Fall 2015

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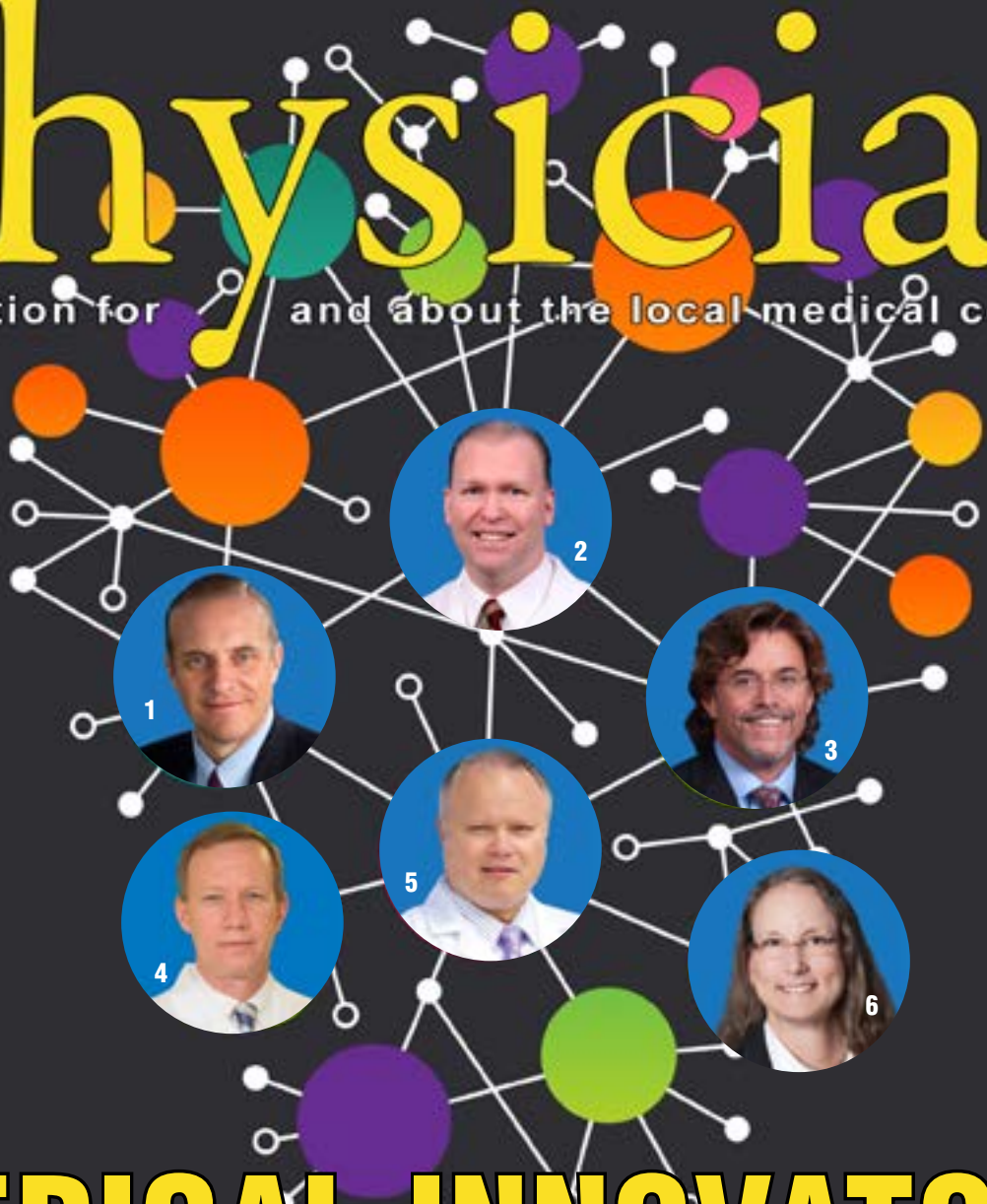
HAMPTON ROADS

Physician

A publication for and about the local medical community



MEDICAL INNOVATORS

Bringing the Latest Technologies, Techniques and Training to Hampton Roads

1. Romney Andersen, MD
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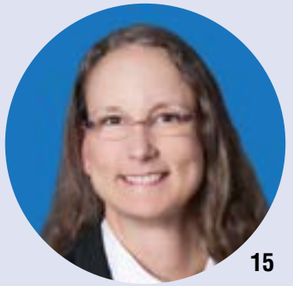
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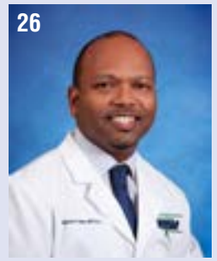
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Fall 2015, Volume III/Issue IV

Recognizing the achievements of the local medical community

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WELCOME
to the Fall 2015 Edition

The topic of this issue of Hampton Roads Physician is medical innovators – physicians in Hampton Roads who recently came to the community to introduce new modalities or techniques, or long-standing physicians who acquired specialized training in new areas of care. We were – happily – overwhelmed with nominations, demonstrating once again that the medical community in Hampton Roads is on the cutting edge of medical treatment.

In our nearly four years of publication, we've never had such an outpouring of nominations – so many, in fact, that our Physician Advisory Board couldn't settle on just three to honor. Thus, with this issue, we present six extraordinary doctors who have brought new and innovative care to patients throughout Eastern Virginia.

Holly Barlow
Publisher

It's been one of the most gratifying – and challenging – issues we've ever produced. But it stands as a tribute to the level of exemplary medical care available in this community. Now, more than ever, Hampton Roads stands as a destination for medical care. Our six featured physicians and surgeons represent the highest standards of knowledge, training and experience in their fields: three orthopaedists, each with very distinct expertise born of experience and training – an otolaryngologist caring for patients with the most severe presentations – a specialist in robotic thoracic surgery – a radiation oncologist working with cancer patients – all practicing within our community, accessible and eager to share their specialized training.

Like these six featured physicians and the many others who were nominated for their innovative approach to medicine, Hampton Roads Physician magazine is always looking ahead, looking for the next important innovation to explore, implement – and in our case, to honor.

Bobbie Fisher
Editor

With that in mind, we are thinking ahead to the Winter 2016 edition where the featured topic is SLEEP MEDICINE, and we'll be spotlighting physicians who practice in that field. If you'd like to nominate a colleague or partner, visit our website to download our nomination form – or if you'd prefer, call our editor at 757.773.7550 to have one emailed directly to you.

Deadline for Nominations is December 1
This includes cover doctors, Medical Professionals and Good Deeds.

Please visit our website to view our 2016 editorial calendar.
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.

2015 **Hampton Roads Physician Advisory Board**

Their input will help guide the editorial content, format, and direction of the magazine.
Along with our Emeritus Board, they will select our featured physicians.

Mary A. Burns, MD, FACOG, FPMRS
Urological Surgery Gynecology
Dr. Burns is a partner of Virginia Beach OB GYN and Mid-Atlantic Urogynecology and is past Chairperson of Mid-Atlantic Women's Care. Her primary focus is treating female urinary and pelvic floor disorders. She operates at Sentara and Bon Secours DePaul Hospitals.

Bryan Fox, MD
Orthopaedic Surgeon
Dr. Fox joined Sports Medicine & Orthopaedic Center (SMOC) to establish an adult spinal surgery arm of the practice at Obici Hospital where he is Chief of surgery. He is an expert in minimally invasive spine surgery techniques.

Emmeline C. Gasink, MD, FAAFP, CMD
Family Medicine
Dr. Gasink serves as the full-time Medical Director for the Riverside's Warwick Forest campus in Newport News. She is Board certified in Family Medicine.

Boyd W. Haynes III, MD
Orthopaedic Surgeon
Dr. Haynes is the Senior Partner at Orthopaedic & Spine Center in Newport News, VA. He is fellowship-trained and Board certified in Sports Medicine and Orthopaedic Surgery and specializes in minimally-invasive, outpatient Joint Replacement, Sports Medicine and Endoscopic Carpal & Cubital Tunnel Release surgeries.

Jerry L. Nadler, MD, FAHA, MACP
Internal Medicine
Dr. Nadler serves as the Vice Dean for Research and the Harry H. Mansbach Professor of Medicine and Chair, Department of Internal Medicine at EVMS. He is Board certified in Internal Medicine and Endocrinology and was elected to Mastership in the American College of Physicians for excellence and distinguished contributions to internal medicine.

Paa-Kofi Obeng, DO
Internal Medicine
Dr. Obeng provides a full spectrum of health care services for adults with an emphasis on preventive care at Nansemond Suffolk Family Practice.

Michael J. Petruschak, MD
Diagnostic Radiology
Dr. Petruschak is Director of Breast Imaging at Chesapeake Regional Medical Center. He is Board certified in Diagnostic Radiology and fellowship trained in body imaging.

Michael Schwartz, MD
Pathology
Dr. Schwartz is a pathologist with Peninsula Pathology Associates and practices at Riverside Health System. He is Board certified in Anatomic and Clinical Pathology.

Jyoti Upadhyay, MD, FAAP, FACS
Associate Professor of Department of Urology and Pediatrics
Dr. Upadhyay is a staff pediatric urologist at Children's Hospital of the King's Daughters with special interests in complex genitourinary reconstruction.

Elizabeth Yeu, MD
Ophthalmology
Dr. Yeu is a partner to Virginia Eye Consultants and specializes in Cornea, Cataract, Anterior Segment and Refractive Surgery. She is Assistant Professor of Ophthalmology at Eastern Virginia Medical School.

Visit our website to see all members of the Emeritus Board

Bright Ideas:

A Few Innovators From History

By Bobbie Fisher

Since this issue of *Hampton Roads Physician* focuses on Medical Innovators in our community, it seemed appropriate to focus our cover story on the innovators and inventors who went before, whose ideas may well have laid the foundation for our physicians' own work. And it seemed that including a paragraph about the Father of Medicine would be a good place to start.

Hippocrates? Not according to some.

While many people and even some historians call Hippocrates the father of medicine, others believe that title more accurately belongs to an Egyptian poet, architect, lector, and physician of the 27th century before the Common Era, known as Imhotep, who served under King Djoser of the Third Dynasty.

Of Imhotep, the Encyclopedia Brittanica says, "The evidence afforded by Egyptian and Greek texts support the view that Imhotep's reputation was respected in early times... His prestige increased with the lapse of centuries and his temples in Greek times were the centers of medical teachings." Count no less than Sir William Osler as being in Imhotep's camp, calling the Egyptian "the first figure of a physician to stand out clearly from the mists of antiquity."

Imhotep is widely considered to be the author of the Edwin Smith Papyrus, a medical treatise completely devoid of magical thinking – an idea considered remarkable at the time.

