Fall 2014

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HAMPTON ROADS

Physician

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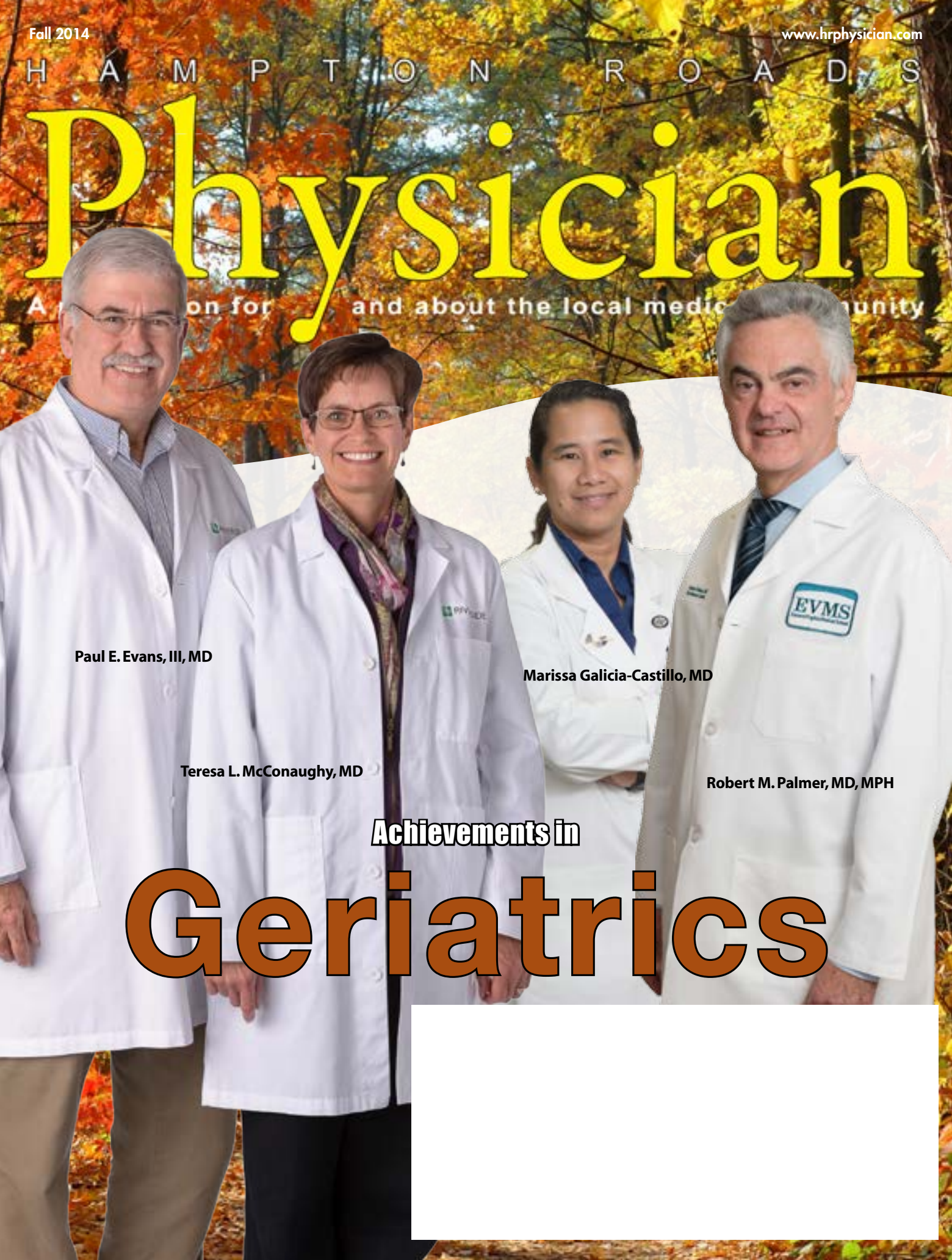

Paul E. Evans, III, MD

Marissa Galicia-Castillo, MD

Teresa L. McConaughy, MD

Robert M. Palmer, MD, MPH

Achievements in

Geriatrics

FALL 2014 VOLUME II, ISSUE IV

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HAMPTON ROADS
Physician
A publication for and about the local medical community

Fall 2014, Volume II/Issue IV

Recognizing the achievements of the local medical community

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Welcome to the Fall 2014 Edition

With this issue, *Hampton Roads Physician* marks the completion of its second year of publication. When we first envisioned this magazine, it was with the intention of shining a light on the extraordinary level of medical care that is available in Hampton Roads, by recognizing the achievements of the local medical community and presenting them with professionalism and editorial integrity.

Holly Barlow
Publisher

With the guidance of our inaugural Physician Advisory Committee, we established four topics for 2013. Physicians chosen to appear on the cover were selected by our Advisory Committee from among the nominations submitted by physicians, hospitals and large practice systems. The magazine also covered local medical news and events, welcomed new physicians to the community, spotlighted advanced practice professionals and featured a profile of a physician doing extraordinary community service.

Judging from the response we received, the formula worked well, and we repeated it during 2014, establishing our second 10-member Physician Advisory Board. With the advice of both the former and current Boards, we chose for our topics Diabetes, Women's Health, Trauma and Emergency Medicine, and now this issue: Geriatrics.

Bobbie Fisher
Editor

At the end of two years, we are more convinced than ever that no patient in Hampton Roads need travel out of the community or the State to receive world-class medical care. The work being done in offices, hospitals, operatories and skilled nursing facilities rivals any found in larger metropolitan areas.

It is with that firm conviction that we announce our schedule for 2015, and ask for your participation by nominating the physicians and advanced practice professionals who are exhibiting leadership in these areas.

Winter — Oncology
(deadline for physician cover nominations: December 3, 2014!)

Spring — Rheumatology

Summer — Urology

Fall — Rising Stars in the Medical Community

PLEASE ALSO REMEMBER that *Hampton Roads Physician* is an advertiser-supported publication. As such, the practices, hospital systems and other businesses whose ads appear in the magazine are what make it possible for us to continue to publish. We are very thankful for their support and are always available to discuss rates, space availability and writers' fees. We welcome your questions, comments or suggestions.

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www.hrphysician.com

Published four times a year, Hampton Roads Physician provides a wide variety of the most current, accurate and useful information busy doctors and health care providers want and need.

Cover stories concentrate on one branch of medicine, featuring profiles of practitioners in that specialty. Featured physicians are chosen by the advisory board through a nomination process involving fellow physicians and public relations directors from local hospitals and practices.

2014 Physician Advisory Board

We are honored to have their input for editorial content and direction of the magazine. We are grateful for the time they take, along with our Emeritus Board, to view all nominations and select our featured physicians.

Jon M. Adleberg, MD
Ophthalmology/Retinal Surgery

Dr. Adleberg serves as the Chairman of the Department of Ophthalmology, DePaul Medical Center. He is Board certified in Ophthalmology and fellowship trained in Diseases of the Retina and Vitreous.

Jenny L.F. Andrus, MD
Interventional Pain Management

Dr. Andrus practices at the Orthopaedic and Spine Center in Newport News. She is Board certified in Physical Medicine and Rehabilitation and Pain Management.

Anthony M. Bevilacqua, DO
Orthopaedic Surgeon

Dr. Bevilacqua is a partner at Sports Medicine & Orthopaedic Center, Inc. (SMOC). His primary focus is on hip, knee and shoulder surgery, and he is Board certified in Orthopaedic Surgery and Sports Medicine. He is a member of the Sentara Taskforce for Joint Replacement surgery and is the Board President at the Sentara Obici Ambulatory Surgery Center.

Silvina M. Bocca, MD, PhD, HCLD
Reproductive Endocrinology and Infertility

Dr. Bocca is an Associate Professor of ObGyn at EVMS. She is Board certified in Reproductive Endocrinology and Infertility, ObGyn and she is a High Complexity Laboratory Director.

Margaret Gaglione, MD, FACP
Internal Medicine and Bariatric Medicine

Dr. Gaglione is the medical director of Tidewater Bariatrics and is a practicing internist with TPMG Coastal Internal Medicine. Dr. Gaglione is Board certified in Internal and Bariatric Medicine.

Lauren James, MD
Family Medicine

Dr. James is the Lead Physician at Portsmouth Medical Associates of Bon Secours Maryview Medical Center. She is Board certified in Family Medicine.

Stephen H. Lin, MD, FACS
General Surgery

Dr. Lin specializes in minimally invasive and robotic surgery and practices with Chesapeake Surgical Specialists. He is Board certified in Surgery.

Richard G. Rento II, MD
Urology

Dr. Rento practices with Riverside Medical Group and serves as Medical Director, Urologic Oncology at Riverside Cancer Care Center. He is Board certified in Urology.

Deepak Talreja, MD, FACC, FSCAI
Cardiovascular Medicine

Dr. Talreja practices with Cardiovascular Associates, Ltd. He is Board certified in Internal Medicine, Cardiovascular Medicine, Interventional Cardiology, Echocardiography and a Diplomate of the American Board of Clinical Lipidology.

Stephen D. Wohlgemuth, MD, FACS, FASMBS
Bariatric Surgery

Dr. Wohlgemuth serves as the medical director of Sentara Comprehensive Weight Loss Solutions. He is Board certified in Surgery.

Newly appointed private rooms

"No Place for Sissies."

The next big health challenge for older patients may not be their age

By Bobbie Fisher

There's an iconic photograph of movie legend Bette Davis holding an embroidered pillow that says, "Old age ain't no place for sissies." For her it was true: in her biography, she wrote that she was terrified of getting older. Perhaps she foresaw the statistics that are worrying many in the healthcare profession today.

In March 2013, the American Geriatrics Society published a document entitled, "The Demand for Geriatric Care and the Evident Shortage of Geriatrics Healthcare Providers." The document listed the following:

The report noted that it is estimated that approximately 30,000 geriatricians will be needed by 2030 to accommodate these patients.

Unfortunately, the report went on to say that far fewer medical students are pursuing advanced training in geriatrics.

- Americans are living longer and therefore are accumulating more diseases and disabilities.
- One in five Americans will be eligible for Medicare by 2030.
- Those 65 and older are expected to account for almost 20% of the US population by 2030.
- About 80% of older adults require care for chronic conditions, such as hypertension, arthritis and heart disease.
- Older adults account for a disproportionate share of healthcare services:
  - 26% of all physician office visits;
  - 35% of all hospital stays;
  - 34% of all prescriptions;
  - 38% of all emergency medical responses; and
  - 90% of all nursing home use.

More than a year later, the statistics are still unsettling. The June 8, 2014 online edition of *The Wall Street Journal* featured an article by writer Barbara Sadick, confirming that not only are fewer residents choosing the extra year of training required to become a geriatrician, those going into other specialties typically get little exposure to the special health needs of the elderly during the course of their training.

Given how many Americans are aging, what accounts for the shortage? Sadick offers this observation: "[Medical students] discover that in a fee-for-service, volume-based system, caring for older Americans isn't nearly as lucrative as other medical specialties, partly because office visits with frail seniors typically run longer than average so the volume is less. Some may avoid the field because caring for the elderly often means making patients comfortable, not curing them."

Another reason, not touched upon by Sadick, might well be the inherent difficulty of dealing with aging patients whose capacities may have been compromised by advanced years. These older patients can be demanding, argumentative, stubborn and notoriously hard to communicate with.

Whatever the reason, it's hardly a new phenomenon. Dr. Ignatz Leo Nascher, who coined the word 'geriatrics' in 1909, was a champion of geriatric medicine throughout his professional life. According to the published history of Mt. Sinai Hospital, which established the first academic geriatrics department in the United States, Dr. Nascher encountered indifference and often the outright censure of both the medical establishment and the public for his belief that geriatrics should be recognized as a major specialty of medicine. Dr. Nascher's published research included the first US textbook on geriatric medicine in 1914: Geriatrics: *The Diseases of Old Age and Their Treatment.*

Dr. Nascher's belief is now accepted in the mainstream. In 2006, geriatrics was formally recognized by the American Board of Medical Specialties as a subspecialty within Family Medicine, Internal Medicine and Psychiatry & Neurology. And in a July 2007 *British Medical Journal* article, author Dr. A. M. Clarfield wrote, "Much material, especially that on therapeutics, is of course dated. However, the clinical approach described and, above all, the spirit of hope expressed in [Dr. Nascher's] book are as relevant today as they were almost a century ago."

Of course, any comprehensive discussion of geriatrics also means contemplating what patients, caregivers and doctors alike can be reluctant to talk about: how to recognize – and prepare for – the time it becomes evident a geriatric patient's life is drawing to a close. The October 15, 2014 episode of the NPR program *Here and Now* featured an interview with surgeon and Harvard medical professor Dr. Atul Gawande, about his recently published book, *Being Mortal: Medicine and What Matters in the End.* Dr. Gawande describes, from a surgeon's point of view, the decision-making process about care at that point. A staunch advocate of palliative care and hospice services, Dr. Gawande describes several cases where these services have sustained the quality of a terminal patient's life – even if it meant shortening that life. Talking to patients, explaining that even at that stage, they can have a choice, is a profound gift, he writes: where one patient might wish only for comfort and ease and lucidity, another might be willing to put up with great pain in order to experience a future milestone like a wedding or a birth. Recognizing the special role each can play in the life of a geriatric patient, the American Board of Internal Medicine recently added Hospice and Palliative Care as a separate Board certification.

Above all, it's important that doctors know what their patients want. Physicians and other healthcare providers know far too well the devastating and far-reaching effects of trying to offer compassionate and appropriate care to patients whose wishes aren't known. Talking about advanced care planning may not be easy, but it might well be one of the most important conversations a doctor will ever have with a patient.

At the end of the day, as the following pages of this magazine will demonstrate, Hampton Roads is blessed with a medical community skilled in providing care for older Virginians at every stage of their lives – even at the end – and dedicated to educating a new generation of physicians who will put the lie to Bette Davis' fears. In 21st Century Hampton Roads, old age is a place in which to thrive.

