evolution of care
Our goal at Bay Area Hospital is to provide the highest level of care as the premier medical center for the Oregon Coast. I don’t believe that goal can be attained by standing still however. So, while we work to deliver excellent care every day, we are always looking for ways to evolve.

This issue of Currents looks at some of the recent advances we have made and the steps we are taking to advance our mission. You will read about our new, cutting-edge technology being used in the fight against cancer—a linear accelerator that allows Dr. Mark Henderson and his radiation oncology team to expand their battlefront and offer more people the option of being treated closer to home.

In fact, we include testimonials from two local patients—one being treated for cancer and the other who received lifesaving cardiovascular treatment at our Prefontaine Cardiovascular Center—who are appreciative of having received world-class care right at home.

Not all evolution in local healthcare is limited to technological innovations. You will be introduced to the new Joint Replacement Destination Center, which advances the way total joint replacement procedures are viewed, treated, and studied.

Evolution is also synonymous with change, and in that way Bay Area Hospital is evolving, as well. You will meet some new members of our team and hear from a member of the Bay Area Health District Board, who is returning to a volunteer post on that important body, which oversees all that goes on within and concerning the hospital.

In short, this issue of Currents will bring you up-to-date on some of the great things that are happening in and around our hospital, and it will introduce you to some new members of the community who are working with us to bring you the highest possible level of care.

Paul G. Janke, FACHE
President and CEO
Recently United

Bay Area Cancer Center

Gets a New High-Tech Weapon

Bay Area Cancer Center has come a long way in a little over a year and a half since it formally united the local fields of radiation oncology and medical oncology.

Our new linear accelerator shortens treatment time and increases effectiveness.
The doors of the updated facility on the campus of Bay Area Hospital opened in July 2015, and patients have been flowing through ever since. The uninterrupted treatment of patients was taking place even as the two offices worked tirelessly behind the scenes to continue the vital process of integrating the Cancer Center as a single department.

Dr. Henderson handles radiation oncology on one side, with Dr. Cherry and Dr. Cook heading up medical oncology on the other. Dr. Henderson says that a lot of time has been spent working on the electronic medical record system, known as MOSAIC, which allows both departments to see a patient’s records in real time.

“I think this is very important because knowing, in real time, what the other part of the Cancer Center is doing helps us better coordinate care with patients,” says Dr. Henderson. “There are many patients who receive both radiation and chemotherapy. By having both under one roof, not only can we have on-the-spot consultations with one another if we have a question but we can also see on the computer when someone has been seen, when someone is going to be seen next by the other office, and where they are in their treatment. Then we can coordinate the corresponding treatment even better.”

One big weapon to use in that treatment is a brand-new linear accelerator. This multimillion-dollar upgrade over the previous linear accelerator includes recent advances that allow for very high doses of radiation to be delivered over one, three, or five treatments. This shortens the treatment time by many weeks and increases the effectiveness. This new process, called stereotactic treatment, isn’t beneficial in all cases, however. Dr. Henderson says you have to treat things that are small enough and that are separated enough from important organs to be safe.

The linear accelerator is being installed in phases. The second phase will provide attachments that allow for easier treatment of very small targets inside the brain. The third phase comes as part of the stereotactic program.
As a US Air Force brat growing-up and later an F-15 pilot during his own long career in the air force, Richard "Mac" McIntosh has seen much of the world. But when cancer rocked his own world in 2015, he chose a battleground close to home.

Home for Mac is Coos Bay, where as a teenage track athlete he met the girl of his dreams at Marshfield High School. After graduation he and Linnea Wright would go on to marry and chart a course together that included a number of stops around the country, but they always knew they would be back to Oregon to retire. For Mac true retirement didn’t last long. In 2009 he returned to his roots and became the head coach of the Marshfield High track team—a team he leads for a ninth season this spring.

But the past couple of years have been a little different. In September 2015 Mac was diagnosed with Stage IV pancreatic cancer. Says Mac, “Some people look back and say, What if I had done that? or What if I had known earlier? I’ve lived my life with the mantra, What could’ve happened did. I refuse to look back. Now I’m here. Now what do I do with what I’ve got?”

A few months earlier, Mac’s Rotary Club had happened to tour the new Bay Area Cancer Center facility. He was impressed, but he never thought he would be thinking about seeking treatment there. When the cancer spread, however, and
radiation and chemotherapy were the next course of action, he fought to go out of his insurance network to get his treatment at Bay Area Cancer Center—and he hasn’t looked back.