He diagnosed and treated more than 200 diseases, 15 diseases of the abdomen, 11 of the bladder, 10 of the rectum, 29 of the eyes, and 18 of the skin, hair, nails and tongue. He treated tuberculosis, gallstones, appendicitis, gout and arthritis. He also performed surgery and some dentistry, and knew the position and function of the vital organs. He had an understanding of the circulation of the blood system, which led to centuries of speculation about the possibility of transferring blood from one person to another.

Alexander Wood's idea.

In fact, experiments with blood transfusions, the transfer of blood or blood components into a person's blood stream, have been carried out for hundreds of years. AABB, a Bethesda, Maryland-based nonprofit organization that advances the practice and standards of transfusion medicine and cellular therapies, notes that when William Harvey discovered the circulation of blood in 1628, the first blood transfusion was attempted shortly thereafter. It wasn't until 1665 that blood transfusion was reported as having been successfully accomplished in dogs, and until 1667 in humans – although that practice was prohibited because of adverse reactions. Other attempts were made and considered successful, although not published. The first published human blood transfusion was in 1818 in Philadelphia.

"Many of the technical difficulties which had faced those experimenting with blood transfusion were removed after 1853 by the invention of the hypodermic syringe, with its hollow pointed needle. Credit for the evolution of this universally useful appliance is usually given to Doctor Alexander Wood (born 1817), who was appointed Secretary of the Royal College of Physicians of Edinburgh in 1850. For some time, Doctor Wood had been experimenting with a hollow needle for the administration of drugs. Eventually, he felt confident enough to publish in 'The Edinburgh Medical and Surgical Review' a short paper - 'A New Method of treating Neuralgia by the direct application of Opiates to the Painful Points' - in which he showed that the method was not necessarily limited to the administration of opiates." (Extract from "Blood and Blood Transfusions" By Major R. Ellison, Surgeon 33rd Regiment, 1st Brigade Virginia Vol.)

Karl Landsteiner's discovery.

In 1901, Austrian Karl Landsteiner discovered the human blood groups, leading to increasing safety in the transfusion of blood. Landsteiner discovered that agglutination, or blood clumping, an immunological reaction that occurred because the receiver of a transfusion had antibodies against the donor's blood cells, was the cause of toxic reactions and fatal consequences secondary to transfusions. His work made it possible to determine blood groups and thus paved the way for blood transfusions to be carried out safely. He was awarded the Nobel Prize in Physiology or Medicine in 1930.

Charles Richard Drew's pioneering invention.

Dr. Drew received his MD and Master of Surgery from McGill University Faculty of Medicine in Montreal, Canada, in 1933. He researched in the field of blood transfusions, developing improved techniques for blood storage, and applied his expert knowledge to developing large-scale blood banks early in World War II, for which he received his Doctorate in Medical Science from Columbia University.

In the late 1930s, Dr. Drew invented a way to process and preserve blood plasma, allowing it to be stored and shipped for blood transfusions. Drew's invention vastly improved the efficiency of blood banks.

Dr. Drew's work took on new urgency during World War II. As the leading expert on blood storage, he worked with the Blood for Britain project to oversee blood banks for British troops. In 1941, he was named medical director of the American Red Cross National Blood Donor Service. He recruited and organized the collection of thousands of pints of blood donations for American troops, the first mass blood-collection program of its kind. In 1944, Dr. Drew received the NAACP's Spingarn Medal for work on the British and American blood plasma projects.

William Johan Kolff's "junk-yard" machine.

Medical historian Steven J. Peitzman of Drexel University called Dr. Willem Kolff "an emblematic figure in 20th century medicine. His way of moving medicine forward was through technology." Despite suffering from dyslexia, a condition not understood at the time, Kolff earned a medical degree and went on to invent the first practical artificial kidney. He was working in a ward at the University of Groningen Hospital in the Netherlands in the late 1930s, when he watched helplessly as a young man died slowly of kidney failure. He decided to make a machine to do the work of the kidneys.

Kolff's initial work, begun about the same time World War II was starting, was "almost a junk-yard challenge," according to kidneydialysis.org. Forced to improvise under the occupying forces, he built his machines from "salvaged car and washing machine parts, orange juice cans and sausage skins." Although his machine was rather crude, he treated 16 patients with acute kidney failure. He had little initial success, but in 1945, one of his patients recovered and lived another seven years.

In what kidneydialysis.org describes as "an act of incredible generosity," Kolff never patented his invention, and after the War, he donated five artificial kidneys to hospitals across the world. His machine is considered the first modern drum dialyzer, and it remained the standard for the next decade. At the time of its creation, Kolff's goal was to help kidneys recover. In fact, his invention is considered one of the foremost life-saving developments in the history of modern medicine.

Where's the next bright idea coming from?

In the words of the late Robin Williams, ideas really do change the world. The ideas and contributions of our six cover physicians, and those mentioned in our pediatric care article and throughout this issue, are laying new foundations in the world of orthopaedics, otolaryngology, thoracic surgery, radiation oncology and many other fields of medicine. It is their perseverance, dedication to excellence and refusal to take no for an answer that will inspire the next generation of innovators and inventors. ■

ROMNEY ANDERSEN, MD

COL (Retired), US Army

Orthopaedic Trauma Surgeon, Riverside Health System at Riverside Regional Medical Center

The treatment of war wounds is an ancient art, documented as far back as human activities have been recorded. Throughout history, as weapons have become more sophisticated and precise, so the need for more advanced medical practice and technique has expanded. In fact, it's said that the only good things to come out of war are medical advances.

"Certainly looking at WWII, that's where the development and advancement of hand surgery came from, when so many soldiers came back with mangled extremities," says Dr. Romney Andersen, who joined Riverside Health System early in 2015. "And ten years from now, the wars in Iraq and Afghanistan will be known for advances in reconstructing severely damaged limbs, advances in treating amputations, and saving lives on the battlefield."

Dr. Andersen saw many of those advances firsthand, in the combat surgical suites of Operation Just Cause in Panama (1989-90), as Chief of Orthopaedic Surgery at Ibn Sina Hospital and as Theater Consultant for Orthopaedics in Baghdad (2008-09). Most recently, Dr. Andersen served as Chair of Orthopaedics at Walter Reed National Military Medical Center, where he performed more operations on combat casualties than anyone in the US Military.

Following graduation from West Point, he earned his medical degree at the Uniformed Services University of the Health Sciences (USUHS). He served two years in the 1st Infantry Division as a Brigade Surgeon prior to completing his orthopaedic training at Walter Reed Army Medical Center. Following his residency, he completed a fellowship in trauma at the R. Adams Cowley Shock Trauma Center. He served as Director of Orthopaedic Trauma at the National Naval Medical Center, and as Director of Orthopaedic Trauma and Assistant Service Chief at Walter Reed. He holds the academic rank of Professor of Surgery at USUHS, and has over 100 published manuscripts.

It is that highly advanced level of skill, training and experience that Dr. Andersen brings to Riverside Regional Medical Center as one of the orthopaedic trauma surgeons at the Peninsula's only Level II Trauma Center. "We take care of all the people who come in through Riverside's Emergency Department," Dr. Andersen explains. "We see patients with severely injured limbs, whether from auto or motorcycle accidents, and we employ established techniques, as well as newer ones that have been refined on the battlefield, to save those limbs from amputation, and to restore some function."

While he treats a large number of gunshot wounds, these are generally the result of low velocity firearms, as opposed to the higher velocity weapons of the battlefield. "For many kinds of wounds, including gunshots," he says, "we can use biologics to help stimulate growth and cure defects within the skin and open wounds that benefit from the newer dressing technologies and pressurized wound therapies."

Reconstructing limbs remains among the most complicated cases Dr. Andersen treats. He recalls a patient who sustained injury to his bilateral distal femurs, loss of both extensors, and loss of his entire patella on one side. "It took 23 procedures," he says. "We had to reconstruct his entire quadriceps mechanism, but now he can walk again."

Even patients with segmental losses to their limbs can be treated, using an old technique refined while treating soldiers injured in Iraq and Afghanistan. "We can lengthen their bones," Dr. Andersen says. "We know that if we cut a bone and move it very slowly over a long distance, we can regenerate bone."

Dr. Andersen says "we" almost exclusively, because he emphasizes that caring for severe trauma cases is a team effort, and he is quick to credit the caliber of the subspecialists he works with at Riverside. ■

JEFFREY R. CARLSON, MD

Spine Surgery
Orthopaedic and Spine Center

When Dr. Jeffrey Carlson joined Orthopaedic and Spine Center in 1999, he was the first fellowship trained spine surgeon on the Virginia Peninsula, having completed a combined Neurosurgical and Orthopaedic Fellowship in Spine Surgery at Harvard's Brigham and Women's Hospital in Boston.

Arriving in Hampton Roads, he learned that simple discectomies were lasting an hour and a half, and disc surgeries on the neck were taking as much as two and a half hours – and both being done as inpatient procedures.

"The thinking used to be that we had to keep these patients in the hospital," Dr. Carlson says. "But we don't have to, and they don't want to stay. There are risks associated with being in the hospital – bacteria, viruses and the like – and nobody really wants to be in the hospital. Patients would much rather be at home in their own environment."

One of his first orders of business was to establish a program to teach area nurses and hospitals about micro-discectomy outpatient spine surgery, which is performed using smaller incisions, causing minor injury to soft tissue and bone, and resulting in less patient pain and a much quicker recovery. These procedures are performed in a shorter amount of time, which lessens the patient's time under anesthesia.

Today, the majority of simple discectomy surgeries in Hampton Roads are performed as outpatient procedures, many of them in inpatient surgery centers.

Virtually all of Dr. Carlson's cervical spine fusion cases are done as outpatient procedures as well. "We take the disc out, but then they need a fusion. The thought process has always been that if we put in screws and rods, that's a much more painful surgery, so those patients really did have to stay in the hospital," he says. "But we can use the same incision to get the screws and rods in that we use to get the disc out, so we're not moving muscle and tendon and irritating the soft tissue."