Robert M. Palmer, MD, MPH

John Franklin Chair of Geriatrics, EVMS
Director, Glennan Center for Geriatrics and Gerontology

Dr. Robert Palmer took a somewhat circuitous route to the directorship of the Glennan Center for Geriatrics and Gerontology. He says he was born to be a doctor, but didn't realize until he was in medical school that he was destined to become an internist – and it wasn't until 10 years after his residency that he went into geriatric medicine. The two compelling passions that have inspired him throughout a nationally distinguished career have been internal medicine – "It offers the combination of taking care of patients and focusing on the mechanisms and treatment of disease," he says – and working to improve the way healthcare is delivered, on both a small and grand scale.

He received his medical degree from the University of Michigan at Ann Arbor, and as his interest in public health continued to grow, he earned a master of public health at the University of California at Los Angeles. He calls those years transformative. He worked for the LA County Department of Health Services in Pico Rivera, a primarily Mexican-American community, where with funding from the National Heart, Lung and Blood Institute, he was principal investigator and director of a program to create hypertension screening, detection and treatment in the community. That program, he says, has been the template for everything he's done throughout his career.

From LA, he took a position at Oregon Health Sciences University Medical School in Portland, ultimately being appointed director of the internal medicine residency program.

At that time, geriatrics was a new specialty, not yet a certified fellowship program. "There was such a lack of understanding about how to take care of older people," he says. "Our knowledge of aging was almost non-existent." In geriatrics, he saw opportunities both as an educator and a community advocate to enter a field that clearly needed champions.

After pursuing a fellowship in geriatric medicine at UCLA, he moved to Cleveland and joined the faculty at Case Western Reserve University Medical School. With his colleagues at Case, he created a comprehensive geriatrics program focusing on hospital, long-term and outpatient care.

He became research partners with Dr. Seth Landefeld, a general internist and kindred spirit. "We wanted to figure out a cost effective way to take better care of hospitalized patients, in a continuous quality improvement process," Dr. Palmer says. Their work became known as Acute Care for Elders – or ACE – a nationally recognized model that offers enhanced care for older adults in specially designed hospital units, delivered by an interdisciplinary team of medical professionals, including geriatricians, advanced practice nurses, social workers, pharmacists and physical and occupational therapists. The care in an ACE unit is compassionate and patient-centered, with a demonstrated measurable reduction in the length of hospital stays for these patients. In addition, the costs are less on an ACE unit than on typical care units. Despite this, Dr. Palmer says, "We're still struggling to get this model of care to become standard practice." The National Institutes of Health agrees: in a recent abstract, NIH researchers wrote, "Low presence of ACE units warrants further research as to reasons more hospitals have not included them, given the available evidence for clinical, functional, and economic benefits."

Dr. Palmer assumed the directorship of the Glennan Center for Geriatrics and Gerontology in 2011, and he has attacked that position with the same zeal and innovation that marked his other endeavors. Since his arrival, the Glennan Center has collaborated widely with other departments at EVMS in a variety of research and educational endeavors, and continues to strengthen its ties to organizations within the community.

The faculty of the Glennan Center enjoy clinical practice in outpatient, nursing facility, and palliative care settings. The Memory Consultation Clinic performs detailed evaluation of patients with cognitive decline through a comprehensive team approach to both the medical and psychosocial needs of the patient and caregivers. Dr. Palmer and his colleagues are expanding the practice and the research program, adding a Geriatrics Consult clinic to provide a comprehensive geriatric assessment for frail seniors, with recommendations given to the patient, family and referring physician.

He is working with Dr. Marissa Galicia-Castillo to expand clinical programs in hospital and long-term care-based palliative medicine: "We're now providing inpatient palliative care consults in two Sentara hospitals and a Sentara skilled nursing facility. We're also directing a palliative care and hospice program in collaboration with our partners at Beth Sholom Village and Jewish Family Services." He's also a consultant at one of the Sentara hospitals that feature an ACE Unit, and direct Geriatric Medical Services at Sentara Norfolk General Hospital.

His commitment to improving the quality of resident education in geriatrics is evident. "We're heavily engaged in teaching of all learners at EVMS," he says, "medical and physician assistant students, residents in internal medicine and family medicine, and fellows training in geriatrics. This past year we launched a grant to train Chief Residents of nine different departments in the principles of geriatric practice, patient safety and quality improvement."

Future plans for the Glennan Center include creating innovative, sustainable clinical programs to benefit the seniors in the community, and to expand research in geriatric safety, palliative care and dementia. With its community-based health care partners, the Glennan Center is ready to implement the "Triple Aim"-to improve the patient experience in all sites of care; to improve the health of the elderly population of Hampton Roads; and to reduce the costs of health care.

"The challenge for us now," he says, "is to more deeply engage the community in advocating for even better care for our seniors."

Teresa L. McConaughy, MD
Medical Director, Riverside House Calls

Dr. Teresa McConaughy and Dr. Paul Evans have a lot in common. They're both Board certified in Family Medicine; they're both Assistant Clinical Professors of Family Practice at Virginia Commonwealth University. They've both dedicated their careers to caring for the at-risk older population.

They also happen to be husband and wife – and while they both did their residencies at Riverside Regional Medical Center, they're quick to note that Dr. McConaughy went to medical school in the South (Medical University of South Carolina College of Medicine) while Dr. Evans earned his MD in the North (at the University of Connecticut School of Medicine).

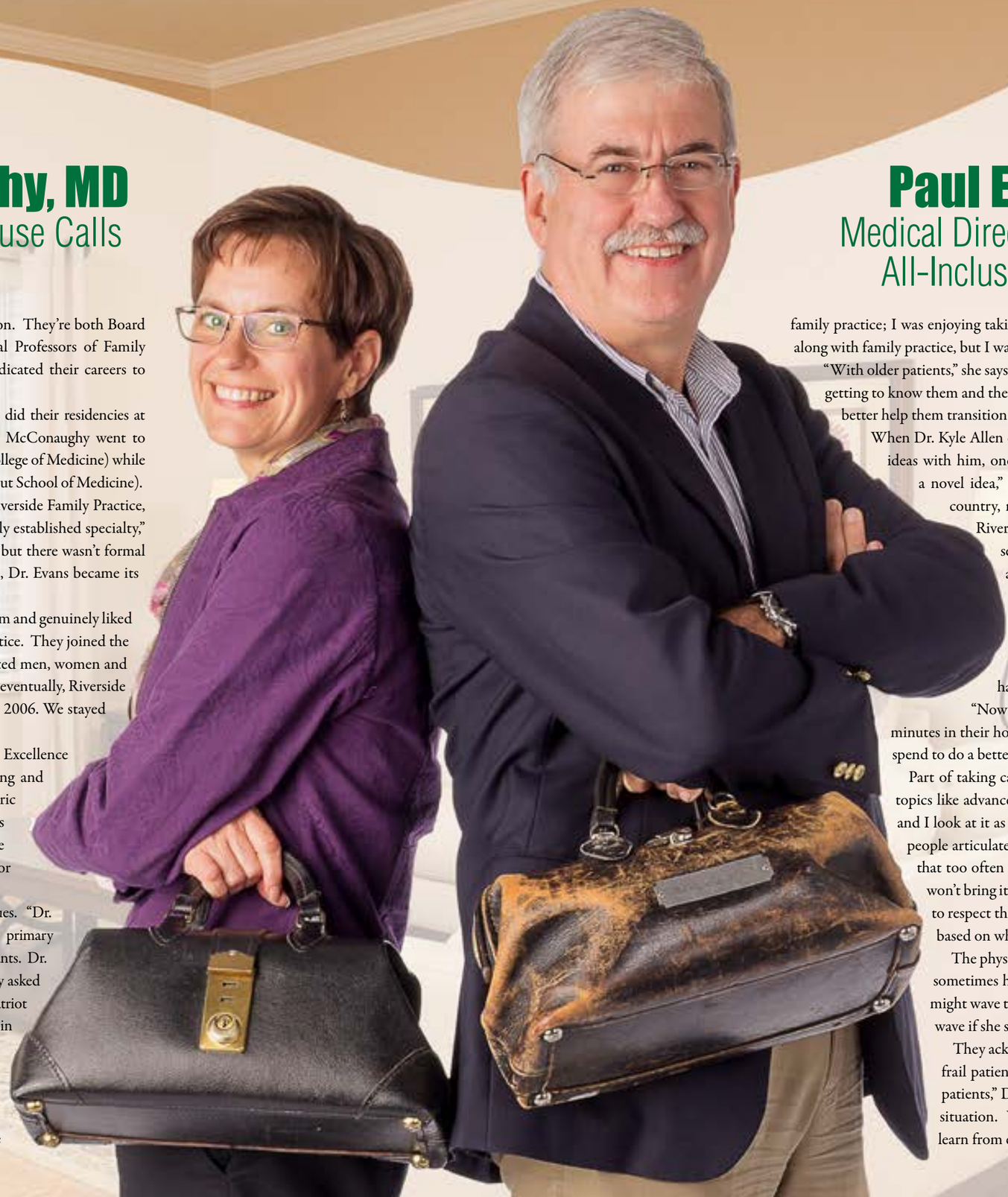
The two physicians met while they were both on the faculty of Riverside Family Practice, in the residency program. "At that time, geriatrics wasn't really a fully established specialty," Dr. Evans says. "There were people doing geriatrics for many years, but there wasn't formal special training." When the fellowship in geriatrics was introduced, Dr. Evans became its first director.

Dr. Evans and Dr. McConaughy both enjoyed the residency program and genuinely liked teaching, but ultimately decided to leave the faculty and go into practice. They joined the Commonwealth Family Practice in Newport News, where they treated men, women and children. "There were a lot of geriatric patients," Dr. Evans says, "and eventually, Riverside asked us to start a new practice in Grafton, Patriot Primary Care, in 2006. We stayed there until 2013."

He also began doing geriatric consultative work at the Center for Excellence in Aging in Williamsburg (now the Center for Excellence in Aging and Lifelong Health, or CEALH), working with patients with early geriatric syndromes. Through the Center's research arm, Dr. Evans and his colleagues were working with new medicine and other innovative treatments for Alzheimer's disease. He serves as principal investigator for clinical studies at CEALH.

"And then, PACE had just opened in Hampton," Dr. Evans continues. "Dr. Petitjean, who had served on the residency faculty with us, was the primary physician at the program, which had quickly grown to 70 or 80 participants. Dr. Petitjean was still doing some teaching at the residency program, so they asked if I would be willing to help out. I began splitting my time between Patriot Primary Care and PACE. That transitioned to full time at PACE, which in turn transitioned to my being named Medical Director at PACE."

When Dr. Evans left Patriot Primary Care, Dr. McConaughy says he bequeathed her many of his patients, adding to her already large practice. "I had been thinking about leaving the office practice, and looking for ways to do geriatrics differently," she remembers. "I love



Paul E. Evans, III, MD
Medical Director, Riverside Program of All-Inclusive Care for the Elderly

family practice; I was enjoying taking care of babies and adolescents and all other ages that came along with family practice, but I was evolving as a physician.

"With older patients," she says, "I loved listening to them, I liked hearing their life stories, and getting to know them and their families. And I wanted to be able to provide care that would better help them transition to wherever they were going."

When Dr. Kyle Allen came to Riverside in 2011, he brought a number of innovative ideas with him, one of which was establishing a house calls practice. "It wasn't a novel idea," Dr. McConaughy says, "as they're in existence all across the country, mostly in the midwest. But it was definitely a novel idea for Riverside." It was an idea that touched her personally, as she had seen her own mother's health decline in the final years of her life, and understood immediately how a program of regular home visits could benefit such patients.

Today, as Medical Director of Riverside House Calls, Dr. McConaughy cares for more than 130 patients, seeing each one about once every four weeks. "In a busy practice, I might have 15 minutes with a patient in an exam room," she explains. "Now I can manage my time to accommodate a half hour to 45 minutes in their home, whatever time it takes. And I can spend the time I need to spend to do a better job taking care of these incredibly amazing people."

Part of taking care of these patients can involve conversations about sensitive topics like advanced care planning and end-of-life decision making. "Both Paul and I look at it as part of our responsibility to initiate the conversation and help people articulate their wishes," Dr. McConaughy says. "It's one of those things that too often gets shoved under the rug, and unless we bring it up, patients won't bring it up. So we have to do it in a way that expresses our commitment to respect their wishes and needs, so that they know we're guiding their care based on what they want."

The physicians' paths don't often cross these days, they say, although they sometimes have the opportunity to send each other patients. "Typically, I might wave to her on I-64 if I see her car going by," Dr. Evans says, "and she'll wave if she sees mine."

They acknowledge some of the same stresses inherent in caring for older, frail patients with complex medical conditions. "We share stories of our patients," Dr. Evans says. "We ask what the other would do in a particular situation. We share the joys and some of the hardships – and we always learn from each other."

Marissa Galicia-Castillo, MD

Section Head of Palliative Medicine at the Glennan Center
Medical Director of Palliative Medicine at Sentara Norfolk General Hospital
Medical Director of Harbor's Edge
Sue Faulkner Scribner Professor of Geriatrics, EVMS

Dr. Marissa Galicia-Castillo is an anomaly: born in Hampton Roads, she attended college and medical school in Hampton Roads, completed her residency and internship in Hampton Roads, and did her fellowship in Hampton Roads. An early interest in science and medicine drew her to the Magnet School for Health Professionals, a collaboration formed in 1986 to initiate early preparation for high school students for careers in the health professions through innovative biomedical curriculum and mentoring. She attended Old Dominion University for three years, completing her fourth and final year at EVMS, graduating in 1994 with a degree in Biochemistry and Biology.

She received her MD degree from EVMS in 1997, completing her internship and residency in Internal Medicine, followed by a fellowship in geriatrics in 2002. Dr. Castillo is Board certified in Internal Medicine, Geriatrics and Hospice and Palliative Care.

Her specific interest in geriatrics grew out of two events: as a teenager, she saw her grandmother grow suddenly ill and deteriorate, very soon dying of kidney failure. "She was only in her 60s," Dr. Castillo recalls, "and she seemed so healthy. The next thing I knew, she was in ICU and then she died. It never made sense to me."

Then during the year of her internship, she met two geriatricians – Dr. Stefan Gravenstein and Dr. Janet McElhaney – and working with their patients ignited her interest even further. "Not only were their cases more complicated and interesting from a medical perspective, I also found that for the most part, the patients were so appreciative, even of the tiniest gesture," Dr. Castillo remembers. "We'd do something so small, so simple, and it made a huge difference to them." Even getting them out of bed made a difference, she discovered. "You still see it today with geriatric patients," she notes. "When they won't (or can't) get out of bed, they can decondition so quickly. It has a tremendous impact on them."