“It is world-class,” says Mac. “I tell everybody that. Here’s why: I’ve become a semi-expert in Internet lore in pancreatic cancer because, like everything else, I’m all in. I’m going to become an expert; I’m going to read about it and understand it. I’ve learned that the procedures I’m going through at Bay Area Cancer Center—the chemotherapy protocol, the regimen that they are putting me on—are exactly what they are doing at the Mayo Clinic and at all the great cancer centers. They’re standard protocols of treatment. There is nothing different that happens here.”

Mac also gives high marks to his doctor, Bret Cook, MD, the nurses, and the office staff. It is much more than just proximity to his home, though that helps, as well. “There are three legs to my treatment protocol. One is the medical staff and the world-class treatment that I’m getting there. Another is the support system: I’ve married the woman of my dreams, and there is no one better. Outside of that my family is very supportive, and the local community is very supportive. Beyond that, the guys I was in the air force with are all pulling for me. There is a group of people who I know care, and I don’t want to disappoint them. I just don’t want to let them down.

“Spiritually, you’ve just got to have faith in something. I have faith in the medical protocol, but I also have faith that there is something bigger at work. If I can somehow harness that—that is the third leg. For me my journey, at least, is enhanced by my attitude. "I refuse to quit. I’ve never quit anything in my life. I refuse to quit this as well.”
“The first phase was the main portion of the linear accelerator,” says Dr. Henderson. “That has increased our imaging capabilities, so I can see more before each treatment. But we need some additional add-on equipment—which has already been purchased; we are going to be installing it over the next few months, and that will allow us to do the stereotactic treatments.

“Then the hospital is going to be purchasing a new planning CT [computerized axial tomography] scanner that we will use to create radiation plans,” he adds. “That’s going to let us open up these treatments to even more patients because the planning scanner will allow us to follow tumors as somebody breathes; we can see where they are in time—as somebody is breathing on the table.”

All this technological progress is occurring alongside an increase in the partnerships that have been created through the Knight Cancer Institute Community Partnership Program at OHSU (Oregon Health & Science University). Grant funds from the OHSU Knight Cancer Institute allowed for the establishment of telemedicine services at Bay Area Cancer Center, to enable specialty consultations with physicians at OHSU in Portland.

This is a tremendous benefit, says Dr. Henderson: “Sometimes we need to hear from people who specialize in a certain disease site. When you are at a large academic center, you subspecialize, so you are no longer a radiation oncologist—you are a radiation oncologist who treats head and neck cancer. As you can imagine, if you are seeing a patient with a very complex case and you treat all different types of cancers, you might want to hear from somebody who treats just that type of cancer.”

And the sharing of knowledge doesn’t end with the telemedicine consult. Bay Area Cancer Center was also the first to sign on with the OHSU Knight Cancer Network to ensure that the evolution of care continues for the foreseeable future.

“That is a way for the Knight Cancer Institute to bring its knowledge to other places in the state,” says Dr. Henderson. “We are in constant collaboration with them to help continuously raise the level of cancer care that we provide here.”

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Welcome (Back),
Mark Sheldon

Mark Sheldon is returning to service in the Bay Area Health District. After having already served terms on the Finance Committee and the Board of Directors, he is making his return to the Board. He says his addition means that the Board will now consist of a retired physician, an active physician, a retired CPA, an active CPA, and—as Sheldon sees himself—a business operator. He says that is a good mix, as aspects of all those professions are ongoing in the operation of the Bay Area Health District.

We recently sat down with Sheldon to discuss this move and his perspective of Board work.

What interests you in working on the Board?

My background is in business. I’ve been in private business for 47 years, and this is a way I can contribute. I’m not a guy with a hammer and nails or a wrench, but I do understand organizations and how they operate. This is a way for me to be able to help.

How important is it for the Board to include people who don’t come from a medical background?

It’s very important. We have shifting footing underneath us regarding changes in how 70 percent of our population is going to pay for medical care. That would be changes through CMS [Centers for Medicare & Medicaid Services] and Medicaid. We have the Affordable Care Act—and we have discussions about that changing. There are a variety of financial aspects of our operation—or the underpinnings of the operation—that are changing on an ongoing basis, and that is a familiar environment for anyone who has owned or operated or managed businesses.

What do you feel is a primary mission of the Board?

While we are fortunate to have fantastic services and top-class staff, you are trying always to improve the quality of the services you provide. You are also trying to expand the services you provide because we need a variety of services here in our area. I’m very proud that there has been—over every decade—that kind of growth and that kind of improvement.
Jon Yost, MD, FAAP, officially took over as Bay Area Hospital’s chief of staff on January 1, 2017. The 1990 Bandon High School graduate is the latest to take a turn at the important liaison role between the hospital and its physicians, a role that had most recently been filled by Wendy Haack, DO.