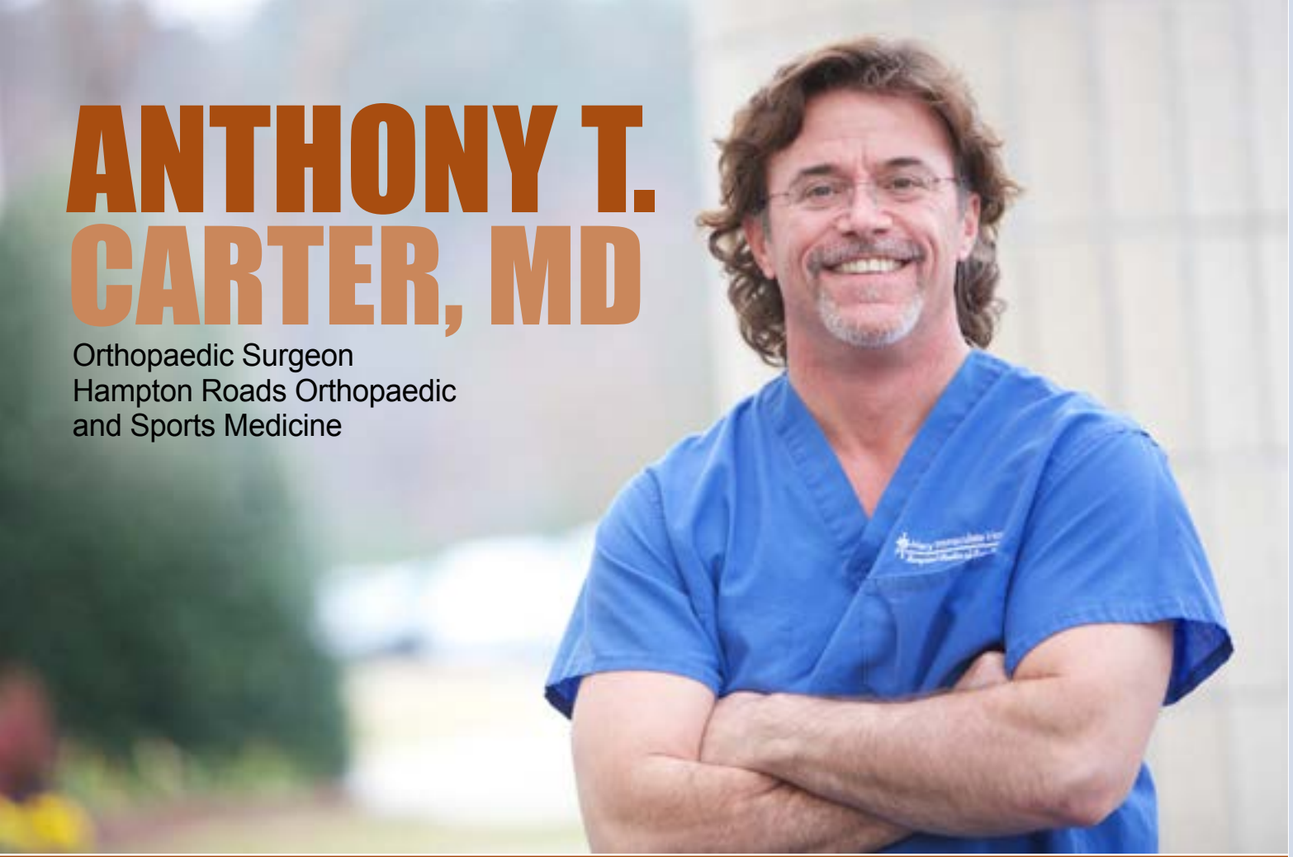
The procedure involves putting the hardware in at a different angle that grasps stronger bone. "By looking at the vertebral body, we can avoid having to do the wide dissections that have been done at the past," he explains, "and they're more stable."

Surgeons have adopted these techniques because they result in less injury, less pain for the patient, a shorter recovery time, and they are familiar procedures.

The next logical progression for Dr. Carlson was to expand his practice to include outpatient lumbar fusions. He has adapted standard surgical techniques to correct patients' neurologic issues, and provides long-term stability for any existing bone problems. It hasn't caught on as quickly as other outpatient spine surgeries, but it's only a matter of time.

"We've done 150 of these operations as outpatient procedures," Dr. Carlson says, "and patients are now starting to demand it. They're asking why they should undergo a four-hour surgery requiring a two-night stay in the hospital, when they can have the same procedure done in 90 minutes, and go home the same day."

Dr. Carlson believes that for many surgeons, it's as much a question of changing their mind set as it is in adopting new technologies that make these procedures actionable. "It's a question of thinking globally about these things," he says. "It's a question of using the best method to fix our patients' problems as quickly and efficiently as possible, reconstructing the spine, and getting them back to doing what they want to do, in as short a period of time and with as little pain as possible." ■



ANTHONY T. CARTER, MD

Orthopaedic Surgeon
Hampton Roads Orthopaedic
and Sports Medicine

In 2006, Dr. Anthony Carter made history when he introduced the muscle-sparing anterior approach hip replacement surgery to Hampton Roads. Dr. Carter, an orthopaedic surgeon with Hampton Roads Orthopaedic and Sports Medicine, learned the procedure – known in layman's circles as the "jiffy hip" – from Dr. Joel Matta of Santa Monica, California. Dr. Matta introduced the procedure in this country, after learning it from French surgeon Dr. Thierry Judet. Dr. Carter remembers being criticized at the time by surgeons outside his practice: "They were saying that there'd be too high a complication rate, or that there was no proof that it would produce better results, all kinds of things."

But he stuck with it, he says, "because I saw the benefits of it. My patients were doing remarkably well. I love it when a patient comes back after surgery doing so much better so quickly." As he performed more of these surgeries, word of his results spread and his patient load grew and grew. That has been gratifying, Dr. Carter says, "but more importantly, many surgeons have adopted the procedure because it's so much better for their patients. It's changed the landscape around here."

He estimates he's done more than four thousand of these surgeries, and now performs them for all of his hip replacement patients – at a rate of 650 per year.

In December of 2012, he introduced a new option for knee replacement patients: the 3-D robotic arm-driven MAKOplasty. "It helps with positioning primarily because we're using the robotic arm to assist us," he says, "and it puts the components in very precisely. With the knee resurfacing for the partial knee replacements, we can take away only what's diseased, so we can preserve all the ligaments and the knee tends to feel much more natural. Recovery is much akin to what we see with the hips; it's cutting recovery time in half. It's been really exciting."

Dr. Carter credits the comprehensive blood management program he instituted for some of his successful outcomes: "By optimizing patients' hemoglobin preoperatively we decrease the risk of transfusion."

Dr. Carter says the next evolution is to ensure these procedures can be safely and routinely done in the outpatient setting. "It's better for the patients, and cuts costs all the way around," he says. Of course, it will also necessitate more effective pain management, and that's just one component of his current research. He's also involved in various research projects on hip and knee replacements involving the use of ceramic components, as well as a tourniquet-less knee replacement. And there's the promise of a new knee prosthesis with longer life and better function, and a study out of Massachusetts General about lowering the dislocation rates of hip replacement prostheses.

He's eager to learn, and then to share these innovations, and travels frequently around the country and the world to teach them to other orthopaedists. His next stop is Bangkok, where he'll address a group of surgeons there.

Dr. Carter completed his medical training at Boston University, and his internship and residency programs at NYU/Bellevue Medical Center. He was Board certified in orthopaedic surgery in 1994, and after three years treating patients at Langley Air Force Base, joined Hampton Roads Orthopaedic and Sport Medicine.

While he's excited about innovations in his field, Dr. Carter remains judicious. "There's always a way to do things better," he says, "and I always want to stay ahead of the curve – but always with my eyes wide open." ■

Daniel W. Karakla, MD

Otolaryngology
Head and Neck Oncological Surgery,
Thyroid and Parathyroid Surgery
Eastern Virginia Medical School

In 1993, when Dr. Daniel Karakla completed his residency in otolaryngology at Naval Medical Center Portsmouth, there were two options open to patients with laryngeal cancer: largyngectomy (either partial or total) or radiotherapy. Chemotherapy at that time was generally only for palliation.

"Between World War I and World War II, radiation therapy was used broadly for head and neck cancer patients," Dr. Karakla says. "And as chemotherapy agents improved, that modality became a stronger part of the treatment."

Today, the pendulum is swinging more and more back toward surgery, he notes, because different surgical innovations and reconstruction techniques offer patients hope for a more normal quality of life. Many of those innovations, described herein, were brought to EVMS by Dr. Karakla.

Although radiation, chemotherapy and surgery, or a combination, are still widely employed when individual cases merit, "We always want to steer our patients toward organ preservation whenever possible," Dr. Karakla says . "And whenever possible, we offer a partial laryngectomy rather than a total." Every head and neck cancer patient is presented at a multidisciplinary conference, to determine the best and most effective course for each individual patient.

Depending on the location of the tumor, some patients with smaller cancers are candidates for a partial laryngectomy, which removes only part of the voice box. These procedures leave some or even all of normal speech unaffected, and swallowing is ideally unimpeded.

In a total laryngectomy, however, the entire voice box is removed, and patients can no longer speak normally. In either case, but especially for total laryngectomy patients, there is a huge life change, Dr. Karakla knows, and thus he emphasizes that "...any time we have to offer a patient a larynx removal, we should be talking about how we can rehabilitate them to be as normal as possible in terms of speaking and swallowing after surgery and recovery."

Dr. Karakla learned voice restoration in his Head & Neck Surgery/Microvascular Reconstruction fellowship at Methodist Hospital of Indiana from Drs. Blom and Hamaker, and he remains a staunch advocate.

The earliest options for laryngectomy patients included the electrolarynx, a battery-operated device placed under the patient's mandible, which produced vibrations and enabled speech. "The sound was mechanical and could be very difficult to understand," Dr. Karakla says. Today, he can assist patients by recommending other voice restoration devices, while emphasizing to these patients that they require intensive work with a speech-language pathologist for the technology to be optimal.

For patients with tongue based and/or tonsil cancers, Dr. Karakla offers transoral robotic surgery. If patients have select cancers in that area, with neck metastasis that is still resectable – within certain limits, he says – "We can do transoral robotic surgery as the primary management, followed by lower dose radiation."

Dr. Karakla recognizes the current epidemic of HPV related throat cancers: in the last decade, there has been at least a four- to five-fold increase in the number of oropharynx cancers in the US. He believes many of those patients can successfully have surgery prior to other modalities, then followed by low dose radiation. Some might not even require chemotherapy. "We've offered that course for the past five years," he says, "and we're seeing similar cure rates, and better functional swallowing."

In addition to caring for his EVMS patients, once a year, Dr. Karakla joins several other Hampton Roads physicians for a medical mission to the Philippines. "It's the northern part, near Luzon, very rural and remote," he says, "where we treat the local population – mostly rice farmers – and provide the only specialized medical and surgical care these people receive." ■

BRADLEY R. PRESTIDGE, MD, MS

Regional Medical Director
for Radiation Oncology
Bon Secours Cancer Institute
at DePaul

In November of 2012, when Bon Secours Virginia broke ground on the Bon Secours DePaul Medical Plaza, it was with the vision of establishing a comprehensive cancer institute, which would place state-of-the-art technology in the hands of cancer experts, enabling them to address the unique needs of patients battling cancer. Less than a year later, Dr. Bradley Prestidge, a world-renowned radiation oncologist, came to DePaul with his own particular vision: a comprehensive suite in which to treat cancer patients with the specialized radiation technique known as brachytherapy.