Caring for geriatric patients is about more than practicing internal medicine. It's also about talking to patients about what they want, and learning what their goals are. "The biggest difference is that their care is a team event," Dr. Castillo notes. "And not just doctors. We need to also work with nurses, dieticians, physical therapists, occupational therapists, social workers so we address all areas to really take care of these patients."

"Geriatrics is much like palliative medicine, in the sense that we try to improve quality of life and function for these patients, to the best degree possible. These two concepts go hand-in-hand, and they are enormously satisfying."

When Dr. Castillo isn't serving as a Palliative Medicine physician in the hospital, she tends to patients at Harbor's Edge, a Continuing Care Retirement Community in Norfolk that features independent apartments, assisted living, skilled nursing, and long-term care. She focuses her practice in those who live in the Health Care side of Harbor's Edge.

Dr. Castillo has found that more and more, patients coming to skilled nursing facilities are much more ill than they used to be even five years ago. "Sometimes, they're so debilitated, they're at the point where rehabilitative care isn't needed or wanted," she says. "We see patients who have congestive heart failure and renal failure, maybe emphysema, and maybe cancer as well. Their prognosis is very limited. These are the patients who need palliative care and sometimes hospice."

Much of her care depends on understanding what these patients want, and tailoring their treatment accordingly. She describes a typical situation: "A patient has a deadly combination, congestive heart failure and kidney failure. If I treat his heart failure by getting rid of the fluid, his kidney failure worsens; it's a vicious cycle. So I ask him what his goals are, and he says he just wants to be comfortable.

"That's what's so interesting about geriatrics and palliative care: it's all about function, and what's important to the patient. In that patient's case, knowing that he won't suffer because of his kidney situation, and understanding what he wants, I pursue comfort measures for him. I give him medication to reduce his shortness of breath."

It always depends, Dr. Castillo says, on what the patient wants. "Often they'll say 'please don't send me back to the hospital, no poking or prodding, just make me comfortable.' Others might say they want some measures taken, like some labs and maybe a ventilator, if there's a chance they can come back. And others may want a full-court press: everything that's medically appropriate. That's why talking – and listening – to patients is so important.

"Geriatrics is much like palliative medicine, in the sense that we try to improve quality of life and function for these patients, to the best degree possible. These two concepts go hand-in-hand, and they are enormously satisfying." At EVMS, Dr. Castillo teaches primary palliative medicine to medical students, residents and Fellows, which includes teaching them to talk to patients and their families about the entire spectrum of caring for geriatric patients. She laments the shortage of both geriatricians and palliative care physicians, and hopes that training the next generation of physicians in both Geriatrics and Palliative Medicine concepts can help address the growing need. ■

Blindness: Preventable and REVERSIBLE

By Alan L. Wagner, MD, FACS

During the past seven years, there have been miraculous improvements in the tools available to prevent and reverse blindness.

Before these improvements, I hated explaining to patients that we are going to help them live with vision loss. Now, that is no longer necessary.

The leading cause of blindness in the industrialized world is diabetes. Until recently, we treated blood vessels in the eye damaged by the disease with lasers. If necessary, we would operate inside the eye, to salvage sight. Today, we have a wide spectrum of minimally invasive tools to treat the disease during varying levels of progression. The earlier we catch the disease, the greater the success.

Wagner Macula & Retina Center, in collaboration with Eastern Virginia Medical School and corporate partners, is engaged in research that is preventing blindness. In most cases we can restore some, if not all, the vision that has been lost. Most importantly, the effects of these treatments are durable: when the treatment plan is started and continued, more than 80 percent of the patients will see a lasting positive effect. Patients will be independent—they may even be able to return to driving. The successful treatment of eye disease allows the patients to live independently, go to work, grocery shop and cook. Above all, being able to see the faces of loved ones once again is priceless!

All of our research and treatment of patients is very important. However, getting the word out about prevention and early detection is crucial.

We tell our patients how important it is to "feed the eyes normal blood at a normal pressure." Obviously, that's not as easy as it sounds, but it really is that important.

Fortunately, or unfortunately, vision loss from diabetes is painless. The same is true for another eye disease – macular degeneration.

Regular monitoring is critical. It should be done both by an eye professional and by patients at home. For patients at high risk of developing macular degeneration, there is a new FDA-approved device, Foresee, which detects the earliest changes that will cause blindness from macular degeneration. The compact Foresee device communicates directly to our office, allowing us to quickly detect problems and start treatment right away. Prior to this new technology, just looking at a piece of graph paper was the best resource available.

If patients take responsibility for protecting their eyesight, we can preserve, and even restore, their sight. It is essential that patients see an eye professional regularly so that we can help keep their vision intact. With the ability to see, patients can continue to have full and prosperous lives! ■

All of our research and treatment of patients is very important. However, getting the word out about prevention and early detection is crucial.

Alan L. Wagner, MD, FACS, founded the Wagner Macula & Retina Center in 1987. A Board certified ophthalmologist specializing in vitreoretinal surgery, Dr. Wagner received his medical degree from Vanderbilt University School of Medicine. He completed his residency in Ophthalmology at EVMS, and furthered his training as the Dyson Fellow in vitreoretinal disease and surgery at Weill Cornell University Medical Center. 757.481.4400 or www.wagnerretina.com.

"Patient" Conversations

By Kathryn Freeman-Jones and Diane L. Dull

In today's health care environment, patients are confronted by an ever-expanding myriad of technologies and treatments, leading to an increasing reliance on the clinical experience, advice and guidance of their physicians when making difficult medical decisions. Navigating the waters of health care decisions with patients can be challenging, especially in the midst of increasing patient loads, decreased and restrictive reimbursements, and the implementation of electronic health records, all of which impact health care providers' available "face time" with patients. However, failing to engage patients in conversations about their priorities and treatment preferences and encouraging them to complete an advance directive and to appoint a designated decision-maker to act in the event of future incapacity comes at great cost. The absence of thoughtful planning can impose significant burdens on patients, their families, treating health care providers, and the sustainability of an already over-extended system of health care in the United States.

A recent study[1] of capable adults who are not currently confronting end-of-life care issues confirmed their thinking about end-of-life care preferences and priorities, but a majority had not completed an advance directive to communicate and make those preferences legally enforceable. More than 60 percent of individuals aged 18 years and older wanted their end-of-life wishes to be respected, but only 33 percent had completed an advance directive. The reasons stated included 25 percent who did not know about advance directives. Others felt they were too young or too healthy to complete them or expressed concern about the cost, complexity, or time required to do so. Cultural differences including family-centered decision-making, distrust of the health care system, and poor communication between health care professionals and patients were also contributing factors.

Not surprisingly, participants confirmed a preference to obtain advance directive information from their doctors or other health care providers, rather than from attorneys, clergy, or online sources, creating a unique opportunity for primary care physicians to play an invaluable and critical role in engaging patients, young and old, in conversations about their priorities and treatment preferences in various health care scenarios and at the end of life. Despite time limitations, as physician and author Atul Gawande, MD observes, these conversations with patients need not be lengthy to be successful:

> "[T]he best way to learn those priorities is to ask about them… [using] just a few important questions: (1) What is their understanding of their health or condition? (2) What are their goals if their health worsens? (3) What are their fears? (4) What are the trade-offs they are willing to make and not willing to make? These discussions must be repeated over time, because people's answers change..."[2]

Many advance directive templates can seem legalistic, lengthy and confusing. This should not inhibit physician efforts to discuss these important questions. Patient- and provider-friendly directives are readily available from a variety of resources. We encourage you to take time to engage your patients in these critically important conversations. ■

Morhaim, D. and Pollack, K. Am J Public Health. 2013;103(6):e8-e10.

Gawande, A. "Being Mortal: Medicine and What Matters in the End," Metropolitan Books, 2014.

Aging with Dignity – Five Wishes @ http://www.fivewishes.org/; Virginia Hospital and Healthcare Association –Healthcare Decision-Making (Forms in English and Spanish) @ http://www.vhha.com/healthcaredecisionmaking.html; American Bar Association Commission on Law and Aging – Myths and Facts About Health Care Advance Directives @ http://www.americanbar.org/content/dam/aba/migrated/Commissions/myths_fact_hc_ad.authcheckdam.pdf; American Bar Association – My Health Care Wishes App @ http://www.americanbar.org/groups/law_aging/MyHealthCareWishesApp.html

[1]Morhaim, D. and Pollack, K. Am J Public Health. 2013;103(6):e8-e10.

[2]Gawande, A. "Being Mortal: Medicine and What Matters in the End," Metropolitan Books, 2014.

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PHYSICAL THERAPISTS AS PHYSICIAN EXTENDERS

By Wayne MacMasters, PT, MSPT

One of the most important cost saving concepts in medicine today is the use of the physician extender. When I started practice in 1985, there was no such term; but look up 'physician extender' in the dictionary today, and you'll find: "a health care provider who is not a physician but who performs medical activities typically performed by a physician."

Physician extenders can provide care at a lower cost to patients and their insurance companies. They are competent in treating many health care issues, and have the knowledge, training and experience to determine when a physician consult is appropriate. Usually, we think of Physicians Assistants or Certified Family Nurse Practitioners.

But there are other health care providers who are primary care providers for patients with musculoskeletal problems: Certified Athletic Trainers and Licensed Physical Therapists.

Athletic Trainers (ATC) certified by the National Athletic Trainers Association typically work in institutional settings. They are usually the first responders at an injury scene. They triage the injured athlete and decide if a physician consult is appropriate. For minor problems, the patient is managed without physician involvement.

Most Physical Therapists (DPT) are doctorate degreed professionals licensed through their respective state Boards. Their practice requirements are similar to Physician Assistants. In a recent study of family practice and orthopaedic physicians, published in *The Journal of Orthopaedic Sports Physical Therapy*, physical therapists were found to be second only to orthopaedic surgeons in performing competent musculoskeletal exams.

Physical therapists have been physician extenders throughout the world for a long time, but only in the past 15 years has the American medical community endorsed the model. Recent research demonstrates it is safe and effective, and 49 states (including Virginia) are considered Direct Access states; that is, referral by a physician is not necessary in order for care to be provided by a licensed physical therapist.

For my Direct Access Licensure, I obtained further education for differential diagnoses and additional course work. Since 2011, I have been practicing Direct Access Physical Therapy.

I must admit I was hesitant to endorse my profession as physician extenders. I was trained thirty years ago under a traditional model and continue to have great respect for our physician community and the medical profession. But times change, our education has progressed to doctoral level training, the research is clear and we all have to control medical costs.

So who should see a physical therapist directly? Any patient with significant trauma or a severe injury should go to the ER or a doctor, but an adult with mild to moderate muscle aches and pains, a runner with over-use injuries, or a welder with persistent muscle or joint issues can see a physical therapist to help determine the cause. If physical therapy is indicated, tissue tightness, muscle weakness or alignment disorders can be treated with modalities, exercise and manual mobilization of joints or soft tissues can be treated by law for up to 14 business days without a prescription from a physician. The treating physical therapist sends a report to the patient's doctor, and if progress is not made, a physician consult is requested.

Working together – physicians and *all* physician extenders – we can serve our communities and our patients, offering the best care in the most cost effective manner possible. ■

Wayne A. MacMasters, PT, MSPT, is the president and founder of Tidewater Physical Therapy, Inc. Mr. MacMasters, a practicing physical therapist, received his undergraduate degree from the College of William & Mary and his Masters degree in Physical Therapy from Duke University.

Hearing loss is a disability

why isn't Medicare listening?

By Theresa H. Bartlett, AuD

You cannot see hearing loss by looking at someone; you can't determine hearing loss until you actually talk to someone. If you're not careful, you might miss it. Some people with hearing loss can actually train themselves to keep up with the conversation, but what happens if they do not? The usual response is anger and frustration. Not on the part of the hearing impaired person, but rather the person trying to communicate with the hearing impaired person.

And yet Medicare does not recognize hearing loss as a disability. The audiology community has published white papers that show diabetes and heart problems can lead to hearing loss. The audiology community has also published white papers showing that hearing loss indirectly leads to dementia. Statistics show that hearing loss is a major public health issue, the third most common physical condition after arthritis and heart disease. Why then does Medicare not recognize hearing loss as a disability?

Medicare will not pay for annual hearing evaluations. Medicare will pay for an initial evaluation, but in order to have annual evaluations, patients must have subjective changes in their hearing or tinnitus. Medicare will not cover the cost of a hearing test if it is to measure someone for a new hearing aid? If patients feel that there are changes in their hearing and the recommendation is made for a hearing aid, Medicare will cover the cost. If a hearing aid is the main reason to have the hearing test, Medicare will not cover it.

Medicare requires a script from the primary care physician, or any referring physician, before a hearing evaluation can be performed. There is no other condition for which Medicare requires a script be obtained. As a result, persons concerned about hearing loss must first see their primary care physicians. Finally, Medicare does not pay anything toward the cost of hearing aids. In fact, most insurance companies follow suit with Medicare and do not cover hearing aids. The only insurance companies that offer hearing aid reimbursement are employer sponsored plans.

Hearing loss can have such a negative impact on people's lives. It affects their life at home with family members, at work with fellow employees and in all other areas of life. Physicians need to understand the negative impacts of hearing loss and how to have their patient's hearing evaluated. An initial evaluation should be recommended at age 65, and subsequent evaluations should be completed if subjective changes in hearing acuity occur. Understanding the significant impact of hearing loss and knowing how to make a referral for an evaluation can help patients deal with an otherwise unhealthy problem. ■

Theresa H. Bartlett, AuD, is a Doctorate Level Audiologist who currently owns and operates a small, private, Audiology practice in Norfolk, Virginia. Dr. Bartlett specializes in Lyric hearing products and will soon be a Golden Circle Audiologist for Sensaphonics hearing conservation products. www.virginiahearing.com

EXCEPTIONAL PROFESSIONAL

Mary Hudson, FNP-C A Heart for Service

Mary Hudson is a Board-certified family nurse practitioner who has lived in a great many places during her 30-year career. Growing up in Louisiana, she received her bachelor of science in nursing and a master of science in nursing from McNeese State University in Lake Charles. After graduating, she married a military man and her travels began. "We lived in Mississippi, in Italy – even once in Virginia, when we were stationed at Fort Eustis," she remembers. She enjoyed the travel because, as she says, "I embrace change. I'm always looking for new opportunities, and in medicine, there's always something new to learn."