“I’m excited where we are at,” says Dr. Yost. “I think the former chief of staff has done a lot to reinvigorate the medical exec staff and make us more effective. I’m just looking to take that framework that Dr. Haack built and continue to grow it and develop it further.”

Dr. Yost brings a different kind of skill set to the position. After Bandon High and Oregon State University, he graduated from the OHSU School of Medicine in 2000 and served his residency at the Children’s National Medical Center in Washington, DC, before returning to work at Bay Clinic in Coos Bay.

He says there are a lot of communication skills that are needed as a pediatrician, referencing an adage that there are two patients in the room: the child and the parent. “I like to build rapport with patients. I like consensus. I like to lay out options and get the parent’s input.”

Sometimes a parent wants a dictator, but Dr. Yost says he tends to be more of a consultant. It is that tendency that he feels will serve him well as chief of staff, as one of its roles is serving as the physicians’ main voice: “Sometimes the needs of the hospital are not exactly aligned with the needs of the physicians. Both always need to be aligned with the patients’ needs. When there is a misalignment, I am the voice of the physicians.”

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Dr. Yost adds with a wry smile, “I’m wondering if some of the parenting tricks I teach my parents are going to help as chief of staff, but it’s probably a little more complicated than that.”
Anesthesiologist
Mark Gillis
Assists Patients through Humor

When it comes to surgery, the anesthesiologist is typically one of the last people a patient sees before the procedure starts. It is a responsibility that Mark Gillis, MD, and his 10-person department take very seriously, although often with a bit of humor thrown in to help put patients at ease.

“I think people, right before surgery, are very stressed,” says Dr. Gillis. “They are afraid of the unknown, and that is a normal thing, so I like to bring a friendly demeanor so that they are able to laugh a little bit and let the stress out. Of course, we can do some of that chemically, but it is so much more fun to have a laugh with the patient, to joke with them, to let them know that we are human and we care about who they are.”

The board-certified anesthesiologist from New Mexico joined Bay Area Hospital as its new head of anesthesiology in July 2016, and he hit the ground running, trying to make sure everyone was on the same page and moving in the same direction. That didn’t take very long, he says, because he quickly found that the department has outstanding people who do excellent work every day.

Now that he has settled in, the rest of his mission is to stay on top of what is a rapidly changing practice. “It is very dynamic,” says Dr. Gillis. “Some of the things that are coming to light now are the advantages of doing different types of blocks—not anesthetizing the whole person but rather just the area that needs to have surgery. We don’t stress your heart and lungs. We can’t do that for all surgeries, but it is a useful tool and it continues to evolve to where we are doing more and more with fewer anesthetics.”

Outside the hospital, Dr. Gillis says he is a sailor and he loves living and working near the water. “I’m really happy to be in Coos Bay. I think people underestimate the beauty of this place and the warmth of the people here.”
Among the recent new arrivals to Bay Area Hospital came a pair of interventional cardiologists. John Frank, MD, and Wojciech Nowak, DO, who had practiced together in Appleton, Wisconsin, joined Ricky Latham, MD, at the Prefontaine Cardiovascular Center in February. The pair will not only help shorten the wait for a cardiologist consult on the South Coast but also provide other services, such as peripheral interventions. Dr. Latham says that covers other heart-related issues, in addition to problems with blood flow to the legs. For instance, they can help people who get cramps in their legs when they walk—called claudication—as well as people who have very bad profusion in their extremities, from diabetes or chronic smoking, to the point where the surgeon may even be considering amputation.

“These gentlemen can actually go in and help open those arteries for limb salvage to save people from having that kind of surgery,” says Dr. Latham. “Not only do they know each other and do this complex peripheral work together as a team but also it expands our cardiology emergency on-call services.”

Although Dr. Frank and Dr. Nowak worked together in Appleton, their backgrounds are diverse. Dr. Frank was born and studied in India before making his way to the Midwest. Dr. Nowak hails from Poland but studied at Michigan State. Both chose to come to Coos Bay for the opportunity to help build a growing cardiology program.

“We saw that there was an opportunity and there was a need,” says Dr. Frank. “They had a program to take care of people with heart attacks—a STEMI [ST-segment elevation myocardial infarction] program—but there wasn’t a full-blown cardiology program, in terms of having a clinic, in terms of having an outreach program, in terms of having a follow-up opportunity for patients. We have since started up our clinic, and now we are going on to other things like setting up an outreach program, and—more importantly—we’ve started up the peripheral vascular program.”