Thus he had a hand in the design of the brachytherapy suite at the DePaul Cancer Institute; a hand so large, in fact, that he says the architects often tried to look the other way when they saw him coming. He's only half joking, but the result is clear: "Very few centers have the efficiency and the capability we have at DePaul," Dr. Prestidge says. "We can do many things that can be done in an operating room there. It's completely shielded behind a three-ton door, so we can administer brachytherapy in the same room after we perform our procedures, without ever having to wake and move the patient. I specifically asked for that before I came here."

In some centers, he explains, it can take as much as a day to complete a treatment, because the anesthetized patient is taken to one room to have the radiation applicators placed, awakened to get on a gurney and taken for a CT scan so the computer plan can be completed. The patient is then brought back into the original room for treatment. At DePaul, it's all done in the brachytherapy suite, and treatment be completed in as little as an hour.

Brachytherapy wasn't new to Hampton Roads when Dr. Prestidge came to DePaul, but he quickly learned that one vital application of the modality wasn't being offered: high dose rate brachytherapy for patients with non-melanoma skin cancers like squamous cell carcinoma and basal cell carcinoma. In Hampton Roads, with its welcoming climate, beaches and outdoor activities, these cancers are commonly diagnosed. He began reaching out to dermatologists and plastic surgeons to explain the benefits of brachytherapy as an alternative for their more complex cases, which can require extensive surgeries.

"Using an intraoperative 3-D computer plan, we put a single, highly radioactive source, not much larger than a quarter inch, on the end of a cable that goes down a tube into an applicator placed into or on the tumor," Dr. Prestidge explains. "The applicators are specifically shaped, molded to the area of the cancer – often the ear or the nose." That single, highly radioactive pellet comes down through a catheter into the applicator, either inside or on the surface of the skin, and sits there for a number of seconds while the computer moves it to different positions inside the applicator to deliver the dose. When the dose is delivered, the source is retracted into the shielded after-loader, and the treatment is done. Patients leave with no radiation in their body.

It's a highly effective therapy, Dr. Prestidge says, which he also employs for breast, prostate, cervical, esophageal and rectal cancer cases. And he emphasizes, "The Cancer Institute is very comprehensive in terms of all its radiation modalities. I think we're on par with most any academic radiation department in a university center. We also do external beam, stereotactic radiosurgery, stereotactic body radiation. And we just opened the infusion center in September."

Many cancer patients in Hampton Roads have historically felt the need to travel to Duke or Johns Hopkins, but we have world class cancer care available here. ■

LYNNE A. SKARYAK, MD

Head, Division of Thoracic Surgery, Chesapeake Regional Medical Center
Co-director, Chesapeake Regional Medical Center Lung Health Program
~ Robotic Thoracic Surgery

Dr. Lynne Skaryak joined the team at Chesapeake Regional Medical Center in December 2014. She specializes in malignancies of the lung, esophagus and chest wall. Dr. Skaryak graduated from Duke University School of Medicine, and completed both her general surgery and cardiothoracic residencies at Duke University Medical Center – the first female to complete Duke's cardiothoracic program. "We were just starting to do video-assisted minimally invasive thoracic surgery," she remembers, of the procedure pioneered by Dr. Robert McKenna of Cedars-Sinai. When she was an attending surgeon at Swedish Medical Center in Seattle, Dr. Skaryak learned the technique from Dr. Ralph Aye, who trained with Dr. McKenna at Cedars.

She continued to perform these procedures for several years, while becoming increasingly interested in the potential of robotic surgery. When the daVinci® Xi™ system debuted, she says, she became more enthusiastic. "The Xi is really designed for thoracic surgery," she says. "Its platform is much more suitable, with a new stapler that provides fully wristed articulation, allowing surgeons to control stapling directly from the console. Even the way we dock the robot is simpler." She traveled to New York University for extensive training courses on the da Vinci Xi with Dr. Michael Zervos, starting with smaller cases like wedge resections, before undertaking the more advanced lobectomies and thymectomies that she has introduced to Hampton Roads.

Her first major case at Chesapeake Regional Medical Center was a lobectomy on July 6, 2015, with her NYU trainer as proctor. Six weeks later, she performed a thymectomy, again with Dr. Zervos as proctor. Both procedures were successful, and both of her patients have continued to do well.

Patients like the robotic procedures, Dr. Skaryak says, "because we're offering a less painful surgery, and a shorter recovery period." And from the oncologic standpoint, she notes, "The visualization is unparalleled. It's 3-D versus 2-D, so we're able to obtain more lymph nodes with the Xi, and some physicians believe that helps prevent recurrence." She believes that's true, but adds, "I think the biggest advantage is that it helps us accurately stage the patient." She explains: "If surgeons don't take enough lymph nodes, they can miss metastasis, and possibly give patients a prognosis that might significantly improve with the addition of chemotherapy or radiation post-op."

The Xi has proved significant for Dr. Skaryak's thymectomy patients as well. Tumors in the thymus gland are usually associated with myasthenia gravis, a chronic autoimmune neuromuscular disease that can be devastating. "We know that if you have myasthenia, you have a chance of having a thymoma," Dr. Skaryak says. "But if we can remove the thymus in the first year of diagnosis of myasthenia, it reduces the amount of medication the patient needs, and sometimes we can get patients off medication altogether by removing the thymus early." To be effective, surgeons must remove the entire thymus, but historically had to perform a sternotomy, and even then, experienced problems with visibility. "Now, using the robot, with just three tiny incisions, we can see and remove the entire thymus," she says. Her first thymectomy patient went home on day one, and four days later, was managing her pain effectively with Motrin.

Dr. Skaryak notes that only about 25 percent of lobectomies in Hampton Roads have been done with any minimally invasive technique. "That number is low given the percentages across the country," she says. "The lowest in America is usually around 30 percent, even up to 50 percent."

With her arrival in Hampton Roads, the odds for all of Dr. Lynne Skaryak's patients just got better. ■

GOOD DEEDS

Honoring physicians who are working for the benefit of others.

Jennifer F. Pagador, MD

Dr. Jennifer Pagador is well known for her charity and volunteerism. She's been an active volunteer for Physicians for Peace, having gone on missions to her native Philippines with the group in 2012 and 2013. She still finds it difficult to explain how profound going on these missions can be: "As much as we all complain about the medical care in this country, when we go into these missions fields, we see people who have little or no access to any medical care. Most of them have no quality of life, and some of them die. Being able to help them is what has always kept me going."

In 2013, Dr. Pagador joined forces with another physician from her homeland, Dr. Juan Montero, a well-respected local (now retired) thoracic surgeon with his own long established reputation as an advocate for the poor. Dr. Montero, who founded the Chesapeake Free Care Clinic, was also a volunteer with Physicians for Peace.

In 2012, Dr. Montero established Montero Medical Missions, a non-profit interfaith international humanitarian organization dedicated to the promotion of world friendship through the healing arts. When he invited Dr. Pagador to join him, she didn't hesitate. "Dr. Montero created Montero Medical Missions to provide ophthalmologic, prosthetic and dental care projects for physicians and allied health professionals with international roots, which allows those of us who participate to share our blessings by caring for the people of our native countries," she says.

She even asked Dr. Montero if she could host a mission to the Philippines herself, which meant undertaking a year's worth of intensive work herself, before the mission could even begin – all while maintaining her own medical practice. Obtaining the proper medical permits from the host country can take months. Fundraising is part of planning as well, but there, Dr. Pagador had help. "We held garage sales and bake sales at church," she says, "and my son was involved as well. We are so amazed at the generosity of the people." There were untold logistics to deal with. Taking Americans into foreign countries, into sometimes dangerous areas, involves a great deal of advance planning, she learned, especially in terms of security. And advance planning is especially critical, because "When you get to the host country, you always encounter other issues."

Closer to home, Dr. Pagador assists Montero Medical Missions in its Health Fair for Veterans, a medical screening program focused on serving military veterans in need, many of whom are homeless. There are more than 70 volunteers at each of these screenings, and each veteran is given a personal escort to assist them through the screening project. "The fair also provides free transportation for those who can't get to the facility," she says. Happily, she adds, the project is expanding, branching out to other areas in Virginia where the need is great for these vets.

Inspired by her strong Christian faith and a desire to return some of her blessings, Dr. Pagador was also inspired by her parents. Growing up in the Philippines, she was accustomed to her parents' humanitarianism. Her father was a lawyer, whose clients often tried to pay him with their children's labor. Instead, she remembers, "he'd send these kids to school. He even started a pre-K school for these children, which we didn't learn about until his death." And she recalls seeing her mother, a nurse, bringing children to their home so she could vaccinate them against cholera in the wake of a typhoon. "That's what I saw every day," Dr. Pagador says. "I thought that was just how people acted." ■

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.

Caring for Children with Difficult Conditions

When our Physician Advisory Board suggested we write about caring for the children of Hampton Roads, we knew we could dedicate an entire issue to the topic and not scratch the surface. We had to narrow our approach, so after thoughtful consideration, we decided to focus on four difficult conditions that affect the young, and the care available locally.

Chest Wall Deformities

Pectus excavatum, commonly known as sunken chest, affects one to three children in a thousand, mostly boys, usually Caucasian or Asian. In 1987, Donald Nuss, MD, a pediatric surgeon at Children's Hospital of The King's Daughters, dramatically changed the way these children were treated when he developed the procedure that now bears his name. In contrast to the open repair technique, which involved incising and exposing the chest wall, removing cartilage ribs and cracking the sternum, the Nuss procedure requires two small incisions that allow the surgeon to insert a curved bar beneath the ribs and sternum. The bar is then flipped over and held in place until the bones and cartilage remold themselves in the new position.

CHKD surgeons have continued to build upon the foundation that Dr. Nuss established, both refining and expanding the procedure. In the nearly three decades since Dr. Nuss first performed his procedure, CHKD has become the busiest center in the country for treating pediatric patients with chest wall deformities, averaging 125 surgical cases per year. Patients come from across the Americas, and from Europe and Asia as well.

Frazier W. Frantz, MD

CHKD attracts another subset of patients – those who have suffered the unfortunate sequelae of previous failed chest wall procedures. One case inspired CHKD pediatric surgeon Frazier Frantz, MD to develop an entirely new procedure, utilizing customized titanium implants to reconstruct the sternum and ribs for treatment of a devastating case of floating sternum and flail chest. Patient 0001, so named because he was the first to undergo this innovative type of repair, came to CHKD after three failed surgeries. After these procedures, his cartilage ribs and sternum failed to grow normally, and he was left with no cartilage ribs and a very short sternum, both major challenges to conventional repair techniques. From a functional standpoint, he suffered from chronic chest pain, severe respiratory compromise that was activity and lifestyle limiting, and inadequate structural protection for his internal organs.