It was that quest for learning that led her to return to McNeese State in 1999 to earn her NP. "When I graduated in 2001, there were very few Nurse Practitioners in Louisiana," she says. "In fact, I was in only the second class at the University to graduate as family nurse practitioners."

The additional training was soon to serve her very well, as did her extensive experience treating patients in emergency room and infectious disease clinic situations. In 2005, working in the public health system, Hudson wasn't surprised when she was dispatched to Lafayette Parish, just days before Hurricane Katrina. "Living in Louisiana, we were always getting ready for hurricanes," she says. "We drilled constantly, to be sure we were prepared – how to staff, how to set up triage."

Her team – consisting of fellow nurses, NPs, EMT and a physician – arrived to set up, preparing for the patients to arrive. "It took a while, as much as a day-and-a-half to two full days for them to get to us," Hudson remembers. "The rescuers couldn't get them off their rooftops before then. And when they got to Lafayette, they were dropped off on a bridge and then put on a bus and brought to different shelters. We had maybe a hundred beds."

When they finally reached Hudson's team, they came with lacerations, electrical burns, in pain and distress, often not knowing where the rest of their families were. "They were injured so badly," she says. "And there were so many. The hospitals had no rooms left. And so many never even made it to us." She and her team tended to the wounds, and comforted the patients as best they could, but as they were working without power for much of the time, they had no means to find missing families. "We'd hug them, and they'd cry," she says, "but it was a long time before they were reunited."

It took a long time to get over the sequelae of Katrina – a long time that Hudson and her fellow caregivers didn't have: less than a month later, they were called into service again, as Hurricane Rita approached Louisiana. She was preparing to return to Italy for the birth of her first grandchild when the call came. "I had no time to do anything but pick up my elderly mother and head north," she recalls. "It was 25 days before we could go back home to Lake Charles."

It was a time Mary Hudson will never forget, but she says it made her a better person because she saw firsthand the goodness of humanity.

Her daughter Lindsey, a third-year resident at EVMS, was the impetus for her return to Virginia. "Hampton Roads is such a great medical hub," she says, "and I'm happy to be with Bon Secours, whose faith-based values and ethics I admire. I love working in collaboration with our physicians and medical team to provide the highest quality health care."

In the meantime, her quest for learning continues: she recently completed DOT training and will be on the National Registry of Certified Medical Examiners.

If you work with or know a physician's assistant or nurse practitioner you'd like us to consider, please visit our website – www.hrphysician.com – or call our editor, Bobbie Fisher, at 757-773-7550.

GOOD DEEDS

Recognizing physicians who are doing community service locally or outside the state or nation

KEITH H. NEWBY, SR., MD, FACC

Cardiologist and President, Fort Norfolk Medical Associates

There was probably never much doubt that Keith Newby would follow in the footsteps of his father by becoming a physician: Dr. James E. Newby, Jr. was a well-known Hampton Roads internist who served as Chief of Medicine at Norfolk Community Hospital, where young Keith liked to volunteer as a teenager, because he wanted to be around medicine. Dr. James Newby had the distinction of being the first African-American Board certified Internist to obtain privileges at Norfolk General Hospital.

"He was also the first black appointed to the Norfolk City Planning Commission," Dr. Keith Newby says. "He had a strong sense of community, which he passed on to his children." Dr. Newby calls it "growing up ingrained in the Norfolk culture," and it never left him. Thus there was even less doubt that he'd return to his hometown to practice.

After graduating from Eastern Virginia Medical School in 1990, Dr. Newby did his internship in Internal Medicine at Emory University Medical School in Atlanta, followed by a fellowship in cardiology with emphasis in invasive electrophysiology at Duke University Medical Center in Durham.

His interest in cardiology sprang from the fact that his father, Dr. James Newby, died at the age of 41 of a primary cardiac tumor when Keith was just seven years old. Of his father, Dr. Newby says, "I knew I had a lot to live up to. I knew I had to strive to be my best."

Part of being his best means living the Christian values his mother instilled in him: "She taught us about giving back to the community and being a community advocate, because that's how we grow, how we work, and how we foster each other, by helping each other," he says.

He also wanted to be sure his father's legacy would prevail. When he became aware of the disparity in cardiovascular death rates in Virginia (291 deaths per 100,000 overall population vs. 378 deaths per 100,000 in the African Americans population), he sought a way to combine his commitment to honoring his father's legacy by utilizing his medical training for the benefit of his community.

"When I first came back to Virginia in 1996, I'd go to different churches and give talks on different health topics," he explains. "I wanted to help people understand how their decision impacted on their health and their diseases. I felt if I could teach them what they needed to know about these different chronic disease processes, I could impact their lives in a positive way. I felt if they understood, they could do things to make sure it didn't go to levels that cause a great number of complications."

He was soon volunteering at small health fairs, refusing any payment and even returning small honoraria. He found himself talking with more and more groups, and began considering other ways he might touch the community. In 2009, he established the non-profit James E. Newby, Jr., MD Foundation, with the mission "to improve the health and welfare of the various communities within the Commonwealth of Virginia and its citizens."

He organized a health summit in 2011, enlisting physician colleagues from local practices to educate the community on a wide variety of health-related topics. More than 800 people attended the first summit, leading to a second in 2013. Plans are underway for a 2015 summit, which will look at various aspects of health: "Not just medical, but spiritual, emotional and financial health as well," Dr. Newby says, "looking at the entire person."

As for payment for his services, he says, "If one person tells me they quit smoking because of something I said, or improved their diet, that's my payment. That's what brings purpose to my life." ■

If you know physicians who are performing good deeds – great or small – who you would like to see highlighted in this publication, please submit information on our website – www.hrphysician.com – or call our editor, Bobbie Fisher, at 757-773-7550.

Year-end TAX PLANNING for Your Practice

There's never a bad time to review your current tax situation. But year-end can be an especially good time to plan and implement tax-saving strategies.

Time Year-end Payments

If your practice uses the cash method of accounting, it may be a good idea to review the timing of year-end payments so that you can more effectively coordinate their tax impact. For example, you can increase your 2014 deductions by paying certain expenses in December instead of January.

Expenses paid by credit card in 2014 are deductible in 2014 even if you don't pay the bill until 2015. The same holds true for an expense paid by check in 2014, since the amount is generally deductible in 2014 even if the check does not clear the bank until 2015.

Buy Medical Equipment

If you have thought about buying new medical or office equipment for your practice, now may be a good time to take the plunge. The Section 179 expensing election allows you to take an immediate deduction for the cost of most kinds of depreciable assets in the year they are acquired and placed in service (within tax law limits) instead of claiming depreciation deductions over a multiyear period. The dollar limit on asset purchases eligible for Section 179 expensing is $25,000 for the 2014 tax year. The $25,000 deduction maximum is reduced dollar for dollar to the extent that the cost of qualifying property placed in service during the taxable year is greater than $200,000.

Identify Credit-eligible Expenses

As opposed to a tax deduction, which lowers taxable income, a tax credit directly offsets tax liability. Two credits that may be of interest:

A disabled access credit for expenses paid or incurred to modify or acquire equipment or devices for disabled individuals, or to improve an older building to make it accessible to the disabled

An energy credit for the installation of solar or certain other energy-efficient property in your medical office building. ■

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Your Geriatric Patients and Vertebral Compression Fractures

By Mark W. McFarland, DO and Raj N. Sureja, MD

Vertebral compression fractures are observed in any age demographic due to trauma from a fall or a car accident; however, they are most prevalent in the geriatric population. Significant loss of bone may occur due to pathology (cancer, osteomyelitis); chemotherapy or radiation therapy used to treat cancer; age-related conditions (hyperthyroidism, menopause, osteoporosis) or can be caused by an overuse of steroids. When enough bone loss occurs, and a vertebra becomes unstable, spinal fracture or collapse is likely to occur. These vertebral fractures can be extremely debilitating for the seniors who suffer them, causing pain, uncomfortable neurologic symptoms, disability and urinary or fecal incontinence/retention.

Until recently, these individuals would have been sent to the hospital for treatment with Vertebroplasty or Kyphoplasty procedures. Both procedures provide a method for stabilizing the vertebral fracture, using a bone cement to restore height and strength to the collapsed or fractured bone. Kyphoplasty differs from a Vertebroplasty, mainly because a balloon is inserted into the fractured vertebra, inflated to restore the height and then cement injected into the space, which hardens to provide stability. In an outpatient setting at a hospital or ASC, the patient would be usually subjected to general anesthesia and a stay which typically would take four to six hours. The hospital cost for the procedure is substantial, resulting in a greater out-of-pocket expenditure for the patient.

In 2012, Medicare approved in-office Kyphoplasty for reimbursement, due to significant improvements and miniaturization of the required instrumentation, such as smaller needles and special blocks for anesthetizing the operative site. After this approval, many Orthopaedic Spine physicians and Radiological Interventionists began performing this procedure in their clinical office procedure suites. The patient is awake during the procedure, which takes about 30 minutes, and is ready to go home in approximately 90 minutes. Another improvement occurred in 2014, with the development of a small trochanter which provided a less-invasive way for the surgeon to enter the body near the fractured vertebrae, causing less trauma for the patient.

Although a few earlier studies brought the efficacy of Kyphoplasty into question, more recent clinical research has found that Kyphoplasty is preferable over Vertebroplasty and non-surgical management for vertebral compression fractures. Kyphoplasty provides distinct benefits when measured against in pain reduction, disability management and quality of life indicators. Anecdotally, we observe these patients in our office on a regular basis. They frequently arrive in a wheelchair, unable to walk and in a great deal of pain. After their in-office balloon Kyphoplasty, patients can walk, their disability gone. The pain relief they experience is immediate, and their gratitude is one the best rewards for any physician performing the procedure.

We perform several Kyphoplasties a week in our office at OSC. Our patients tolerate the procedure very well and experience immediate relief from their symptoms. If your geriatric patients experience vertebral compression fractures, consider the benefits of in-office Kyphoplasty. ■

Mark W. McFarland, DO

Raj N. Sureja, MD

Mark W. McFarland, DO (Orthopaedic Spine), and Raj N. Sureja, MD (Interventional Pain Management) practice at Orthopaedic & Spine Center in Newport News, VA. For more information on Kyphoplasty, please contact them at 757-596-1900 or visit osc-ortho.com.

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The Future of Healthcare

By Alex Strauss

Measuring (and Incenting) Quality: The Move from Fee-for-Service to Prevention-Based Medicine

Changes are coming so fast as medicine moves into its uncertain future that standing at the helm of a healthcare organization these days can feel a little like chasing a ball downhill. As we talked with five area CEOs for our ongoing series on The Future of Healthcare, we discovered one impending change that seems to underlie all of the others: The move from the traditional American "fee-for-service" payment system, where providers get paid to treat illness, to one that is based on prevention, wellness, and so-called "accountable care". It is what Bon Secours Hampton Roads CEO Michael Kerner calls a "sea change".

"The transition from fee-for-service medicine is a big challenge because we providers have been focused on growing volume," says Kerner. "In our world, our budgets are still based on volume, so we haven't made the full transition. But the future is likely to be more focused on prevention and wellness than what we have seen in the past."

"In our world, our budgets are still based on volume…"

– Michael Kerner, CEO, Bon Secours Hampton Roads

"For now, we don't get paid on keeping people healthy."

– Peter Bastone, CEO, Chesapeake Regional Medical Center

While all of the CEOs we talked to agreed that this change is coming, not everyone believes that fee-for-service is doomed – at least not right away. "Over the rest of this decade, quality is going to become an increasingly important determinant of reimbursement and fee-for-service is going to decrease," says Jim Lind, CEO of EVMS Medical Group. "I do believe that quality will become more important, but I don't think fee-for-service is ever going to go away."

Chesapeake Regional Medical Center CEO Peter Bastone agrees that it will be some time before a true value-based system is implemented in the US. "We are still riding the fee-for-service structure for a long time," says Bastone, whose small hospital has remained independent through strategic alignments with other organizations. "For now, we don't get paid on keeping people healthy. We get paid on episodic illness."

Sentara Healthcare President and CEO David Bernd also calls this transition "the biggest issue in healthcare" in the next three to five years. At a recent White House meeting including CEOs from six different US hospitals and health systems, Bernd says he was asked to name the number one thing that the administration could do to reform American healthcare.

"I told them to change from fee-for-serve to value based medicine," says Bernd. "I told them that I believe that is the single biggest thing that can happen to improve healthcare." Though he is passionate about the value of value-based medicine, Bernd also acknowledges that the fee-for-service structure is too deeply entrenched for changes to happen quickly.

Defining Shared Savings

Regardless of how soon the fee-for-service system is phased out, some of the basic terminology will need to be defined before the biggest changes can happen. Exactly what this new "value-based" system will look like, and how it will bring providers on board while keeping them in business, has yet to be determined.

"There is still a lot of work to be done to even identify what a prevention-based system means," says Bill Downey, President and CEO of Riverside Health System. "From a reimbursement standpoint, the insurance companies and the federal government talk about shared savings but right now in those models, since a lot of it is based on lower utilization, there are not a lot of places where the savings are going to be shared back with providers."

As healthcare wavers between two reimbursement philosophies, the issue remains a Catch-22. Healthcare leaders agree that, for a shared savings system to be effective and get providers on board, restructured reimbursement programs will have to recognize and reward the contributions that providers make to keep patients out of the system. "Right now, we are incented to provide tests and treatments for customers and patients," observes Bernd. "Preventive services are largely not covered."

Some healthcare leaders believe that bundled payments, payment structures that pay more to providers when the insurer ends up spending less than the average on their patient, may offer a solution. Some insurance companies are already doing this. Unfortunately, as several area CEOs pointed out, Virginia may not be a top priority for this type of structure since healthcare here is already considered a "good value." Insurers are more likely to concentrate their cost-saving efforts in higher-cost regions of the country, at least for the next few years.

"I believe that [value-based medicine] is the single biggest thing that can happen to improve healthcare."

– David Bernd, President and CEO, Sentara Healthcare

The Risk of Lower Utilization

While payors may have an interest in keeping patients out of the system, providers know that the system exists for a reason. Several healthcare leaders we spoke with say they are worried about the potential negative result of an entirely value-based system – that fewer people will get the care they need in the coming years.

