my job at the end of fellowship, but I was not prepared for the shift in responsibility and the anxiety that hit when I was solely responsible for patient’s lives and did not have attendings in close back-up. Even though you don’t think about it on a daily basis and think you are making decision on your own, the knowledge that attendings are right there provides a subconscious relief that is not realized until you’re in the real world.

*What do you miss most about the Corvallis area?*
My wife and I miss the circle of friends and support from Corvallis. It is a nice city to raise family with great local events.

*Where do you see yourself in the next 10 years?*
We see ourselves settling into a family friendly community with supportive colleagues and friends.

*Favorite Hobby?*
Watching movies with my wife and jogging when I get a chance.

*If you were to start all over again would you choose your same career/specialty?*
I would choose the same specialty if I had to do it again. I enjoy the Cath Lab.

"Enjoy the camaraderie in residency/fellowship and cherish the academic learning and discussions"
Quality and Patient Safety
Clinical Learning Environment Review (CLER) report

On October 30-31, 2018, Good Samaritan Regional Medical Center, as Sponsoring Institution of our residency and fellowship programs, had its first CLER site visit. The CLER program was implemented by our accrediting body, ACGME, to provide teaching institutions periodic feedback designed to improve how their clinical sites engage residents and fellow physicians in learning to provide safe, high quality patient care (ACGME). Over a two-day period the site visitors met with multiple stakeholders in our institution.

Rather than looking strictly at our residency and fellowship programs (which occurs during accreditation site visits), they review our institution as a whole and meet with our executive leadership team; our leaders in patient safety, health care quality and wellbeing; our GME leadership team; groups of residents and fellows along with faculty members and program directors. The site visitors also visited various patient floors, units and service areas and interacted with all clinical staff members to gain a better understanding of how we function as a whole.

After the two-day review the Institution awaits the written CLER report that provides feedback in each of the six focus areas and from there use the report as a tool to create ongoing goals for improvement. Based on the report, the Designated Institutional Official (DIO) wrote up the following response plans:

**Patient Safety:** Improve reporting of patient safety events by continuing to encourage meaningful event reporting by trainees, faculty and staff. Improve understanding of the wide range of reportable events and to provide timely feedback on outcomes of events reported. Improve knowledge on event investigations such as root cause analysis and patient safety principles, methods and tools through direct education workshops and by partnering with the institutions quality and patient safety departments.

**Healthcare Quality:** Continued improvements in aligning priorities of the faculty and program directors with that of the sponsoring institution. Improve residents knowledge of quality improvement processes through direct education. Develop tools to improve clinical outcome and provide provider specific data on their patients.

**Healthcare Disparities:** The sponsoring institution does not have a formalized strategic plan for addressing health care disparities and will work towards developing a strategic plan as one of our top priorities.

**Transitions in Care:** Continue to look for opportunities to improve transitions of care. We are pleased to announce that the site visitors witnessed a transition of care event that met all of the goals of a properly conducted transitions of care. We seek to improve education on transitions of care by implementing a dedicated session on transitions of care during intern and fellow orientation.

**Supervision:** Improve staff awareness of our web-based database that provides a list of procedures and supervision required for each resident and fellow. Improve faculty education on supervision.

**Well-being:** GSRMC has created Wellness Committee with the goal of implemented various initiatives to include proactive monitoring burnout amongst providers, creation of a peer mentorship program, offering mindfulness course and re-evaluating the EMR and physician portal to eliminate barriers to efficacy and fostering a sense of community.

**Professionalism:** We were pleased to see the overall assessment in honestly in reporting, integrity and respectful treatment of others was good. GME will continue to provide TeamSTEPPS Level 2 training for all residents and fellows.

The GME office, with collaboration from our executive leaders and quality and patient safety departments, will continue to monitor our initiatives and strive for continued improvements among the six focus areas. The greatest takeaway from all this was the opportunity to bring together GME and other departments in our institution to work as one resource and better align our goals.

Did You Know?
Program Evaluation Committees (PEC)

As mentioned in the DIO’s message—spring time in GME is the time to evaluate and reflect on the previous academic year and begin planning for the next. Per the requirements of ACGME, our accrediting body, each residency program must have a Program Evaluation Committee (PEC) that consists of at least two faculty members and a resident from that specific program. In addition to the minimum requirement, many PECs also include the program director, associate program director and program coordinators. The PEC committee is responsible for four major areas:

1. Planning, developing, implementing and evaluating educational activities of the program
2. Reviewing and making recommendations for revision of competency-based curriculum goals and objectives
3. Addressing areas of non-compliance with ACGME standards, and,
4. Reviewing the program annually using evaluations of faculty, trainees, and others