Dr. Frantz took a visionary approach, enlisting the help of Biomet Microfixation, manufacturers of the Nuss bar. After reviewing the patient's MRI and CT, and working with Dr. Frantz for months, the Biomet engineers crafted four titanium plates that would be attached to the patient's remaining sternum and ribs. Fitted together, the plates resembled a chest shield, which would be worn internally. Dr. Frantz and his surgical team first fractured the patient's sternum to create a smooth surface for the titanium plates to rest upon. The four plates were then attached to the sternum and bony ribs with more than 70 screws of varying lengths, all mapped out for size and depth for optimum stability and safety. Once the plates were in place, the pectoral muscles were stretched across the top surface to create a normal-appearing chest wall and to provide protection. The patient was up, walking and breathing normally that evening – and continues to thrive.

CHKD is honored to be hosting the world meeting of the Chest Wall International Group, a body of the European Association of Cardio-Thoracic Surgeons, in 2016. Among the guest speakers will be Dr. Nuss, and surgeons from the Mayo Clinic, Memorial Sloan Kettering, Brazil, Korea, Chile and China.

Autism

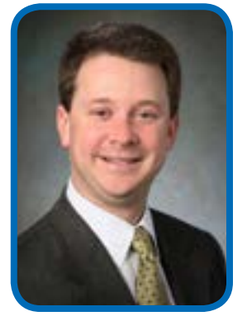
Autism affects one in 68 children – and one in 42 boys. According to Autism Speaks, the world's leading autism science and advocacy organization, it is the fastest-growing developmental disorder in the United States, costing a family an average of $60,000 per year. And there is no known cure for autism.

These facts are very well known to Eric Madren, MD, a family physician with Volvo Medical Associates, a division of Bayview Physicians Group. Approximately 30 percent of his practice is devoted to caring for children with autism, and he has presented several presentations on the condition. He participated in the first randomized, double-blind, placebo-controlled study on the use of hyperbaric oxygen therapy for children with autism.

Six sites across the country participated in the study, which included 60-70 children – nine from Dr. Madren's practice. "We used hyperbaric oxygen as compared to a placebo treatment," he says. "We did formal psychological tests before and after the study, to determine if the treatment was effective in terms of improving functioning in these children."

They found some subtle improvement. "We felt there were at least some mild to moderate benefits," Dr. Madren says, but adds, "I know of a similar study published after ours, which found no significant benefits. So it's still experimental. There is probably a subset of children who might benefit, but I don't believe it's the magic bullet we've all been hoping for."

One of the challenges of treating children with autism is that they're not all the same. For instance, some also have significant ADHD symptoms that can require medication, while others – as many as 60+ percent – have gastrointestinal dysfunction. They have a wide range of abilities in terms of language development, socialization skills, etc. As Dr. Madren often says, "If you know one patient with autism, you know one patient with autism."



Eric Madren, MD

The most widely used and established treatments for autism are still behavioral therapies, especially applied behavioral analysis. In terms of other medical treatments, those are generally tailored to each individual patient.

In the meantime, Dr. Madren says, there has been a great deal of research looking at genetic markers present in a subset of children with autism, with a view to potentially being able to manipulate them. A September 28, 2015 release from Johns Hopkins reported, "In the largest, most comprehensive genomic analysis of autism spectrum disorder conducted to date, an international research team led by UC San Francisco scientists has identified 65 genes that play a role in the disorder, 28 of which are reported with 'very high confidence,' meaning that there is 99 percent certainty that these genes contribute to the risk of developing ASD."

Dr. Madren believes it's entirely feasible that research will – within his lifetime – reveal some ways to manipulate genes and improve their function. "And if we can intervene at a very early age," he says, "we can make a substantial difference in their developmental progress over time, to benefit autism patients and so many others."

Rees Lintzenich, MD

Vocal Cord Nodules and Other Voice Disorders

Children are susceptible to a number of voice disorders; between four and six out of every hundred children has some form of voice disorder.

The most common of these is vocal cord nodules or lesions, usually caused by vocal abuse secondary to behavioral problems, which include screaming, yelling, or any overuse. Because of the potentially damaging effects of such tension and strain on the larynx, voice therapy is indicated. Voice therapists work with children and their families to help them understand how the vocal cords work, how voice is produced, and the importance of respiration and resonance. Children learn to protect their vocal cords by employing breath support and better volume control, and by performing voice exercises tailored to their individual needs.

In severe cases, surgery may be needed as well, says Catherine Rees Lintzenich, MD, an otolaryngologist with Riverside Medical Group, but those instances are quite rare. She emphasizes that unless the reasons for the abuse are addressed, nodules have a tendency to recur even after treatment. But even when nodules persist, voice quality can be substantially improved with effective therapy.

Children can suffer vocal cord paralysis as well, requiring more aggressive treatment. In some cases, often after procedures such as chest or heart surgeries, children can develop this condition, where one vocal cord doesn't move. A common cardiac defect in newborns is patent ductus arteriosus. In that reparative surgery, the nerves of the vocal cords deep into the chest can be injured.

For vocal cord paralysis surgery, the surgeon goes through the neck to reestablish some nerve activity to the vocal cord by rerouting another nerve to the vocal cord nerve, the recurrent laryngeal nerve, a branch of the vagus nerve that supplies the muscles of the voice box.

"We can't do anything to make the paralyzed vocal cord move again," Dr. Lintzenich says, "but we can get it into a better position so the opposite cord can make contact with it, producing vibration between the vocal cords necessary for sound production."

One of the more problematic diagnoses is papilloma virus in the larynx, which usually presents at birth, Dr. Lintzenich notes, and is caused by the human papilloma virus. "For those children, we do surgery, going in through the mouth and using special instruments to remove as much of the papilloma as we can," she says, "but repeat procedures are usually necessary because of the nature of the virus."

In any case, Dr. Lintzenich emphasizes, children with voice problems, and particularly when combined with other problems, can be effectively treated.

Jyoti Upadhyay, MD

Vaginal Abnormalities in Pediatric Patients.

Imperforate hymen is the most common form of vaginal outflow obstruction, occurring once in every 1,000 births, as a result of the failure of the hymen to perforate during fetal development.

The diagnosis of IH can be made during a comprehensive postpartum perineal examination of the neonate by gently pulling the labia majora inferiorly, allowing visualization of the urethra, interoitus, and anus. It is, however, frequently missed, says Jyoti Upadhyay, MD, a pediatric urologist at Children's Hospital of The King's Daughters. In the last two years, she has seen as many as a half dozen young women with the condition.

"When imperforate hymen is diagnosed at birth, it can be corrected before girls reach menarche," explains Dr. Upadhyay. "If the condition is not diagnosed before menarche, normal menstruation cannot occur because there is no outlet for the blood. "The girls may experience menstrual pain and cramping, but with no outlet, the blood accumulates in the vagina, and sometimes in the uterus. With a presentation of primary amenorrhea, these girls are taken for ultrasound, where the anomaly is finally identified.

At that time, Dr. Upadhyay says, surgery is required, often emergently. "We end up having to take them to the operating room, make a cruciate incision to remove the tissue, which sometimes requires stitches to keep the mucosal edge open. It can be painful and traumatizing to a young girl just reaching her teens."

Even when the condition is diagnosed at birth, there has been a tendency to counsel parents to wait until the child reaches her teenage years to be treated. That thinking is outdated, Dr. Upadhyay says. "Imperforate hymen should be taken care of at a young age. There is no reason to postpone the repair. When we open the vagina in the very young patient, the risk of scarring and other sequelae is very low."

She has treated patients as early as two weeks old and well into their teenage years. "In the young, it can be a minor outpatient procedure," she says. "And patients do much better when the repair is done at a young age."

No matter what the anomaly is, any abnormality of a child's anatomy should be investigated. In the case of vaginal abnormalities, Dr. Upadhyay says, they are best treated by pediatric urologists. ■

Preventing Childhood Blindness is YOUR Responsibility, Too

By Kapil G. Kapoor, M.D.

Eye health starts before we're born. We all know how important prenatal care is, and the impact our ancestry and genetic make up have on us. For a select few, early detection of disease or abnormality can be either sight or life saving!

In the United States, we are fortunate to have a robust post natal ocular screening and disease prophylaxis program administered in most hospital nurseries. Our pediatricians and nurse practitioners include in their checkups evaluations of alignment, visual function milestones, and the very important "red reflex" test- using a penlight in front of the patient and seeing a red reflection from within the eye, proving a clear optical pathway both in and out of the eye being examined.

Large population studies have shown that refractive errors of myopia, hyperopia, and astigmatism can be detected between the ages of six months and two years. Fortunately, the majority of these changes are transient and no intervention is required. However, a mother who smokes can cause her child to be born with a higher risk of permanent hyperopia, astigmatism, and strabismus.

As a child grows, so do the eyes. The grade school and middle school years are filled with lots of changes for our children. Whether it's hard to see the blackboard or a ball on the playing field, it's a pretty straightforward fix - glasses.

Our children's greatest risk of blindness is from ocular trauma, particularly when playing sports. In fact, multiple studies have indicated over 90 percent of pediatric ocular injuries could have been prevented by simply wearing protective eye goggles. This rule of wearing protective eye goggles, of course, extends beyond just the playing field, and includes such activities as doing chores with the lawnmower in the backyard or a fireworks injury on that special holiday.

Our children's greatest risk of blindness is from ocular trauma, particularly when playing sports.

Retinal and ocular oncology specialists work tirelessly to protect our children from these very challenges. If a child fails a screening or red-reflex test, we utilize state-of-the-art digital imaging and examination equipment to understand if true pathology is present, and establish a treatment protocol. Potential causes of vision loss associated with a failed red reflex screen include retinoblastoma – the most common childhood ocular cancer, retinopathy of prematurity – the growth of new blood vessels in the eye, occurring in premature infants, or pediatric cataracts. Potential causes of vision loss associated with ocular trauma in kids include a ruptured globe from severe trauma, retinal tear or retinal detachment, or bleeding in the front (hyphema) or back (vitreous hemorrhage) of the eye.

Taking these very simple steps can make large strides in protecting our children's eyes. Prenatal counseling of expectant mothers, robust and diligent screening of newborns and toddlers – particularly those with risk factors – are easy, and prevent vision loss long term.

Most importantly, preventing eye trauma through education, and insisting on eye protection, are crucial in protecting our children's precious eyesight. If you see a child at risk, please say or do something. Hopefully, someone would do it for your child and eliminate a lifetime of loss. ■

Kapil G. Kapoor, MD completed medical school at Ohio State University, residency at the University of Texas Medical Branch-Galveston and a fellowship at The Mayo Clinic.
Dr.Kapoor is a Board certified ophthalmologist specializing in vitreoretinal surgery. www.wagnerretina.com.