Dr. Nowak says that the people of the South Coast will find him to be pretty straightforward, with the goal of keeping them in good health. “I want to know what their problems are. I’ll tell them what I think. And we’ll take it from there and work together to better their health.”
“We were going to cruise from Rome to Miami. On my last day in Rome, I start getting some chest pains—modest chest pains. I think nothing of it. I think, It can’t be my heart; you know, with the heart you get the big chest pains like an elephant sitting on your chest. I didn’t have an elephant; I had a sparrow, and it lasted only five minutes. So, I’m not worried about it.”

Throughout the cruise however, the sparrow returned, but the pain lasted only a few minutes, so Gordon still thought nothing of it. Upon his return he mentioned it in passing to a friend. Fortunately for Gordon, that friend took things much more seriously and insisted he see his doctor.

Lab results and an EKG (electrocardiogram) seemed to reinforce Gordon’s suspicion that it was nothing, but Kent Sharman, MD, wasn’t completely sold. He sent Gordon for what is called a nuclear stress test.

“Two days later they got me in and took a lot of pictures of my heart; then they got me on the treadmill, and that’s where the world caved in. I was on that treadmill for less than four minutes. I was not working up a sweat. I was hardly working, and all of a sudden my chest started hurting like it had every other day. I said to them while I was on the treadmill, ‘This is really cool. My chest is starting to hurt, and I’m going to prove to you it’s not my heart because it will be gone before I even get off this stupid treadmill.”

But his blood pressure told another, more serious tale. It was over 250, and soon they were taking a closer look at his heart. What they found was an extreme blockage—preventing almost any blood from finding its way into his heart. Moments later Gordon was being prepped for surgery.

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Total Joint Wellness Program

Joint Replacement Destination Center

Sometimes a change of care in a certain medical field hinges on a technological or academic breakthrough; other times it comes down to a meeting of the minds. Chief Nursing Officer Regina Rose says the Joint Replacement Destination Center, which kicked off last November and officially launched in April, is one example of the latter.

“This is a nationally recognized program that we are putting in place,” says Rose, adding that it came with heavy input from local physicians—particularly orthopedic surgeon Shaun Hobson, MD. “We began to look for a methodology that would optimize care and communication, improve outcomes, and have evidence-based care for the patient who wanted total joint replacement surgery.”

Jennifer Green, RN, the clinical nurse manager for the PSU, or Post Surgical Unit—which will be home to the Joint Replacement Destination Center—says what makes this program different from others is that it is patient centered and it is standardized. “The patients are optimized for surgery, so they are healthier when they come in and there are clear expectations—with all the physicians ordering and providing care in the same way. Instead of individual therapy, they do group therapy in group settings.”

Thanks to the standardization of care, there will be more monitoring of quality outcomes. Essentially, with everyone on the same page it will be easier to see which treatments work and which ones need to be tweaked.

There is also a Joint Coach online tool that provides patient education, spacing out information over a period of time instead of all at once. And it follows the patient for a year after surgery, again to better track success.

Total joint orthopedic patients will have designated patient rooms (seven of the 30 beds in the PSU) and be cared for by unit staff who are specially trained in orthopedic nursing, as well as staff in the surgery suite.

Another big evolution in the process is in how PSU staff view the mind-set of the total joint patient. The patient, they note, is coming to the hospital to have joint replacement surgery. They are not coming in because they are sick.
“We want to optimize that feeling of wellness,” says Rose, “so patients wear their own clothes after surgery rather than hospital gowns. We want to continue that wellness philosophy so that when patients go home they realize they are well. Their life has been improved with their new joint. They are able to move more easily and so they say to themselves, Hey, I can get going.”

“It is a different mind-set,” Green reiterates. “They get dressed early in the morning. They are out of their bed all day long. They have breakfast, they go to group therapy, they do their discharge class, then they do group lunch and maybe have a little break before going back to group therapy. They are up all day long. Patients are reminded that this is a wellness program.”

There are many other important aspects of this new program—from the oversight and assistance of Orthopedic Nurse Navigator Gary Salcedo, RN, ONC, to the addition of a friend or family member to serve as a coach throughout the process—but one of the biggest is physical therapy. It includes the use of a motivational ambulation board so that patients can “compete” to help inspire one another through the recovery.

For Karen Rohlf, DPT (Doctor of Physical Therapy), an overlooked part of the recovery process is helping patients become better educated before surgery. That is another part of the program—a part that the physical therapist at Bay Area Hospital thinks is key.

“They are going to be prepared,” says Dr. Rohlf. “They are going to get some preop exercises so they can start and get stronger before they get here. Hopefully, that will benefit them after surgery when they go to physical therapy by helping them become more mobile faster.”
Improving the health of our community every day.

Thank you for working together with us to make a healthier community.

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The Medical Center for Oregon’s Coast