"Deductibles and copayments are higher now, putting more of the burden of payment on the patient," observes Kerner. "But sometimes that can cause under-utilization and access to care can be lower than it needs to be."

That may be especially true in Virginia, which failed to approve the expansion of Medicaid. As a result, an estimated 400,000 Virginians are without healthcare coverage, a situation several CEOs say may make it more difficult to care for them when patients finally do come in with more advanced conditions. This presents a dual challenge for providers, who will increasingly be judged (and reimbursed) based on their outcomes.

Gathering Quality Data

All of the CEOs we spoke with agree that the collection of quality data will be a vital part of the move away from a fee-for-service system. The idea is that patients will naturally gravitate toward providers whose outcome data look good and those whose data is not as good will be motivated to improve in order to stay in the game.

"I don't think fee-for-service is ever going to go away." *– James Lind, Jr., CEO, EVMS Medical Group*

While healthcare leaders say it is a solid theory, there is still uncertainty over exactly what data is most important and against what standards it will be measured. For the transition of the healthcare system to be effective, they say there must be a greater emphasis on the standardization of outcome and quality data in the future.

"Hospitals have really changed," says Bastone. "If you ask them anything about the bottom line, they know those numbers cold. But when it comes to quality outcomes, they don't have those performance metrics nearly as readily."

"Part of the problem is that there are a myriad of quality of indicators," says Downey. "Medicare has certain ones, Anthem has certain indicators that they want. I think we need to come up with a national benchmark that says here are the top 25 quality indicators that we want everyone to track."

"There is still a lot of work to be done to even identify what a prevention-based system means."

– Bill Downey, President and CEO, Riverside Health System

Most area providers are already gathering this data to a greater or lesser degree, based on their size and budgets. Some were early implementers of EHR technology and began using it to standardize best practices as early as a decade ago, while others are still struggling to integrate the system into day-to-day patient care and gather critical data. Ultimately, all are well aware that the investments they are making now in improving and tracking quality will determine their future – provided they can stay in the black until that future arrives.

"We are changing peoples' behavior. It's a new paradigm," says Lind. "We are spending time and infrastructure today trying to demonstrate to our providers where we think we need to be in the future. The problem is that the cost of that infrastructure can outpace your reimbursements."

When our Future of Healthcare series continues, we will look at what these five healthcare organizations are doing to prepare for the new paradigm, including implementing new technology, addressing quality issues, gathering and reporting outcome data, and driving patient engagement. ■

Watch for "The Future of Healthcare" in our next issue!

Peter Bastone, CEO,
Chesapeake Regional Medical Center

David Bernd, President and CEO,
Sentara Healthcare

Bill Downey, President and CEO,
Riverside Health System

Michael Kerner, CEO,
Bon Secours Hampton Roads

James Lind, Jr., CEO,
EVMS Medical Group

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Riverside Lifelong Health:

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"As I age, I will control my destiny in a place of my choosing."
— Riverside Lifelong Health vision statement

Every day since January 1, 2011, 10,000 Americans have turned 65, a trend that's expected to continue – every day – until the year 2030. Ask any one of these individuals what they want most as they age, and the answer invariably comes back, "good health, and the ability to maintain my independence." Dig a little deeper, and a more thoughtful response often follows: "I don't want to be a burden. I want to stay in my home for as long as I can." In other words, "I want to control my own destiny."

Dr. Allen, Medical Director for Geriatric Medicine and Lifelong Health; Vice President of Clinical Integration for Riverside Health System

The job of providing medical care for these aging Americans falls to a healthcare system that is already overburdened, as the cost of providing care continues to rise. And while Americans may be living longer, they're not necessarily living healthier. According to the latest data from the federal Centers for Disease Control and Prevention, at least 70 percent of American adults are overweight and even obese, while 26 percent have diabetes and 31 percent have hypertension – all of which points to an even greater financial strain on the system. In fact, the Centers for Medicare and Medicaid Services report that 15 percent of the nursing home population in America is under 65 years of age, having acquired geriatric conditions years before reaching that milestone.

To Riverside Health System, it makes more sense to invest in keeping people healthy all throughout their lives through coordinated, integrated care. And as they age, Riverside's innovative Lifelong Health Division empowers patients to live the way they want to live, by creating an atmosphere in which they can grow older gracefully and independently.

At Riverside, age really isn't 'Just a Number'

In 1935, the Committee on Economic Security proposed 65 as the retirement age under Social Security, and that number has become a milestone for crossing from middle to old age. When Riverside looks at age, however, it uses a more expansive definition, dividing patients into three distinct categories, explains Dr. Kyle Allen, Vice President of Clinical Integration and Medical Director for Geriatric Medicine and Lifelong Health:

- **Active** – healthy, living independently, playing tennis, etc.;
- **Chronic** – dealing with three or more chronic illnesses like hypertension or diabetes;
- **At risk** – the frailest patient, in need of intensive nursing home care.

"We want to empower those we serve, regardless of age, disability or situation," Dr. Allen emphasizes, "recognizing that each experience is different, depending on the patient's individual medical and personal needs."

Over the last thirty years, Riverside has developed an unrivalled network of services providing focused care and expert capability to its aging community.

Dr. O.T. Adcock, lead physician for Riverside's Patient-Centered Medical Home model, doing an annual wellness exam for one of his primary care patients.

"We've had extraordinary leadership under visionaries like former CEO Richard J. Pearce and former Senior Vice President Michael Martin, a gerontology trained administrator who led our aging related services for more than 27 years," says Robert Bryant, Senior Vice President of Riverside Lifelong Health and Aging Related Services Division. "And that well-founded tradition is continuing under the leadership of Bill Downey, the current CEO of Riverside Health System, as well as Dr. Allen, who we were fortunate enough to recruit from Ohio. Dr. Allen is Board certified in geriatrics and family medicine, and is nationally recognized as a thought leader in the field of caring for older adults. Bringing him to Riverside reflects our commitment to expanding our services to meet the needs of our growing community. Dr. Allen is a strong believer in person centered care, innovation and working collaboratively to coordinate care – which are the very foundations of Riverside Lifelong Health."

Continuing the legacy of dedication and commitment.

"Based on our experience, the expertise of our professionals and the dedication of our team, we have developed a series of thoughtful commitments to patients, their families and caregivers," Bryant emphasizes. "And we've turned those commitments into practices and protocols in accordance with Riverside's Care Difference Philosophy: 'putting patients (their families and caregivers) at the heart of all we do to ensure the highest safety and quality, treating every patient with kindness and respect, reflecting a fundamental belief that healthcare is a lifelong relationship that spans the continuum of need.'"

Riverside is committed to clinical models of care that treat the whole patient.

It begins with Riverside's innovative Patient Centered Medical Home model of organizing primary care.

The Patient Centered Medical Home is an approach that emphasizes interdisciplinary care, coordination and communication among all medical providers, at every step of the patient's healthcare experience. "The care is comprehensive," says Dr. O. T. Adcock, Service Line Chief for Primary Care and a family medicine physician with Riverside Medical Group. "We provide daily care to children and adults of all ages, but our biggest focus is working with our geriatric population."

For Riverside, working with the geriatric population means taking care of 7,000 older adults each day, who require varying levels of care and different services. The Patient Centered Medical Home is the coordination and communications arm that ensures each provider knows what the other providers are doing, and that patients and their caregivers know as well. "We schedule appointments, tests and lab studies," Dr. Adcock says, "and ensure follow-up and referral as appropriate, whether to our ACE unit, one of our rehabilitation facilities, a skilled nursing home, an assisted living facility, physicians house calls practice, skilled home health care, or hospice. The Patient Centered Medical Home provides access to the full complement of medical care."

The Individual Plan of Care.

When aging patients require more than in-office medical care, Riverside's Care Navigators work with them and with their caregivers to determine exactly what's needed, and help align those needs with the expanded services Riverside offers. As with all aspects of care at Riverside Lifelong Health, it starts with talking to the patient, family and other caregivers, and asking some fundamental questions: "What do you want? What matters most to you? What are your goals? What do you want to accomplish? Where do you want to be?"

Bob Bryant, Senior Vice President of Lifelong Health

Once the answer is known, explains Patricia Russo, Vice President of Care Management, "We develop an Individual Plan of Care, a specific care plan tailored to each patient's situation, looking at the patient's function, cognition, ability to pay for medications, access to nutrition and fresh air, interests, in addition to clinical presentation."

Riverside's Continuing Care Retirement Communities – a Lifestyle Choice

For individuals who seek the ease and sociability of retirement home living, there are many choices today. One of the most innovative and popular options is the "continuing care retirement community," or CCRC. CCRCs are specifically designed to meet the lifestyle and health needs of older adults throughout their retirement years. Each of Riverside's three CCRCs offers independent living apartments and homes, as well as assisted living, skilled nursing, memory care, and rehabilitation on one campus. Because the full continuum of care needs is anticipated and delivered in one location, residents living at each of these communities can avoid having to move if their needs—or the needs of their spouse—should change.

Riverside currently operates three Continuing Care Retirement Communities across the region: Warwick Forest, Patriots Colony, and Sanders (home of Heron Cove), each with its own unique identity and brand of care. Each offers independent living apartments and homes, as well as assisted living, skilled nursing, memory care, and rehabilitation on one campus. Because the full continuum of care needs is anticipated and delivered in one location, residents living at each of these communities need not move if their needs should change.

Sanders Retirement Village has been caring for residents on the Middle Peninsula for more than 50 years. Patients who need the structure of more extensive, long-term care often reject the idea of residential care because they fear losing many of the things they value, including a sense of control over their lives and their environment.

Lt. Governor Bill Bolling visits Heron Cove at Sanders to learn about this new model of care.

Heron Cove at Sanders is changing the culture of nursing care, as well as the physical environment.

Walking through the open kitchen inside Heron Cove at Sanders, Virginia's first deinstitutionalized nursing facility

Riverside Health System is changing the way care is delivered in these settings, reflecting a new culture that is all about patient choice. Within Sanders is the innovative community known as Heron Cove, which features the framework known as the Household Model. Heron Cove sheds the institutionalized regimentation, the top-down management emphasis on efficiency first that is the stereotypical image of the traditional "nursing home," focusing instead on relationships and choice. Residents make decisions about how their household will function and about how they will manage their own personal lives. Heron Cove's approach recognizes and fosters dignity, respect, love, and privacy – values every individual needs.

In 1988, recognizing the growing needs of the Peninsula's aging population, Riverside opened its first retirement facility, Warwick Forest. Today Warwick Forest offers the entire continuum of care: Independent Living, Assisted Living, Nursing and Memory Care, as well as Rehabilitation.

Patriots Colony was founded by a group of retired military officers who saw the need for a community dedicated to those who shared the common bond of service to country. They approached Riverside Health System with their plan, and in 1996, Patriots Colony opened in 1996. Today, Patriots Colony is a Continuing Care Retirement Community offering all levels of care on one expansive campus.

Patriots Colony's health care services, including The Berkeley Assisted Living, Springhouse Memory Support and The Convalescent/Rehabilitation Center, are open to the public. Reflecting its origins, Patriots Colony's Independent Living section is restricted to retired and former (honorably discharged) officers of the seven uniformed services, retired and former civilian employees of the federal government (grade GS-7 & above), and their spouses or widow(er)s.

Riverside is committed to serving patients who wish to stay in their own homes.

ChooseHome: retirement community care – available in the home.

The Commonwealth of Virginia recently passed legislation allowing for the development, licensing and regulation of "community-based continuing care" programs, also known as "life care at home" or "continuing care at home" programs. Riverside's ChooseHome option offers patients 60 and older a comprehensive and cost-effective option to long-term care insurance, bringing the individualized resources patients need to continue living safely and comfortably in their home. These resources include wellness and home safety assessments and individualized plans, in-home technologies, medication dispensing units, adult day services, home health aide, homemaker assistance and personal care, among others as needed.

Recognizing that as patients' conditions change, so do their needs, ChooseHome provides members with a Personal Services Coordinator (or navigator), who functions as an advocate and guide, helping patients and their families determine their goals and which programs best meet immediate and future needs at every step of their care.

The ACE (Acute Care for Elders) model of care.

Dr. Allen was one of the investigators who helped study how to improve hospital care for older adults and participated in the clinical trials of the Acute Care for Elders Model of Care. He has helped implement the ACE model of care at Riverside, which combines principles of geriatric assessment and quality improvement. The ACE model is designed to foster independent functioning of older patients during their hospitalization, to reduce hospital- associated conditions, e.g. confusion, and to prepare them to function at home as well. The ACE program at Riverside provides patients and caregivers with tools and support to encourage them to more actively participate in the transition from hospital to home, and once home, to master effective self-management skills. Riverside has also partnered with the Eastern Virginia Care Transitions Partnership, which uses the Coleman Care Transitions model, a model that assigns a coach to patients and their caregivers to help them better understand their medication schedule, to know what to be alert for with their medical condition, to know about appropriate follow-up care and maintaining a personal health record. This coaching model is activating patients and caregivers to become more confident in their self-care of their health. In addition, because RHS knows how important care transitions are, the ACE unit is innovatively creating a simulation of what being at home will be like, with nursing and therapy staff providing education and skills before discharge, to help patients and caregivers prepare adequately.

"These transition times can be particularly challenging and stressful on patients," Russo says. "It's well understood that any time a patient moves from one care setting to another – whether from inpatient to skilled nursing facility or from inpatient to home, even from primary care to a specialist – there is the opportunity for miscommunication, so part of our focus is always to insure a smooth transition from one provider to the next. We make sure the patient and the family understand the transition plan, so that when they move from one venue to another, they're a part of the process, as well as the care team."

"We believe in activating the patients in self-care, self-management as much as possible," Dr. Allen adds. "A large part of that is teaching them how to be a partner."

Critical to the success of ACE – and all of Riverside Health System – is the initiative known as NICHE – Nurses Improving Care for Health System Elders.

NICHE is the leading nurse-driven program designed to improve the care of older adults across the health system. It provides nurses with education and best practice models for responding to the unique needs of older adults.