PHYSICAL THERAPY FOR CHILDREN:

MAKING IT FUN, KEEPING THEM SAFE AND INJURY FREE

Meet 10 year-old Bohden Tubbs, a patient of mine who was having trouble in school. Not with his studies, and his behavior was just fine. But every time he raised his hand, his shoulder dislocated.

After dealing with the problem for a while, he told his parents, who took him to an orthopaedist. The diagnosis was hyper mobility. The solution, his physician advised, was physical therapy.

I worked with him for about two months after diagnosing him with multi-directional instability. If Bohden didn't get treatment and the shoulder kept dislocating and putting stress on the socket, it would eventually cause more problems. It was also something that could adversely affect the rest of his joints.

If you ask Bohden today, he'll tell you that physical therapy "helped my shoulder and all other parts of my body. It made me stronger."

He worked so hard, I even nicknamed him The Machine, which stuck.

When it comes to kids, physical therapy is more than just for young athletes recovering from sports injuries – although we see a lot of them and Tubbs himself was an athlete, too.

From infants to teens, physical therapists can offer pediatric patients relief from a number of suffering ailments, ranging from autism, hyper mobility, poor posture or sore backs from toting around heavy backpacks.

What does physical therapy treatment look like for some of the most common ailments we treat?

When it comes to kids, physical therapy is more than just for young athletes recovering from sports injuries – although we see a lot of them and Tubbs himself was an athlete, too.

Pete Elser, MS, PT, OCS, CMTPT, is the Clinical Director of the Tidewater Physical Therapy Norfolk location in Kempsville. Tidewater Physical Therapy features more than 30 Physical Therapy Clinics, five Aquatic Therapy Centers and three Performance Centers from Virginia Beach to Richmond. Learn more about Tidewater Physical Therapy at www.tpti.com.

Posture Problems.

Often, the problem can be traced to weakness in the muscles in the upper and middle back. Even if students try and sit up straight, they can fatigue easily. Physical therapy for those patients entails strengthening muscles equally with a therapy ball and using core exercises to help them stabilize their posture and keep them more upright.

We've seen children suffering from posture problems as a result of improper backpack use. For them, physical therapists can design individualized fitness programs to help strengthen muscles in their back, shoulders, neck and elsewhere, to help them carry the backpack loads.

Young Athlete Injury Prevention Programs.

Many of today's young athletes specialize in one sport and play year-round; they don't get a break. At the same time, they're still growing, and their muscles don't always catch up with their joints. Physical therapists offer expert advice on proper warm-up, emphasizing light jogging and jumping jacks, for example, before stretching, rather than stretching cold.

Build Strong Bodies.

While we don't have prescription pads per se, physical therapists will prescribe homework to patients. For our youngest patients, expect them to receive a prescription to play more! It may sound like the simplest of treatments, but across the board, we see good ol' fashioned playing helps build strong, healthy bodies and minds.

At the end of the day, that's what children need more than anything. ■

EXCEPTIONAL PROFESSIONAL

Melvin B. Palmer, PA-C

Hampton Roads Orthopaedics & Sports Medicine

When he was in high school, Melvin Palmer wasn't entirely sure where his career path would lead him, but he did know that his path would start with a stint in the service of his country. His father was in the Air Force, and when Melvin graduated from York High School in 1987, he enlisted in the Army as a combat medic. "The combat portion wasn't my first choice," he says, but the recruiters showed him a video with "all these medics in white uniforms going through the clinics taking care of patients," he remembers, "and I said yes right away. That's what I wanted to do." After basic training, he says, he realized that medicine was going to be his profession.

In fact, it was during his tenure as an Army medic at Fort Drum, NY, that he was introduced to the Physician Assistant profession. On the Base Clinic, he met a PA who described the profession to him. "She told me that as a PA, I could practice medicine and take care of patients under the supervision of a physician, whether I stayed in the military or as a civilian," he says.

It was a long road, but he never took his eyes off the prize. He served two tours and left the Army in 1996, and immediately began working as a Certified Surgical Technologist at Syracuse University Hospital, a Level 1 Trauma Center. "But I always wanted to return home to Virginia," he says, and in 2002, when the opportunity came to take a position at Community Memorial Hospital in South Hill, he took it. It was a travel assignment, and while it was gratifying work, he knew he wanted to pursue the PA program. A little less than a year later, he was offered a permanent position at Mary Immaculate Hospital's Surgical Pavilion, which gave him the opportunity to both work and go to school.

In December of 2008, Mr. Palmer earned a Bachelor of Science in Biology from Old Dominion University, and in May of 2012, a Masters of Physician Assistant at Eastern Virginia Medical School. His clinical rotations included critical care, plastic and reconstructive surgery, pediatrics, internal and family medicine, women's health – and orthopaedic surgery. "I liked all of it, and found emergency medicine extremely interesting," he remembers, "but when it came time to choose, orthopaedic surgery tugged on my heart, and I knew that's where I belonged."

He had assisted in many orthopaedic surgeries as an OR tech, but what appealed to him most was the opportunity to experience the entire spectrum of care from beginning to end. "I wanted to see the gamut of patients, those who presented with painful joints or severe back pain, to see what we could offer them other than surgery," he says, "as well as those who were at the point where they were lying on an operating table." He always wanted to play a bigger role in care, outside of surgery.

And he was fortunate: he met Dr. John Aldridge, who was attracted to his easy-going personality, and recruited him to join Hampton Roads Orthpaedics & Sports Medicine. "My goal is always to instill confidence in our patients and to play a pivotal role in their care," Palmer says. "We treat a variety of orthopaedic and sports medicine problems, from fracture care to joint and lumbar diseases. More recently, we've been performing sacroiliac joint fusions, which gives us the opportunity to provide relief for patients with severe, non-neurogenic back pain. We've had tremendous outcomes, and we're very proud of that. I'm right where I belong." ■

If you work with or know a Physician 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.

RIVERSIDE

EASTERN VIRGINIA NOW HAS A COMPREHENSIVE STROKE CENTER

Riverside Regional Medical Center is one of only three in the Commonwealth

Following a rigorous application process taking more than 18 months, Riverside Health System is proud to announce that its tertiary care hospital, Riverside Regional Medical Center (RRMC), has been designated a Comprehensive Stroke Center by DNV GL Healthcare.

Riverside becomes one of only three comprehensive stroke centers in Virginia, the other two being located in Richmond. Comprehensive Stroke Center is the highest level that can be achieved by a stroke-care program under DNV GL Healthcare certification.

The Comprehensive Stroke Center designation acknowledges RRMC as consistently providing the most advanced stroke treatment available, including the personnel, infrastructure, and expertise to diagnose and treat stroke patients who require intensive medical and surgical care, specialized tests, and/or interventional therapies. Its focus is on the adult population who suffer from any form of cerebrovascular disease (TIA, ischemic stroke, hemorrhage), including patients requiring specialized testing or therapies (e.g., endovascular, surgery) and those requiring multispecialty management. Riverside's evidence-based, timely care is evidenced by markedly improved outcomes.

DNV GL Healthcare is part of Det Norske Veritas, a global independent foundation dedicated to safeguarding life, property and the environment. DNV accredits acute care and critical access hospitals, and also provides Comprehensive as well as Primary Stroke Center and Acute Stroke Ready certifications. It is a leading accreditor of hospitals and health systems in the United States.

Throughout the certification process, DNV reviewed actual and potential Riverside patient outcomes; assessed the care and services provided, including the appropriateness of the care and services within the context of the certification requirements; visited patient care settings, including inpatient units, outpatient settings, emergency departments, imaging, rehabilitation, remote locations, satellites, etc. associated with the center; and reviewed pertinent clinical records, staff records, and other documentation.

Riverside and its health care affiliates now provide access to unparalleled stroke care for nearly two million people throughout Eastern Virginia. This represents the first time that population will have access to this level of care, which previously required travel to Richmond or further. This proximity is vital, as every second is critical to stroke treatment and outcome. Complex strokes and other neurologic cases require the unprecedented precision and expertise of Riverside's neurosciences department, which has long been recognized as the community's premier referral facility.

"Riverside Health System' unwavering commitment to the care of stroke patients has been formally recognized with the achievement of Comprehensive Stroke Center designation," says John N. Livingstone, MD, Riverside's Stroke Program Medical Director. "This serves to assure our patients and families that they can rest in complete confidence that we provide the highest quality standard of stroke care available." ■

For more information, contact
O'Brien Gossage RN, BSN, SCRN
Riverside Regional Medical Center,
Stroke Program Coordinator
757-534-6227

Front Row: (L-R) Kermit A. Lloyd, M.D.; Javier Amadeo, M.D.; Wolfgang Leesch, M.D.; John N. Livingstone, II, M.D.; Jackson Salvant, M.D.; Kamel Ben-Othmane, M.D.; Jun Zhao, M.D.; Brian T. Farrell, M.D., Ph.D.
Back Row: (L-R) Jesse F. Sanderson, M.D.; Frederick A. Patterson, M.D.; Thomas J. Reagan, M.D.; Gary S. Kavit, M.D.; Dean B. Kostov, M.D.; William H. McAllister IV, M.D.

OSC | ORTHOPAEDIC & SPINE CENTER

ORTHOPAEDIC & SPINE CENTER:
Expanding practices to encompass total care

When Orthopaedic & Spine Center (OSC) was founded in 1990, the physicians had a very clear vision: they wanted to offer the best and most comprehensive orthopaedic treatment available to the patients who entrusted them with their care. And they wanted to create a patient-centered environment in which to provide that care.

That philosophy continues to drive the practice. "OSC is constantly growing in order to provide a better experience of patient care," says Jeffrey R. Carlson, MD, who joined the practice in 1999 and currently serves as President and Practice Manager. "We're always looking for ways to help patients by implementing new surgical techniques and supportive care." And indeed, OSC has recently expanded its services to include new modalities and perspectives on caring for patients with orthopaedic problems and chronic pain, concentrating on both superior patient care and patient service.

All OSC physicians – now numbering nine – are Board certified, and now include a medical psychologist with an extensive career in pain management and pain medicine. They have specialized training in every aspect of orthopaedic surgery and care, as well as chronic and interventional pain management. They are supported by expanded facilities featuring state-of-the-art technologies, complemented by an exceptional, highly trained and skilled staff.

New therapies with proven results.
The role of regenerative medicine.

"Far too often in the past," says Raj N. Sureja, MD, "we've seen patients with conditions for which we've had limited treatment options, in both scope and efficacy. But once in a lifetime, real scientific advances are made that change everything for the patient and the physician." Dr. Sureja and his colleagues at OSC believe Regenerative Medicine is that game-changer, in that it potentially allows physicians to heal patients in ways they could once only imagine.