The final step of the PEC is to prepare a written action plan to document initiatives to improve performance in one or more areas (listed below) of the Program Report Card, as well as delineate how they will be measured and monitored. This full report is known as the Annual Program Evaluation (APE). The metrics of the APE are developed by the DIO to ensure the appropriate oversight of each program and to see a snap shot of how they are performing. These metrics are reviewed annually and may change depending on newly written ACGME standards or due to an oversight preference of the DIO in areas that are of concern. Below is a list of all required metric areas, along with some examples of what is needed in each domain:

1. Resident/Fellow Performance
   - In-Service exam scores for the previous five years
   - USMLE/COMLEX scores for the previous five years
   - Scholarly activity (e.g. PubMed IDs, conference presentations, chapters/textbooks, teaching/presentations)
   - List of all quality projects
2. Faculty Development
   - Scholarly activity of core faculty
   - List of faculty development activities (i.e., participation in ACGME/AOA, national specialty society, and other educational conferences)
3. Graduate Performance
   - Board certification exam pass rates of graduates for the previous five years
   - Number of graduates accepted into fellowship position
   - Numbers of graduates placed in SHS (total), Oregon (total including SHS)
4. Program Quality
   - ACGME accreditation status and recent citations
   - ACGME Resident/Fellow and Faculty survey results
   - Program Director, faculty and administrator turnovers
   - Applicant statistics
   - Match results
5. Program Specific Policies
6. Activities and policies complying with patient safety, quality improvement, supervision and accountability, professionalism, wellbeing, fatigue mitigation and transitions of care
7. Progress on the previous year’s action plans and,
8. New action plan items and monitoring procedures

Every Fall, each program submits their APE to the Graduate Medical Education Committee (GMEC) for review. The DIO gathers all the data provided and uses these metrics to develop the Annual Institutional Review (AIR) report (see the next issue of GME Did You Know for details about the AIR), which is presented to the GSRMC Board of Directors.

Resources: ACGME Common Program Requirements (2017)
Vascular Skills Lab
General surgery residents participate in faculty led skills course

On November 12, 2018, general surgery residents and their faculty took part in a vascular skills lab sponsored by LeMaitre Vascular Inc. Vascular skill labs like this are intended to expose residents to vascular grafts and provide them with the opportunity to use vascular suture/instruments in a controlled environment. "The goal of these labs is to increase comfort with suture and instrument handling when using fine suture," shares Associate Program Director of the General Surgery residency program, Jennifer Serfin, MD, "this gives them an opportunity to practice skills before being involved in a high stakes case.

Residents were instructed by their program director, Toshio Nagamoto, MD and associate program director, Dr. Serfin, along with core faculty members Sean McCully, MD and Erika La Vella, DO.

Resident and Fellow Procedure Verification Lists
Now available on the GME Department Page!

Resident and Fellow procedure verification lists are now available on the SHS Insider by accessing the Department page: Graduate Medical Education: Shared Documents: Resident and Fellow Procedure List

Having these lists available allows all staff to be able to look up the level of supervision required for each resident and fellow. This list is not comprehensive and will be edited semiannually.

Blank box= the resident has not been signed-off to do this procedure with indirect supervision and must have direct supervision, meaning the attending physician or senior resident who is signed off must be present.

"X" = resident can perform this procedure with indirect supervision, meaning the attending physician must be available on site or by phone, but does not need to be in the room.
Featured Abstracts
HEART Score as a Risk Stratification Tool For Patients With Chest Pain at a Community Emergency Department

MT Day, SJ Mangum, O Pipitone, and JF Greenblatt

Acute coronary syndrome (ACS) includes unstable angina, non-ST elevation myocardial infarction, and ST elevation myocardial infarction. Risk factors for ACS include hypertension, hyperlipidemia, diabetes, and other common comorbidities. These risk factors are often used in risk calculators for patients with chest pain to help accurately identify those with ACS and provide timely intervention and management. The HEART score (HS) is a risk calculator that was developed in 2008 to determine the risk of major adverse cardiac events within 6 weeks of presentation to the emergency department (ED) with chest pain. The HS was validated by a prospective multicenter trial in 2013, which reported 96.7% sensitivity and 47% specificity. Previously, we demonstrated that 14% (n=249) of individuals who presented with chest pain to the ED of a community hospital in suburban Oregon in 2016 were eventually diagnosed with ACS; of which 79.5% were diagnosed within one day 14.5% were diagnosed within 6 weeks, and 6% were diagnosed after 6 weeks from their initial presentation. To investigate the utility of the HS in this population, we retrospectively collected data on risk factors at the time of initial presentation and calculated a HS for these 249 individuals diagnosed with ACS. After calculating the HS we found that 111 individuals (45%) were high risk, 130 (52%) were moderate risk, and 8 (3%) were low risk for major adverse cardiac events within 6 weeks. In those with a high HS, 78% had been diagnosed within 24 hours, 14% within 6 weeks, and 7% after 6 weeks of their initial presentation. Similarly, in those with a moderate HS, 81% were diagnosed within 24 hours, 14% within 6 weeks, and 5% after 6 weeks of their initial presentation. Of those with a low HS, 75% were diagnosed within 24 hours, 25% within 6 weeks, and 0% received a diagnosis of ACS after 6 weeks from their initial presentation. Results also showed a higher burden of hypertension (78%) and hyperlipidemia (64%) in this population than in the general population. These findings elucidate prevalent risk factors and the functionality of calculated HS in our community ED for adults who present with chest pain. Furthermore, 51 ACS events (20% of those with diagnosed ACS) were diagnosed more than 24 hours after presentation; with utilization of HS, these patients would likely have had further workup and possibly earlier detection.
Cristina Capannolo DO, Bharat Gopal MD, MPH