"We opened our ACE unit in October 2013," says Kathleen R. Fletcher, a Doctor of Nursing Practice who serves as Director of the Geriatric Nurse Clinical Practice Program at Riverside, and was instrumental in establishing NICHE at Riverside. "The unit consists of 24 private rooms dedicated to those patients who are over the age of 55, typically living at home, who benefit from our team approach to rehabilitation. There are daily rounds on the ACE

unit based on the interdisciplinary plan of care for each patient," Dr. Fletcher explains. "The team includes a physician, a social worker, nurses, physical therapists, all working with patients who may be struggling with different aspects of day-to-day activities. We work aggressively with them, providing services as needed to transition them back to home." NICHE relies on evidence-based protocols that allow for intervention by nurses, which may well preclude escalated conditions that might result in an ER visit, or even hospitalization.

There are no hard and fast rules for what constitutes qualification for ACE care at Riverside, Dr. Kennedy notes, because "people age and develop chronic conditions differently at different paces. That's one of the reasons why this utilization of a model for care that enhances the skills and knowledge sets and capabilities of people taking care of older adults enhances our ability to prevent complications and hospital readmissions."

In addition, notes Dr. Terris Kennedy, Riverside's Chief Nursing Officer, "NICHE provides us with a geriatric nursing research curriculum, as well as a patient care curriculum, to enhance and heighten Certified Nursing Assistance observation skills and geriatric nurses' ability to intervene, based on what they observe in real time. It provides us a laboratory in terms of how we're caring for older adults with chronic co-morbidities, which we can then translate and take from the ACE unit to our smaller community hospitals." Riverside is also using the NICHE program through all its acute care and post-acute facilities. The National NICHE office is interested in this work and has been working closely with Dr Fletcher to understand better how NICHE can be used system wide to improve care of older adults.

Dr. Christine Jensen, Coordinator of the Virginia Caring for You Program meets with Former First Lady Rosalynn Carter in Georgia to discuss the program's impact in Virginia, October 2012.

CEALH – helping patients control their destinies by ensuring that both they and their families fully understand their situation and the options available to them.

The Riverside Center for Excellence in Aging and Lifelong Health (CEALH) provides services ranging from geriatric assessments to teaching individuals with chronic conditions how to manage their symptoms, to providing resources and education for caregivers.

An example is CEALH's Geriatric Assessment Clinic – one of only six in Virginia – which provides a comprehensive look at each patient, and includes a comprehensive evaluation conducted by a team that includes a geriatrician, a nurse, counselor and physical therapist focusing on memory loss, incontinence, fall risk, depression and medication issues. Referrals are made as appropriate, with follow-up and recommendations for families and caregivers individualized to the findings of the assessment.

Either you are a caregiver, you rely on a caregiver, or you will become a caregiver.

"We recognize that caring for the aging patient also means caring for the patient's caregivers," says G. Richard Jackson, CEALH Executive Director. "We train family members as well as professionals to understand the person they're caring for and the diseases that patient has."

Since the "Caring for You, Caring for Me" training, a program of the Rosalynn Carter Institute on Caregiving, was introduced at Riverside, more than 250 family and professional caregivers have enrolled in the five-week program at CEALH, which brings caregivers together in a relaxed setting to discuss common issues, share ideas and learn about available resources. "This program has received Best Practices Awards from both the Southern Gerontologic Society and the Commonwealth Council on Aging," says gerontologist Christine Jensen, PhD, Director of Health Services Research. "The cost of the entire course is $35, which includes educational resources."

It also includes a caution: caregivers frequently neglect their own health in the stress of taking care of older patients, Dr. Jensen notes. "Their own immune systems can become compromised, so we tell them to be sure their own physicians know they're caring for an older patient. And we share Mrs. Carter's entire quote with them: 'There are only four kinds of people in the world: those who have been caregivers, those who are currently caregivers, those who will be caregivers, and those who will need caregivers.'"

Much like the "Caring for You, Caring for Me" program, CEALH also trains leaders to go out into the community to hold group sessions for individuals suffering from chronic diseases, to help them understand how to make decisions that will positively affect their health. "We talk about diet, exercise, stress reduction, spirituality – anything and everything that would help them manage their disease," Jackson explains.

CEALH also serves as the Research and Discovery arm of Riverside Lifelong Health.

"In fact, we're a hybrid of an interdisciplinary aging research agency and a provider of special services for older adults," Dr. Jensen explains, "which allows us to conduct clinical trials designed to explore and evaluate new treatments and medications, as well as clinical and academic research that can be directly applied to the older population. Whenever we're involved in one of those programs, we're also studying and documenting it for future use."

Both Jackson and Dr. Jensen emphasize that while the specialized services CEALH provides are available on a sliding pay scale, "Nobody who knocks on our door is denied service because of the inability to pay. Every grant we write contains a request for scholarship funds for marginalized patients."

PACE – A Program of All-Inclusive Care for the Elderly.

The PACE model is centered on the belief that it's better for the well-being of older patients with more chronic care needs and their families to be served in the community whenever possible. Riverside PACE serves individuals who are age 55 or older, who are certified by the Commonwealth to need nursing home care, who are able to live safely in the community at the time of enrollment, and who live in a PACE service area. There are six PACE centers within the Riverside Lifelong Health system, overseen by Medical Director Dr. Paul Evans, a Board-certified geriatric and family medicine physician.

"One of the most positive aspects of PACE is the acknowledgement that taking care of older patients isn't just about medicine, it's not only providing medical care," Dr. Evans says. "It includes all the other parts of someone's life – their finances, their ability to get to social events, the ability to get adequate food and housing, appropriate resources. It recognizes the importance of things like clean air, clear water, housing free of insects and lead paint, all other social determinants of care and health. PACE acknowledges what doctors have always known," Dr. Evans says, "that there's so much that goes into poor health, poor outcomes, that's out of the control of medicine."

The benefits of participating in the PACE program are multifaceted, and include extensive outpatient services, home healthcare services, inpatient hospital care and nursing facility care.

"Even when there's not much we can do for these patients medically, the things we can do for them through PACE can help them achieve better health, and be more functioning," Dr. Evans says. "We work

A Riverside PACE nursing assistant listens to the heartbeat of a PACE participant at the Center in Hampton

Riverside's sixth PACE Center, Blue Ridge PACE, opened in early 2014

closely with the families of our patients, providing aides during the day or at bedtime when required. We modify the home if necessary, as the patient's needs dictate: we provide aides in the home, or at bedtime, we install ramps and even provide bus transport services. The focus is on what can keep patients at home, what will maintain their highest level of function, what will bring them the most joy, and what will support their families."

Invaluable and Innovative Tools for In-home Patients and Caregivers

"Technology has allowed us to provide products and services for our patients that keep them safer, and enable them to go home from a hospital or nursing home earlier than they would if they didn't have access to such products," says Daniel Ballin, a physical therapist and Administrator of Riverside's Wellness and Outpatient Services. He's particularly excited about Riverside Alert, a personal emergency response system (PERS) that features immediate 24/7 access to Ask Riverside with just the touch of a button. "This can be a great comfort to patients who have questions or concerns," he says, "as they can get answers virtually instantaneously. It's an equal comfort to family members who aren't local, knowing their loved one has ready access to help."

A medication dispensing service is also available. It organizes complex drug regimes, and provides both audio and visual reminders to the patient, including a missed dose alert. Emails are provided to caregivers, who can also monitor patient compliance online. "This is a vital service, because one of the primary reasons older patients are admitted to the hospital is medication mismanagement.

Technology has also enabled remote vital sign management. "Our nurses will visit patients at home and leave a blood pressure monitor," Ballin says. "We can even track blood sugar, glucose and weight five days a week. We can recognize early warning signs, and immediately send nurses out to check on patients when needed."

House Calls: a new spin on an old medical tradition.

Under the direction of Dr. Teresa McConaughy, a Board-certified family medicine physician, Riverside's House Calls Practice provides primary healthcare services to home-limited adults unable to access regular medical care. "It was on Dr. Allen's wish list when he came to Riverside," Dr. McConaughy says. "He created a business plan and model to make it work, and I was immediately interested. I had a large geriatric practice, but I wanted to do geriatrics in a different way, and this presented that opportunity."

With House Calls, Dr. McConaughy and Dr. Travers Edwards function as their patients' PCP. "Some of them have family doctors, but they're too sick or too weak to visit them, so we take on their care," Dr. McConaughy says. "We also get referrals from home health agencies who ask us to step in on behalf of their patients. We coordinate all medical care, including specialty services, whatever they need that we can treat in the home."

House Calls physicians are able to spend more time with patients, and develop warm and ongoing relationships with these patients, and putting a human face and touch on the technologies available to them through Riverside's Lifelong Health division. They find that they're able to have much more meaningful conversations with patients about their care – and about their lives – when they're comfortable in their own homes.

Compassionate care when it's most needed.

For patients with advanced illness, the concern turns to one of the most sensitive decisions in a family's life: what to do as the end of life approaches. Words like 'palliative care' and 'hospice' can seem foreign and frightening to patients at a time when they feel most vulnerable and their family members feel helpless.

Dr. Cunnington works with a family at Riverside Regional Medical Center to develop an Advance Care Plan

It doesn't have to be that way, says Dr. Laura Cunnington, Riverside's Medical Director of Palliative Care and Hospice Services. "We know these are very difficult times for everyone involved. It's hard to contemplate death, especially your own, and it can be even harder to talk about it with people you love, especially if that death seems imminent."

The hope is that physicians will talk to their patients about what they want as they age, Dr. Cunnington notes, "but these conversations can be difficult for doctors as well. They have special relationships with their patients, and it can be hard for them to accept the fact that a patient might be dying. I do a lot of education, one-on-one with doctors, in didactic type settings, to give them better skills as well."

Advance Care Planning Facilitators assist patients and families.

To assist patients and their families (and when appropriate, care providers), Riverside offers the services of trained Advance Care Planning Facilitators, who are certified by Respecting Choices®, an internationally recognized advanced care planning program. "These facilitators talk with patients and their families about quality of life issues," says Carol Wilson, Director of Palliative Care and Advance Care Planning. "They ask the same fundamental questions: 'What are your goals? What do you want to accomplish? Where do you want to be?'" There's no medical jargon in these conversations, Wilson notes. It's just about finding out what the patients want.

With this information in hand, an Advance Care Plan can be created and documented and made a part of the patient's medical record. Patients are satisfied that their dearest and most personal wishes will be honored when they can no longer speak for themselves, and both families and healthcare providers are relieved of the burden of having to make decisions that might be in opposition to those wishes.

Riverside care providers can then proceed to honor those wishes in all aspects of the patient's care, whether on palliative care or in hospice, delivering and coordinating the highest quality and most appropriate care.

"That's what Compassionate Care is really about," Dr. Cunnington says: delivering team-based care at the end of life, focused on the patient, in relief of suffering, and provided in the setting the patient wishes.

It's also about educating the community about the resources Riverside offers to patients and families, particularly with regard to Advance Care Planning. Riverside Lifelong Health is part of the Advance Care Planning Coalition of Eastern Virginia, which also includes Sentara, Bon Secours Hampton Roads and Chesapeake Regional Medical Center. Branded "As You Wish," the Coalition works to increase public awareness of Advance Care Planning among all adults over the age of 18, and those filing Advance Care Planning documents.

Riverside Lifelong Health – making Virginia a great place to grow older.

If Riverside Lifelong Health seems like an overwhelming labyrinth of products, services and initiatives, it's just as much a roadmap for patients, families, caregivers and healthcare providers to maintaining health and vitality – and to enjoying the wisdom and ease that come with age. And to knowing that the fondest and most deeply held personal wishes will be honored.

With a commitment to caring for older patients that spans more than three decades, earning a statewide and national reputation for excellence, Riverside Lifelong Health is acknowledged as the expert on caring for some of Virginia's greatest assets – her elder citizens.

For more information visit our website www.riversideonline.com/lifelonghealth. Or call (757) 856-7030

Promotional Feature

IN THE NEWS

Bradley Prestidge, MD

Bon Secours Cancer Institute is offering a breakthrough radiation treatment for lung cancer called high dose rate endobronchial brachytherapy (HDR EBB), the only facility in Hampton Roads to offer the treatment. The procedure delivers a quick, direct, and localized high dose of radiation in a single, one- to two-minute sitting, instead of the traditional approach which involves daily treatments that are less precise and administered over the course of six or seven weeks. For some lung cancers located near the bronchial tubes—the passages that connect the lungs to the throat—HDR EBB, sometimes called internal radiation, is a technique fast gaining recognition as a state-of-the-art therapeutic alternative and complement to the more conventional external beam radiation therapy.

Alexander Stojadinovich, MD

Itzhak Avital, MD

Bon Secours Cancer Institute physicians are offering hope to advanced-stage stomach cancer through breakthrough research published in the September 2014 issue of the *Journal of Surgical Oncology*, which compared the impact on 17 patients with metastatic cancer of standard systemic chemotherapy vs. a unique two-step technique which in addition to the systemic drugs included cytoreductive or 'debulking' surgery—removal of as many visible tumors or parts of tumors as possible—followed immediately by hyperthermic intraperitoneal chemotherapy (HIPEC)—delivery to only the abdomen of a heated, sterilized chemotherapy solution.

The Bon Secours Heart & Vascular Institute has established the Bon Secours Heart Rhythm Clinic, focusing on providing high quality, advanced care for abnormal heart rhythms. The cornerstone of the Bon Secours Heart Rhythm Clinic is the new advanced electrophysiology lab, located at Bon Secours Maryview Medical Center, which hosts the latest technology for the diagnosis and treatment of arrhythmias. The Bon Secours Heart Rhythm Clinic offers several options for the management and treatment of atrial innovative Arctic Front Advance™ CryoAblation System, to treat atrial fibrillation. Cryoablation uses a special gas inside a catheter tube to freeze small sections of the heart that are causing rhythm problems. Cryoablation's precision means very little healthy heart tissue is affected during the procedure.

Bon Secours Maryview and Bon Secours Health Center at Harbour View Diagnostic Cardiac Services have been granted a three-year term of re-accreditation in Echocardiography in the area of Adult Transthoracic, Adult Transesophageal, Adult Stress by the Intersocietal Accreditation Commission. This designation by the IAC means that the diagnostic cardiac services has undergone a thorough review of its operational and technical components by a panel of experts. The IAC grants accreditation only to those facilities that are found to be providing quality patient care, in compliance with national standards through a comprehensive application process including detailed case study review.