Regenerative Medicine uses autologous or amniotic stem cells, which can develop into many types of cells through differentiation. As so many people in the United States are afflicted with arthritis and other musculoskeletal problems, such as back pain, rotator cuff tears, meniscal tears, etc., stem cell therapy is an excellent non-surgical therapy for patients who cannot have surgery or who choose not to.

"We're already treating these patients with cortisone injections to control their pain," Dr. Sureja says, "so from the patient's perspective as well as the physician's, Regenerative Medicine Therapy is no different. The difference lies in what we're injecting. Instead of merely easing pain, we're trying to repair or strengthen tissue that's damaged or degenerating, using the body's own stem cells or platelets and growth factors to minimize inflammation, which speeds recovery and can potentially heal tissue."

Autologous cells cannot be rejected, and Dr. Sureja assures his patients that PRP is safe and effective, noting its approval by the NFL, MLB and the World Anti-Doping Association. In fact, many national and international sports leagues have adopted platelet rich plasma therapy as one of the first-line treatments of their injured athletes – including, among many others, Kobe Bryant and Hines Ward.

Dr. Andrus

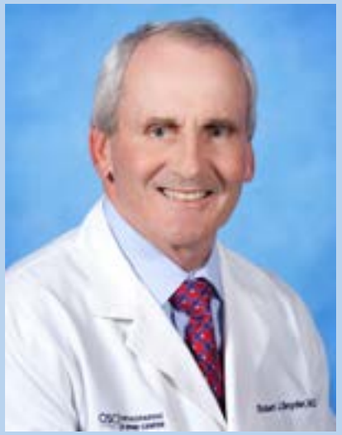
Prolotherapy
– effective treatment for patients with chronic pain.

"Patients often present with a history of chronic pain, for which x-ray and MRI studies offer little or no explanation," says Jenny L. F. Andrus, MD, who focuses on treating painful musculoskeletal and neurologic disorders. She routinely treats neck and back pain, joint pain and painful neuropathy. She often uses physical therapy, pain psychology

Dr. Sureja explains scans to a patient

ORTHOPAEDIC & SPINE CENTER: Meet our Physicians

Boyd W. Haynes, III, MD
Sports Medicine fellowship trained orthopaedic surgeon. Joint replacement specialist.
Joined OSC in 1992.



Robert J. Snyder, MD
Orthopaedic surgeon focused on arthroscopy of the knee and shoulder, as well as total joint replacement and treatment.
Joined OSC in 1994.

Jeffrey R. Carlson, MD
President and Managing Partner
Fellowship trained specialist for treatment of injuries and disorders of the spine.
Joined OSC in 1999.

and medications along with interventional procedures to target difficult chronic pain. She is a proponent of prolotherapy, a treatment of tissue with the injection of an irritant solution into a joint space, weakened ligament, or tendon insertion to relieve pain, which she has found effective in treating these patients.

"Most of the time, the injection is a high concentration of sugar water that brings in blood and causes inflammation, which causes the injury to heal," Dr. Andrus says, acknowledging what has been seen to be a contradiction. "For years, we've been thinking inflammation is always bad, and giving patients an anti-inflammatory every time they have pain, when actually, people need a little inflammation to heal."

Prolotherapy allows the body to do its own work. Instead of injecting a pharmacologic agent into the body, prolotherapy brings in the cells the body needs through its own blood supply, effectively enabling the body to heal itself. She's especially excited about the positive benefit she's seen for patients with chronic sacroiliac joint pain, and has begun working in collaboration with OSC's Physical Therapy Center to establish an SI Joint program.

But, she cautions, there's no magic number of treatments that are guaranteed to produce results for every patient. "Our patients usually begin to see some benefit after their third treatment," she says. "But for those who are biomechanically set up to have a repetitive trauma-type injury, there may be the need to be on a maintenance regimen." Not because the treatment wore off, she adds, but because those patients developed the injury again.

New techniques in spine surgery.

As one of OSC's fellowship trained spine surgeons, Dr. Carlson is a proponent of outpatient spinal surgery procedures and techniques, including Less-Exposure Spine Surgery (LESS), which is minimally invasive and less traumatic for the patient. Along with his colleagues, he actively seeks new and advanced technologies as treatment options, carefully selecting those that will offer the best outcomes for his patients.

◂ Dr. Haynes with Chris Schwizer, PA-C

"The idea is that we try to limit surgical injury," he explains, "so we use the same incision to get screws, rods, plates, bone graft, etc., into the surgical site that we are using to get the disc out – thus limiting the amount of surgical pain by decreasing the amount of soft tissue injury. In a cervical spine procedure, the procedure can be done with an incision no longer than an inch."

He has successfully employed these techniques for lower back cases as well. "In the past, when we did a fusion, those incisions were three to four inches long, which resulted in significant pain requiring a hospital stay," he says. "But we're doing microdiscectomy incisions an inch, or an inch and a half long, and doing the fusion through that same incision." His patients are up, getting their muscles moving so there's much less spasming and far less pain. Their nerve pain is relieved, their bones are fixed and solid, and they're getting back to their lives much more quickly. "It works," Dr. Carlson says, "because we changed our thought process. We simply changed the angle at which we insert the hardware."

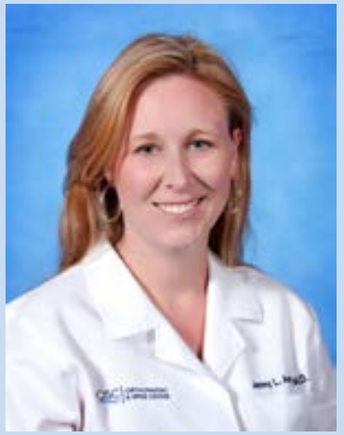
Dr. Mark McFarland with Erin Lee, PA-C

Getting his patients up on their feet quickly and on their way home to recuperate is part of Dr. Carlson's surgical plan. "Nobody wants to stay in the hospital," he says. "Patients do better in their own environment, where they control when they sleep, what they eat and they're surrounded by familiar comforts. These procedures take much less time, involve much less surgical injury and result in less post-operative pain."

Martin Coleman, MD
Orthopaedic and sports medicine surgeon, special interest in disorders of the shoulder.
Joined OSC in 2002.

Mark W. McFarland, DO
Fellowship trained specialist, focused primarily on the care and treatment of injuries and disorders of the spine.
Joined OSC in 2005.

Raj N. Sureja, MD
Fellowship trained pain management specialist focused on pain reduction of the spine and spine-related disorders through minimally-invasive interventional procedures.
Joined OSC in 2008.



Jenny L. F. Andrus, MD
Interventional pain management physician focusing on treatment of musculoskeletal and neurologic disorders, especially neck and back pain, joint pain and neuropathy.
Joined OSC in 2009.

John D. Burrow, DO
Fellowship trained orthopaedic surgeon specializing in Adult Total Joint Reconstruction.
Joined OSC in 2013.

F. Cal Robinson, PsyD
Medical psychologist with a Master's in Clinical Psychopharmacology, focused on pain management and pain medicine.
Joined OSC in 2015.

Outpatient Total Hip and Knee Replacement Program.

Joint replacement surgeries have been performed for more than 100 years, but it was only five years ago that they were done as outpatient procedures in Virginia, and OSC was at the forefront. In July 2010, OSC orthopaedic surgeon Boyd W. Haynes, III, MD performed the Commonwealth's first outpatient knee replacement. Less than a month later, Mark W. McFarland, DO did the first outpatient total hip.

At the time, both surgeons remember, the orthopaedic community differed on whether these procedures were wise, fearing complications might arise that would require patients' return to the hospital.

"The things that make the difference are better anesthetics, computer navigation and the most current surgical techniques," says Dr. Haynes. "And our outpatient therapy program is a huge part of the success."

The program always starts in Dr. Haynes' office, with him talking to his patients, so he can make sure they have the right mindset, and that they understand what they are asking for. It always starts with education.

"We don't want people in the hospital," Dr. Haynes explains. "There are sick people in the hospital, and joint replacement patients aren't sick." But before they leave the operating room, his patients understand that therapy starts the same day as surgery – and therein lies the success of the program. All of the details of therapy have been painstakingly set in motion before the surgery. "I have protocols in place whereby if a patient's surgery is on Wednesday, therapy starts that day and sets everything up to start in-home therapy on Thursday, just as it would if the patient stayed in the hospital," Dr. Haynes says. "Even the hospital personnel are familiar with these protocols and make sure my patients are appropriate for discharge." It's a well-oiled system that works: in the five years since Dr. Haynes' first outpatient surgery, none of these patients have had to come back to the hospital for admission.

Dr. Haynes examines a patient

Open MRI Center.

It had been clear for years that patients were experiencing anxiety and claustrophobia because of the lengthy time they were required to spend in a closed MRI unit. To address their discomfort, in 1992, soon after the technology came on the market, OSC purchased its first open MRI machine. In addition to providing a better experience for their patients, the physicians found the imaging equal to or better than the results of standard closed scanners.

In 2013, the practice invested in a state-of-the-art Hitachi Oasis 1.2T hospital grade MRI system, which sets the highest standard for patient-centric care. OSC has found that even the most challenging patients can be handled with confidence, and without compromising safety, performance or efficiency. A unique achievement in high-performance imaging, the Oasis open architecture features advanced magnet design, Zenith RF Technology and robust clinical capabilities to achieve high throughput diagnostic performance. "The big magnet defines the quality of the images," Dr. Carlson says. "When we show these crisp pictures to the patients, they can see exactly what we're talking about."

The Physical Therapy Center.

Originally situated in 5,000 sq.ft. on the second floor of the main OSC building, the Physical Therapy department soon outgrew that space and in 2013, acquired its own dedicated building adjacent to OSC. To meet the needs of OSC's growing patient population, four therapists – Tom Toothaker, DPT; Amanda Jetty, DPT and Junmei Pan, PT; and Clinic Director Rachel Tyler, DPT, CIMT – are now in place, supported by two licensed physical therapy assistants, Bill Richards, LPTA and Heather Cole, LPTA. Now operating in 8,000 sq.ft., the Physical Therapy Center features five private and five semi-private rooms, and open gym areas on either side of the building that accommodate cardiovascular equipment and more advanced equipment for high performing athletes.

A recent innovation of the Physical Therapy Center is dry needling, a technique for treating muscular pain, which has shown remarkable results. "The technique involves inserting a monofilament needle into a muscle in order to reset the muscle tissue and decrease trigger point activity," says Tyler, who recently received her Doctorate in Physical Therapy. "Dry needling has been shown to be a remarkable adjunct to traditional manual and physical therapy techniques." There are four therapists at the OSC Physical Therapy Center, who received this advanced training from KinetaCore®, a national organization that offers continuing education courses for manual therapists.

Dry needling

Dr. Tyler and her colleagues work in conjunction with all OSC physicians, caring for patients both before and after surgery, as well as non-surgical patients.

Healing body and mind.