The ‘opioid epidemic’ is a ubiquitous topic in present day society, with opioid misuse and the resultant risk of overdose steadily on the rise over the past several years. Consequently, opioid related deaths have followed this upward trend. Oregon ranks amongst the highest in the nation for opioid related overdose. This study offers one clinic’s story of how it has responded to these alarming statistics by working with individual patients to taper off of opioids. The study is a retrospective statistical analysis of the opioid prescribing practices in an outpatient family medicine clinic, the Samaritan Family Medicine Resident Clinic (SFMRC). The primary outcome measure is evaluating if a change in opioid prescribing practices occurred as a direct response to the rising trend of opioid misuse and harm. The primary data in this analysis includes opioid prescriptions that originated from four attending physicians at SFMRC between June 2015 and August 2016 that were gathered via a DEA query of the Oregon Prescription Drug Monitoring Program. A formula was created to calculate the morphine equivalent doses (MEDs) for each patient, which allows for standardization of the different opioid formulations. Data analysis was performed and results show that there was an overall decrease by about 50.11% of prescribed MEDs over the study period. In evaluating the per-capita MEDs, there was an overall decrease of about 41.09%. These results suggest that SFMRC has responded to the current opioid epidemic and uses the ecological systems approach model to demonstrate how these results were achieved. This framework explains the different influences, or layers, involved in changing the individual patient’s perspective regarding changes in the healthcare climate.
Graduate Medical Education is pleased to announce this inaugural faculty development day session. Content is applicable to all clinician educators within our community and will focus on evaluation feedback, professionalism and supervision. CME credit will be offered for each of these sessions. We hope you can join us.

**REGISTER HERE**

**Target Audience:** All teaching clinicians

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**Improving the Evaluation of Residents: Effective Feedback Techniques & Accurate Faculty Evaluations**

**Learning Objectives:**
1. Explain 10 important principles that form the foundation of an effective evaluation system.
2. Identify 10 common psychological barriers that prevent program directors and faculty from talking with residents who exhibit unsatisfactory performance or unacceptable behavior(s) and techniques to overcome these barriers.
3. Describe a Five-Stage Process to effectively give crucial instructive feedback and strategies for managing the resident's reactions at each stage.

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**Professionalism, Entitlement Mentality and the Millennial Learner: The Good, The Bad and The Challenge**

**Learning Objectives:**
1. Describe seven behavioral elements of professionalism to promote excellence in patient care.
2. Describe some positive characteristics of millennial learners as well as some signs of impaired judgement resulting from an "entitlement mentality."
3. Describe four strategies that program directors and faculty can use to help learners overcome this impaired judgment.

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**Improving Faculty Supervision: Implementing a PROACTIVE Approach to Ensure Patient Safety**

**Learning Objectives:**
1. Explain the Five-Step Learning Curve and how to use it for assessing a resident’s learning needs and determining the appropriate level of supervision.
2. Describe a proactive approach to faculty supervision of residents that complies with ACGME requirements and ensures safe patient care.
3. Explain the importance of the Milestones for determining a resident’s achievements.

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**Faculty & Planner Disclosures:** The presenters and the planners of this program report that they have no conflicts of interest or relationships with any commercial entities that might affect the contents of this presentation.

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This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the Samaritan Health Services. Samaritan Health Services is accredited by the Oregon Medical Association to provide continuing medical education for physicians. Samaritan Health Services designates this live educational activity for a maximum of seven (7) AMA PRA Category 1 Credit™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.
GME Directory and Resources

Wellness Resources

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

◊ Vital Work Life (For Residents/Physicians)
◊ Calapooia Employee Assistance Program—From the SHS Insider, search “Calapooia Employee Assistance”, click on the first option and you will be taken to a PDF brochure. Please contact Megan Kinane or your HR office if you are having trouble finding this information.
◊ Health Professionals’ Services Program (HPSP) & Reliant Behavioral Health (offered through the State)

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 (for Residents/Physicians)
◊ 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
◊ Principal Financial Group

Policies and Procedures

Resident and Faculty access: New Innovations Portal
All others: SHS Insider: Policies and Procedures: Departments: Graduate Medical Education