Bon Secours Maryview Medical Center cardiothoracic surgeons are utilizing robots to create a stronger bond between physicians and patients. Dr. Robert Lancey and Dr. Kevin Shortt are using Double Robotics technology to communicate with patients more often than usually possible. While visits from the robots do not replace in-person visits, they add extra visits on weekends and late at night. The technology allows physicians and patients more face-to-face contact through web cameras. The robot consists of a tablet perched on top of a set of remote-controlled wheels. Physicians control the movement of the robot from their smartphone or tablet wherever they are. Nurses escort the robots into patient rooms just as they would if the physician were there in person.

Dr. Samuel Brown, an orthopaedic surgeon with Sports Medicine and Orthopaedic Center, recently served as co-chairman of the Piedmont Orthopaedic Society, spearheading the 62nd Annual Meeting of the Piedmont Orthopaedic Society and Piedmont Orthopaedic Foundation in Athens, Greece. The Society was formally established in 1951 to maintain a cohesive group of Duke University alumni surgeons who communicate at regular intervals and have annual scientific meetings. The society currently consists of over 650 US and international surgeons. Dr. Brown is an active member of many orthopaedic societies, including The American Academy of Orthopaedic Surgeons and the American Orthopaedic Society for Sports Medicine. He is celebrating 25 years of practice with SMOC in 2014.

Samuel Brown, MD

Chesapeake Regional Medical Center is now offering 3D mammography, which coordinates with 2D mammography and breast MRI to increase the rate of breast cancer detection and reduce the amount of unnecessary return visits for repeat breast screenings. Chesapeake Regional is the only facility in the area that offers C-View™, which provides the technology to obtain both of the recommended 3D and 2D images during the same screening, reducing exposure to radiation and provides the latest in breast cancer technology.

Chesapeake Regional Medical Center has been designated a NICHE (Nurses Improving Care for Healthsystem Elders) Hospital, signaling its dedication to providing patient-centered care for older adult patients. The program allows staff to offer evidence-based, interdisciplinary approaches that promote better outcomes, positive experiences and improved care for older adults leading to greater patient, family and staff satisfaction. NICHE, based at NYU College of Nursing, has over 550 hospitals and healthcare organizations from the US, Canada, Bermuda and Singapore in the network.

Doctors from Chesapeake Radiologists, Ltd. and Cardiovascular Associates, Ltd. at Chesapeake Regional Medical Center are among 32 centers participating in an FDA-approved clinical study to improve access to MRI diagnostics for cardiac rhythm patients.

The hospital and specialty group are working together to contribute to a clinical study using the first implantable cardioverter defibrillator (ICD) approved in the US for use in an MRI (magnetic resonance imaging) scanner. Already three patients who have the unique devices implanted have completed MRI scans.

Stephen H. Lin, MD, a Board certified general surgeon who practices with Chesapeake Surgical Specialists, has been chosen to host case observations by da Vinci® Surgery.

This program aims to demonstrate the use of da Vinci® Single-Site™, multiport, and advanced robotic technology in a clinical setting and facilitate clinical discussions between an experienced da Vinci general surgeon and guest surgeons interested in evaluating da Vinci technology. The event includes live cases and will focus on the efficacy and reproducibility of da Vinci Single-Site Cholecystectomy, hernia repair, foregut procedures, and where applicable firefly, stapler, and vessel sealer.

Stephen H. Lin, MD

Riverside Health System has opened a 24-bed pulmonary care rehabilitation unit at its skilled nursing center at The Gardens in Newport News, to help patients receive additional care in the form of a stay at a short-term skilled nursing facility designed to support their specialized respiratory needs, thus avoiding the need for readmission to the hospital. Care at the rehabilitation unit is provided by an interdisciplinary team led by Dr. Robert Orlino, Dr. Emmeline Gasink and Dr. Joe Ward, with registered nurses and in-house respiratory therapists offering around the clock care and support.

Riverside Health System, in partnership with Williamsburg Landing, will offer its ChooseHome program to residents throughout Williamsburg and Newport News, as well as the Middle Peninsula region. ChooseHome is offered to residents 60 and older, who currently live independently and want to have a plan for what their future long-term care needs may be. The program then partners with clients to offer the individualized support necessary to remain living in one's own home safely and comfortably for as long as possible, potentially for life.

Tidewater Physical Therapy is pleased to announce the addition of seven new Doctorate level Physical Therapists to the company. Elena Black, PT, DPT; Brittany Rogers, PT, DPT; Casey Stelatto, PT, DPT; Spencer Combs, PT, DPT; Brittany Bennett, PT, DPT; Brittany Bostwick, PT, DPT and Chandra McClung, PT, DPT.

Elizabeth Yeu, MD has been named a partner in Virginia Eye Consultants. Dr. Yeu is a Board certified ophthalmologist, fellowship trained in cornea, anterior segment and refractive/LASIK Surgery, specializing in cornea and cataract Surgery, LASIK, keratoconus, dry eye disease, anterior segment reconstruction and cosmetic injectables and fillers. She received her medical degree from the University of Florida College of Medicine and completed an ophthalmology residency at the Rush University Medical Center in Chicago. She completed her fellowship in Cornea Anterior Segment and Refractive Surgery at the Cullen Eye Institute, Baylor College of Medicine.

Elena Black
PT, DPT

Brittany Rogers
PT, DPT

Casey Stelatto
PT, DPT

Spencer Combs
PT, DPT

Brittany Bennett
PT, DPT

Brittany Bostwick
PT, DPT

Chandra McClung
PT, DPT

Hampton Roads Physician Salutes our 2014 Cover Doctors

Alfred Z. Abuhamad, MD

Joseph A. Aloi, MD

Francis L. Counselman, MD

Cheryl L. Lawson, MD

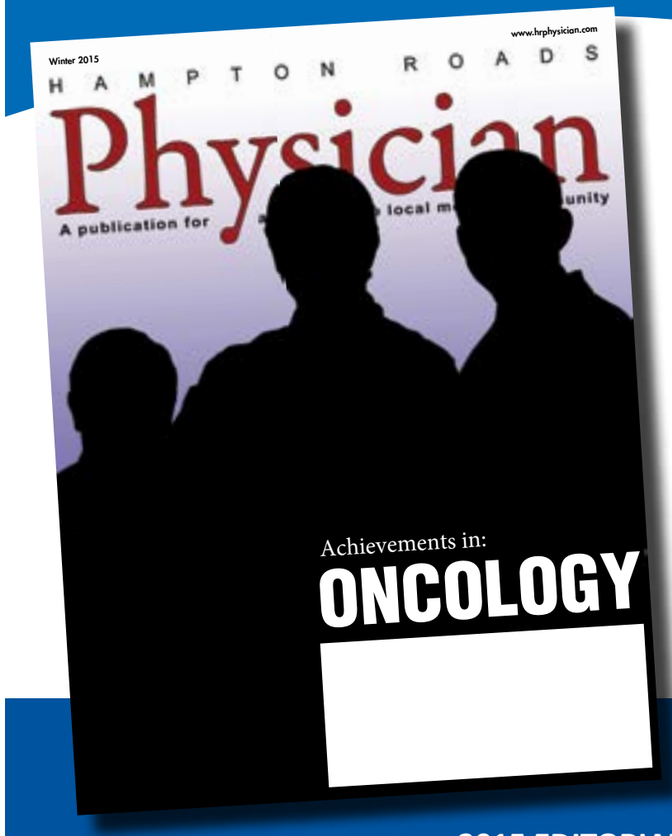
David C. Lieb, MD

J. Craig Merrell, MD, FACS

Jerry L. Nadler, MD

Robert C. Squatrito, MD

Leonard J. Weireter, MD



Taking Nominations for the Winter 2015 Edition
ONCOLOGY

We're looking for leaders in this field of medicine
Tell us who they are and why they deserve recognition.
Nomination forms are available on our website
www.hrphysician.com

or request a nomination form by email:
holly@hrphysician.com

Deadline for Nomination Submissions
December 3

2015 EDITORIAL CALENDAR
Our covers will feature physicians in the following specialties

Winter – ONCOLOGY • Spring – RHEUMATOLOGY
Summer – UROLOGY • Fall – RISING STARS

Paula Crawford-Harris, MD has joined the staff at Bon Secours Airline Boulevard Medical Associates in Portsmouth. Dr. Paula Crawford-Harris is a Board certified family practice physician. She received her bachelor of science in Microbiology and Cell Science and master of public health from University of Florida, and earned her master of business administration with a concentration in Health Administration from Davenport University. Dr. Crawford-Harris earned her medical degree from Saint Matthews University School of Medicine and completed her residency at Riverside Family Medicine.

Michelle Deschamplain, MD, a Board certified vascular surgeon, has joined Atlantic Vein & Vascular Associates in Virginia Beach. Dr. Deschamplain earned her medical degree at Virginia Commonwealth University School of Medicine, and completed residencies in general surgery at Geisinger Medical Center and VCU Health Systems. She completed at fellowship in vascular surgery at VCU Health Systems.

Philip Ding, MD, FACS, a Board-certified general surgeon, has joined Sentara Surgery Specialists in Suffolk and Portsmouth. Dr. Ding received his clinical fellowship training in Multi-Organ Abdominal Transplant Surgery at Cleveland Clinic Hospital in Cleveland, OH, involving liver, kidney, and pancreas transplantation. He earned his medical degree at the University of Alberta Faculty of Medicine & Dentistry in Edmonton, Alberta, Canada, and completed his general surgery residency at St. John Hospital & Medical Center in Detroit, MI, in 2007, serving his last year as Chief Resident.

Susan E. Habibi, MD has joined Sentara Hospital Medicine Physicians at Sentara Williamsburg Regional Medical Center. She earned her medical degree from Eastern Virginia Medical School and completed a residency in internal medicine at Virginia Commonwealth University in Richmond in 2014.

Bert Wellington Holmes III, MD has joined Fort Norfolk Plaza Medical Associates. Dr. Holmes received his MD from Meharry Medical College School of Medicine in Nashville, Tennessee, and completed his residency in internal medicine there as well. Dr. Holmes' father, Bert Holmes, Jr., is a retired urologist who practiced in this community for many years.

Tom Hong, MD has joined Sentara Hand Surgery Specialists in Chesapeake. He earned his medical degree at Drexel University College of Medicine in Philadelphia, and completed his orthopaedic surgery residency at UPMC Hamot and Shriner's Hospital for Children in Erie, PA. Dr. Hong completed his hand surgery fellowship through The Department of Orthopaedics and Rehabilitation at the University of Florida in Gainesville.

Nina D. Lucas, MD has joined Sentara Family & Internal Medicine Physicians in Elizabeth city. She earned her medical degree from Tulane University School of Medicine in New Orleans and her master of public health and tropical medicine degree from Tulane as well. She completed her residency in family medicine at 81st Medical Group in Eglin AFB, FL, and served as a Major in the United States Air Force from 1994 to 2000. She is certified in family medicine by the American Board of Family Medicine.

Jason Mazzurco, DO has joined Oyster Point Dermatology. Dr Mazzurco is a Board certified dermatologist and fellowship trained Mohs surgeon. He is a graduate of Ohio University Heritage College of Osteopathic Medicine, and completed his dermatology residency and Mohs fellowship at Joseph Mercy Hospital at Michigan State University.

Christopher McCann, DO has joined the staff at Bon Secours Gynecologic Oncology Specialists in Newport News. Dr. McCann received his doctor of osteopathic medicine degree from University of New England. He completed his residency in obstetrics and gynecology at Saint Francis Hospital and Medical Center and his fellowship in gynecologic oncology at Massachusetts General Hospital.

Blake E. Moore, MD, an orthopaedic foot and ankle surgeon, has joined Atlantic Orthopaedic Specialists. Dr. Moore completed his medical education at Albany Medical College in Albany, NY, and his orthopaedic surgery residency at Geisinger Medical Center in Danville, PA. He recently completed an orthopaedic foot and ankle surgery fellowship at the Penn State Milton Hershey Medical Center in Hershey, PA and is Board eligible.

Rosanne Newman, MD has joined the staff at Bon Secours Virginia Palliative Medicine, providing services primarily at Bon Secours DePaul Medical Center in Norfolk and Bon Secours Maryview Medical Center in Portsmouth. Dr. Newman is a Board-certified internal medicine, geriatric, hospice and palliative care physician. She has been medical director for nursing homes both in the private sector and at the Veterans Affairs Medical Center in Hampton.

Ugochi Ofole, MD has joined Sentara Hospital Medicine Physicians team at Sentara Obici Hospital in Suffolk. She earned her medical degree (MBBS) at the University of Ibadan in Ibadan, Nigeria, and completed her internal medicine internship at Interfaith Medical Center in Brooklyn, NY, in 2011, as well as her internal medicine residency in 2012. Dr. Ofole is certified by the Educational Commission for Foreign Medical Graduates.

Olusola Kendra Onayemi, MD has joined Sentara Family Medicine Physicians in Virginia Beach. Dr. Onayemi earned her medical degree from Obafemi Awolowo College of Health Sciences in Ogun State, Nigeria, and completed her internship and residency in family medicine at Eastern Virginia Medical School in Norfolk. Dr. Onayemi is certified by the American Board of Family Medicine.

Tarik Phillip, MD has joined the staff at Bon Secours Town Center Medical Associates in Virginia Beach. Dr. Phillip completed his undergraduate studies in biology at Midwestern State University and earned his medical degree from Howard University College of Medicine. Dr. Phillip completed his internal medicine residency at Oakwood Hospital and Medical Center, where he received the Resident of the Year award.

Donald W. Shenenberger, MD, a Board certified dermatologist, has joined Virginia Dermatology and Skin Cancer Center. He received his medical training at the University of South Carolina School of Medicine in Columbia and completed his residency at the Naval Hospital in Jacksonville, Florida. He served as a staff Family Physician at the Naval Medical Center Portsmouth and as Senior Medical Officer on board USS Mount Whitney deploying to the Horn of Africa and Gulf of Aden early in course of Operation Iraqi Freedom.

Eileen L. Sicangco, MD has joined Sentara Family & Internal Medicine Physicians in Chesapeake. Dr. Sicangco is Board-certified in family medicine, having earned her medical degree from the University of Santo Tomas in Manila, Philippines, in 2001. After receiving her medical degree, she completed a medical internship at the University of Santo Tomas in 2002. Dr. Sicangco completed her residency in family medicine at St. John Hospital in Detroit, MI.

Jay C. Starling, MD has joined Virginia Eye Consultants, providing cataract, LASIK and refractive surgery services. Dr. Starling has been a pioneer in cataract and refractive surgery procedures and techniques and was the first eye surgeon in the area to perform the "no-stitch" cataract surgery.

Victor Tseng, DO has joined Sports Medicine and Orthopaedic Center. Dr. Tseng was fellowship-trained in pain medicine at The Mount Sinai Hospital in New York City. He served as the chief resident during his senior year of PM&R residency at Georgetown University Hospital/ National Rehabilitation Hospital in Washington, DC, and he completed his medical internship at Frankford Hospitals/Jefferson Health System in Philadelphia. Dr. Tseng earned his medical degree from Philadelphia College of Osteopathic Medicine.

Michelle C. Walters, MD, a Board certified dermatologist, has joined Virginia Dermatology and Skin Cancer Center. She received both her bachelor of science and doctor of medicine degrees from Georgetown University in Washington, DC. She entered the US Navy upon graduation from medical school and completed a transitional internship at the Naval Medical Center in San Diego before serving as the General Medical Officer aboard the aircraft carrier USS Nimitz (CVN-68). She deployed to the Persian Gulf in support of Operation Enduring Freedom. Dr. Walters then returned to Naval Medical Center San Diego for her dermatology residency training.

Aisha Zaidi, MD, a fellowship-trained hematologist-oncologist, has joined Riverside Cancer Specialists of Tidewater in Chesapeake, Suffolk and Virginia Beach. Her areas of focus include blood-related disorders, cancer treatment including rare cancers and breast cancer. Dr. Zaidi received her medical degree from the University of Health Sciences in Lahore, Pakistan and completed her residency in internal medicine at the University of Louisville, where she went on to receive fellowship training. She is a fellow of the American College of Physicians.

Arinola Allison, NP, a Board certified family nurse practitioner, has joined the staff at Airline Boulevard Medical Associates in Portsmouth. Ms. Allison received her bachelor of science in nursing and master of science in nursing from Tennessee State University in Nashville.

Kirsten Allred, PA-C, a Board certified Physician Assistant and Virginia Beach native, has joined the staff of APM Spine & Sports Physicians. She graduated from Eastern Virginia Medical School with a Master of Science degree in Physician Assistant studies and obtained her bachelor's degree in Therapeutic Recreation from Old Dominion University.

Natalie Cutchin, MSN, FNP-BC has joined Sentara Palliative Care Specialists at Sentara Obici Hospital. She earned her bachelor of arts degree at Sweet Briar College in Sweet Briar, VA and her master of science degree in Nursing at the University of Virginia. She later completed the Post-Master's Family Nurse Practitioner program at Virginia Commonwealth University in Richmond.

Dr. Sandra J. Evans has joined Riverside Health System in Newport News as the System Director for Patient Care Operations. A Registered Nurse, she holds a doctor of nursing practice degree from Old Dominion University, a master of arts in management from Webster University, a master of strategic studies from Air University, and a bachelor of science in nursing from Wagner College. Prior to joining Riverside, Dr. Evans had a dynamic 30-year career in the United States Air Force as a Nurse Corps officer attaining the rank of colonel.

Cassandra L. Grimes, MS, RN, NP-C has joined Allergy & Asthma Specialists. She received her BS in Nursing from Michigan State University and earned her master of science degree from Hampton University in Virginia. She is Board certified with the American Academy of Nurse Practitioners.

Mary Hudson, FNP-C has joined the staff at Bon Secours Town Center Medical Associates in Virginia Beach. See profile on page 22.

Robyn Kunkel, PA, has joined Sentara Pulmonary, Critical Care & Sleep Specialists in Norfolk. She earned her bachelor of science degree at the University of Wisconsin in Stevens Point, and her master of physician assistant studies at the University of Wisconsin in La Crosse.

Jerrica Lyle, NP, a Board certified nurse practitioner, has joined the staff at Bon Secours Portsmouth Medical Associates. Ms. Lyle received her Master of Science in Nursing from the University of Scranton.

Amelyn Magtanong, NP has joined the staff at Amelia Medical Associates in Norfolk. Ms. Magtanong received her bachelor of science in nursing from Philippine Union College and her master of science in nursing from University of Cincinnati. She is also a certified critical care RN and cardiac medicine certified. She speaks English, Tagalog and Spanish.

Jasmine Siska, PA-C has joined the staff of Bon Secours Town Center Medical Associates in Virginia Beach. She received her bachelor of science in biology from Virginia Wesleyan College in Norfolk, and her master of physician assistant degree from Eastern Virginia Medical School.

Nicolle Stopa, MPAS, PA-C has joined Sentara Surgery Specialists in Suffolk. She earned her bachelor of science degree in Psychology at Texas A&M University in College Station and her master of physician assistant studies degree from the University of Texas Medical Branch in Galveston.

Carrie Watts, MPAS, PA-C has joined Sentara Cardiology Specialists located at Sentara Heart Hospital in Norfolk. She earned her bachelor of health science degree and her master of physician assistant science degree at Saint Francis University in Loretta, PA.

Samantha Workman, RN, BSN, CCRN, AG-ACNP has joined Sentara Pulmonary, Critical Care & Sleep Specialists in Virginia Beach. She earned her bachelor of science in Nursing degree at Bellarmine University in Louisville, KY and her master of science degree in Nursing in the Adult Gerontology – Acute Care Nurse Practitioner program at the University of Louisville, in Louisville, KY.

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AWARDS & ACCOLADES

Celebrating the accomplishments of those who have received major honors

Antoine Arrage, MD, an internist, was recently honored by Lake Taylor Medical Center. Dr. Arrage received his medical degree from the University of Alexandria Medical College, Egypt, and conducted his medical training in Rochester, NY, and Johns Hopkins and Church Hospital in Baltimore before beginning a fellowship at the Medical College of Virginia in Richmond. He served on the staff at Lake Taylor for 46 years, retiring in 2014.

Bon Secours Maryview Medical Center, in Portsmouth and Bon Secours Mary Immaculate Hospital in Newport News have received the Get With The Guidelines®-Stroke Gold Plus Quality Achievement Award from the American Heart Association and American Stroke Association. Maryview also received the Target: Stroke Honor Roll Award. Bon Secours facilities achieved 85 percent compliance with all eight Get With The Guidelines-Stroke Achievement Measures and 75 percent compliance with five or more Get With the Guidelines-Stroke Quality Measures in a 12-month period. Maryview achieved a Time to Intravenous Thrombolytic Therapy of 60 minutes or less in 50 percent or more of acute ischemic stroke cases for the Target award.

Bon Secours Health System and three of its local health systems have been recognized among the nation's Most Wired, according to the results of the 16th annual 2014 Most Wired Survey released in the

July issue of the American Hospital Association's Hospitals & Health Networks magazine. Bon Secours Health System, Marriottsville, Maryland; Bon Secours St. Francis Health System, Greenville, South Carolina; Bon Secours Virginia Health System, Hampton Roads and Richmond, Virginia; and Our Lady of Bellefonte Hospital, Bon Secours Kentucky Health System, Ashland, Kentucky, were all recognized.

Chesapeake Regional Medical Center Received the American College of Cardiology's NCDR ACTION Registry–GWTG Platinum Performance Achievement Award for 2014, one of only 256 hospitals nationwide to receive the honor. The award recognizes CRMC's commitment and success in implementing a higher standard of care for heart attack patients and signifies that CRMC has reached an aggressive goal of treating these patients to standard levels of care as outlined by the American College of Cardiology/American Heart Association clinical guidelines and recommendations.

Received the Get With The Guidelines®-Stroke Silver-Plus Quality Achievement Award for implementing specific quality improvement measures outlined by the American Heart Association/American Stroke Association for the treatment of stroke patients. Chesapeake Regional Medical Center earned the award by meeting specific quality achievement measures for the rapid diagnosis and treatment of stroke patients at a set level for a designated period, including aggressive use of medications and risk-reduction therapies aimed at reducing death and disability and improving the lives of stroke patients.

Recently recognized with an Excellence through Insight award for "Overall Employee Satisfaction" for a large hospital by HealthStream, Inc. To qualify for an award, a hospital must have been an employee satisfaction client of HealthStream in 2013 and scored in the 75th percentile or better. CRMC was chosen for receiving the highest ratings in employee satisfaction from among HealthStream's clients, as well as for exceeding industry standards.

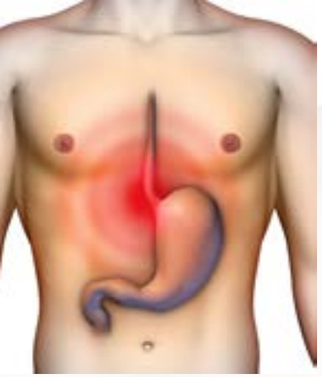
Riverside Shore Memorial Hospital's cancer care program earned an Outstanding Achievement Award from the American College of Surgeons Commission on Cancer, a distinction received by only 74 of the 519 programs surveyed in 2013. The award recognizes cancer programs that achieve excellence in providing highest quality care to cancer patients. Riverside Shore Memorial Hospital was the only program in Virginia during 2013 to receive this award. Riverside Regional Medical Center and Riverside Walter Reed Hospital received the award in previous years. Riverside Shore was also commended for community outreach and awareness efforts.

David M. Smith, MD, a Pathologist with Peninsula Pathology Associates & Medical Director, Laboratories at Riverside Regional Medical Center, was recognized as Champion of Caring with a gift of gratitude. This gift honoring Dr. Smith as a special caregiver has been made to: The Riverside Regional Medical Center Make a Difference Fund. Through the Make a Difference Funds, they have been able to cover the cost of things like the purchase of prescription medications for patients unable to afford them, the purchase of comfort carts for use in patient rooms to help reduce anxiety and prevent falls and payment of utility bills for patients who demonstrate a critical need.


Dr. Waldholtz and colleagues.

Bruce Waldholtz, MD, a Chesapeake Regional-affiliated gastroenterologist, was recently presented with the American Cancer Society's St. George National Award, the society's most prestigious division volunteer honor. Dr. Waldholtz is one of 19 inspirational individuals from across the country who received the award for outstanding service to the community in support of the society's mission to finish the fight against cancer. Recipients were chosen based on their continuous leadership, commitment, and dedication to key initiatives in the areas of fundraising, mission delivery, patient support, legislative advocacy and event engagement.

If you know of an individual physician, medical practice or hospital system that has been awarded an honor, we'd like to include them in this section of the magazine. Please send notices, with photographs when available, to our Editor, Bobbie Fisher, at 757.773.7550.



GERD's often overlooked cousin, LPR

evaluation, diagnosis and treatment

By Gregory F. Adams, MD

Laryngopharyngeal reflux (LPR) has traditionally been more elusive and difficult to diagnose than classic *gastroesophageal reflux* disease (GERD) for two reasons. First, most symptoms of LPR—a raw, irritated throat, chronic cough, trouble breathing and post-nasal drip—are also produced by such common illnesses as colds, flu, sinus and allergy inflammation; second, most patients with LPR don't experience heartburn.

And for about half of the 20-million Americans who don't feel the burn, this 'silent' acid reflux can go undiagnosed and overlooked for years.

In addition to delayed healing of symptoms, LPR left untreated can aggravate asthma, emphysema and bronchitis and may also play a role in development of esophagitis and cancers of the throat and esophagus.

Due to the many possible respiratory and laryngeal symptom etiologies, pointing to LPR as the cause based on symptoms alone can be unreliable.

To avoid weeks of trial-and-error courses of medication, utilizing esophageal manometry in concert with three tests—a barium swallow, endoscopic exam and 24-hour pH probe (with or without impedance testing)—can help establish a correct diagnosis.

Treatment for LPR should be individualized. Though anyone is vulnerable to reflux disease it shows up most often as people age and as a result of lifestyle and dietary choices.

Some patients respond well to do-it-yourself care and medical management. Many foods (fatty, citrus, mint and chocolate) can ramp up symptoms and it is important that these be eliminated. In addition, being overweight, clothes that bind, smoking, caffeine and alcohol are all factors that worsen LPR. Not eating two to three hours before bed, raising the head of the bed four to six inches and attempting to manage stress, all may help.

Other patients, however, need more aggressive treatment to reduce gastric acid. Further medical management using proton-pump inhibitors is common practice but several studies have demonstrated that for up to one-third of patients PPIs are not effective (Surgical Endoscopy, March 2012). There is also a growing awareness in peer-reviewed literature and in the public at large about the potential side-effects of extended PPI use, including osteoporosis.

When medical management fails, the FDA-approved Stretta procedure—radio frequency energy delivered to the lower esophageal sphincter (LES)—is a good middle therapy between medicine and surgery (insurance approval is often but not always successful). Seventy-two percent of patients achieved normalization of GERD symptoms for 10 years after the procedure according to a just-published analysis (Surgical Endoscopy, August 2014).

A continuum of mild to strong fundoplications or LES 'wrap' procedures is effective surgical treatment for most LPR symptoms with post-surgery patient satisfaction going as high as 92.6 percent (American Surgeon, July 2011).

Because most of the causes can be controlled, as evaluation, diagnosis and treatment awareness increases, the prognosis for LPR is very good. ■

Gregory F. Adams, MD, is a Board certified surgeon specializing in bariatric and minimally invasive general surgery who practices at Bon Secours Surgical Specialists in Norfolk, VA. He is a designated Surgeon of Excellence in Metabolic and Bariatric Surgery by the Surgical Review Corporation. Dr. Adams is affiliated with the Bon Secours Surgical Weight Loss Center at Bon Secours DePaul and Bon Secours Maryview, both Centers of Excellence. He is currently the medical staff president at Bon Secours DePaul Medical Center and is a member of the Bon Secours Digestive Health Institute.


MEET CANCER'S WORST NIGHTMARE
Dr. Bradley Prestidge
Radiation Oncologist
Dr. Prestidge, a board-certified radiation oncologist, is internationally recognized in brachytherapy cancer treatment research. He offers the most advanced radiation therapy options and high-dose rate (HDR) brachytherapy techniques for the fight against cancer. With extensive experience in all aspects of radiation oncology and expertise in brachytherapy, Dr. Prestidge brings a new level of cancer treatment to the region and is setting the standard in evidence-based, compassionate care.
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