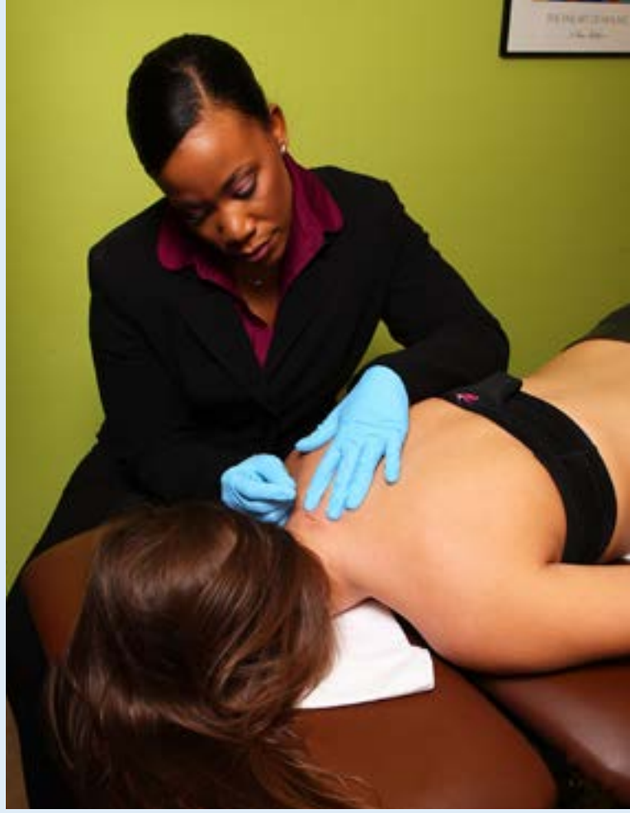
Relieving orthopaedic pain is more complex than merely identifying and fixing the mechanisms causing the pain. "Even with patients who have a clear pathology, there's a psychological component that is sometimes overlooked," Dr. Andrus says. "We're trying to focus on the whole person."

In that vein, in August of 2015, OSC welcomed F. Cal Robinson, PsyD, MSCP, a Board certified medical psychologist with a Masters of Science in Clinical Psychopharmacology. Prior to joining OSC in August 2015, Dr. Robinson had an extensive career in pain management and pain medicine.

Dr. Robinson cites an Institute of Medicine report from 2011 evaluating the effectiveness of chronic pain treatment in the US, which showed that the interventional movement in pain management had resulted in many patients becoming passive recipients of opioid analgesic injections and procedures. "Very few interventions are more than a temporary fix," Dr. Robinson says, "and as evidenced by that IOM report, the health community supports an integrated biopsychosocial approach to health and pain care. We want to see people shift to becoming more active participants in their own care." He adds, "Orthopaedic and Spine Center has shown great wisdom in recognizing that we have to offer something other than pain reduction to these patients. We can help them from a treatment perspective by assisting them in finding ways to more effectively accept and live with pain."

Acceptance and Commitment Therapies (ACT).

The American Psychological Association has endorsed ACT as a very effective therapy for chronic pain. "Within cognitive behavior



science, the concepts of mindfulness, and acceptance and commitment therapies, have been emerging," Dr. Robinson says. "The meaning and purpose of pain in one's life have to be addressed. The idea is to learn to be present with the pain, finding one's way toward accepting it: being intentionally mindful of the experience without reacting to it has been found to be incredibly helpful."

People can change their mindsets. Rather than fighting and struggling with pain, he says, "We can teach them that they have the power to accept and deal with their pain. It's not an easy shift, but it can be made."

Always looking ahead.

The practice's original vision – the most exceptional orthopaedic care in the most patient-welcoming atmosphere – is pursued by OSC every day, but never to the extent of resting on its considerable laurels. Every new modality will be tested, every new technique explored, every burgeoning therapy investigated – because OSC knows that with today's medical advances, technology and innovation, there is no reason for anyone to put their lives on hold for orthopaedic or pain problems. OSC continues to demonstrate its longstanding commitment to putting patients first.

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Clarifying Questions and Answers Related to the July 6, 2015 CMS/AMA Joint Announcement and Guidance Regarding ICD-10 Flexibilities

1 When will the ICD-10 Ombudsman be in place?
The Ombudsman will be in place by October 1, 2015.

2 Does the Guidance mean there is a delay in ICD-10 implementation?

No. The CMS/AMA Guidance does not mean there is a delay in the implementation of the ICD-10 code set requirement for Medicare or any other organization. Medicare claims with a date of service on or after October 1, 2015, will be rejected if they do not contain a valid ICD-10 code. The Medicare claims processing systems do not have the capability to accept ICD-9 codes for dates of service after September 30, 2015 or accept claims that contain both ICD-9 and ICD-10 codes for any dates of service. Submitters should follow existing procedures for correcting and resubmitting rejected claims.

3 What is a valid ICD-10 code?

ICD-10-CM is composed of codes with 3, 4, 5, 6 or 7 characters. Codes with three characters are included in ICD-10-CM as the heading of a category of codes that may be further subdivided by the use of fourth, fifth, sixth or seventh characters to provide greater specificity. A three-character code is to be used only if it is not further subdivided. To be valid, a code must be coded to the full number of characters required for that code, including the 7th character, if applicable. Many people use the term billable codes to mean valid codes. For example, E10 (Type 1 diabetes mellitus), is a category title that includes a number of specific ICD-10-CM codes for type 1 diabetes. Examples of valid codes within category E10 include E10.21 (Type 1 diabetes mellitus with diabetic nephropathy) which contains five characters and code E10.9 (Type 1 diabetes mellitus without complications) which contains four characters.

A complete list of the 2016 ICD-10-CM valid codes and code titles is posted on the CMS website at http://www.cms.gov/Medicare/Coding/ICD10/2016-ICD-10-CM-and-GEMs.html. The codes are listed in tabular order (the order found in the ICD-10-CM code book). This list should assist providers who are unsure as to whether additional characters are needed, such as the addition of a 7th character in order to arrive at a valid code.

4 What should I do if my claim is rejected? Will I know whether it was rejected because it is not a valid code versus denied due to a lack of specificity required for a NCD or LCD or other claim edit?

Yes, submitters will know that it was rejected because it was not a valid code versus a denial for lack of specificity required for a NCD or LCD or other claim edit. Submitters should follow existing procedures for correcting and resubmitting rejected claims and issues related to denied claims.

5 What is meant by a family of codes?

"Family of codes" is the same as the ICD-10 three-character category. Codes within a category are clinically related and provide differences in capturing specific information on the type of condition. For instance, category H25 (Age-related cataract) contains a number of specific codes that capture information on the type of cataract as well as information on the eye involved. Examples include: H25.031 (Anterior subcapsular polar age-related cataract, right eye), which has six characters; H25.22 (Age-related cataract, morgagnian type, left eye), which has five characters; and H25.9 (Unspecified age-related cataract), which has four characters. One must report a valid code and not a category number. In many instances, the code will require more than 3 characters in order to be valid.

6 Does the recent Guidance mean that no claims will be denied if they are submitted with an ICD-10 code that is not at the maximum level of specificity?

In certain circumstances, a claim may be denied because the ICD-10 code is not consistent with an applicable policy, such as Local Coverage Determinations or National Coverage Determinations. (See Question 7 for more information about this). This reflects the fact that current automated claims processing edits are not being modified as a result of the guidance. In addition, the ICD-10 code on a claim must be a valid ICD-10 code. If the submitted code is not recognized as a valid code, the claim will be rejected. The physician can resubmit the claims with a valid code.

7 National Coverage Determinations (NCD) and Local Coverage Determinations (LCD) often indicate specific diagnosis codes are required. Does the recent Guidance mean the published NCDs and LCDs will be changed to include families of codes rather than specific codes?

No. As stated in the CMS' Guidance, for 12 months after ICD-10 implementation, Medicare review contractors will not deny physician or other practitioner claims billed under the Part B physician fee schedule through either automated medical review or complex medical record review based solely on the specificity of the ICD-10 diagnosis code as long as the physician/practitioner used a valid code from the right family of codes. The Medicare review contractors include the Medicare Administrative Contractors, the Recovery Auditors, the Zone Program Integrity Contractors, and the Supplemental Medical Review Contractor.

As such, the recent Guidance does not change the coding specificity required by the NCDs and LCDs. Coverage policies that currently require a specific diagnosis under ICD-9 will continue to require a specific diagnosis under ICD-10. It is important to note that these policies will require no greater specificity in ICD-10 than was required in ICD-9, with the exception of laterality, which does not exist in ICD-9. LCDs and NCDs that contain ICD-10 codes for right side, left side, or bilateral do not allow for unspecified side. The NCDs and LCDs are publicly available and can be found at http://www.cms.gov/medicare-coverage-database/.

8 Are technical component (TC) only and global claims included in this same CMS/AMA guidance because they are paid under the Part B physician fee schedule?

Yes, all services paid under the Medicare Fee-for-Service Part B physician fee schedule are covered by the guidance.

9 Do the ICD-10 audit and quality program flexibilities extend to Medicare fee-for-service prior authorization requests?

No, the audit and quality program flexibilities only pertain to post payment reviews. ICD-10 codes with the correct level of specificity will be required for prepayment reviews and prior authorization requests.

10 If a Medicare paid claim is crossed over to Medicaid for a dual-eligible beneficiary, is Medicaid required to pay the claim?

State Medicaid programs are required to process submitted claims that include ICD-10 codes for services furnished on or after October 1 in a timely manner. Claims processing verifies that the individual is eligible, the claimed service is covered, and that all administrative requirements for a Medicaid claim have been met. If these tests are met, payment can be made, taking into account the amount paid or payable by Medicare. Consistent with those processes, Medicaid can deny claims based on system edits that indicate that a diagnosis code is not valid.

11 Does this added ICD-10 flexibility regarding audits only apply to Medicare?

The official Guidance only applies to Medicare fee-for-service claims from physician or other practitioner claims billed under the Medicare Fee-for-Service Part B physician fee schedule. This Guidance does not apply to claims submitted for beneficiaries with Medicaid coverage, either primary or secondary.

12 Will CMS permit state Medicaid agencies to issue interim payments to providers unable to submit a claim using valid, billable ICD-10 codes?

Federal matching funding will not be available for provider payments that are not processed through a compliant MMIS and supported by valid, billable ICD-10 codes.

13 Will the commercial payers observe the one-year period of claims payment review leniency for ICD-10 codes that are from the appropriate family of codes?

The official Guidance only applies to Medicare fee-for-service claims from physician or other practitioner claims billed under the Medicare Fee-for-Service Part B physician fee schedule. Each commercial payer will have to determine whether it will offer similar audit flexibilities. ■

ARE YOU COMPLIANT?

What You Need to Know About the EMV Fraud Liability Shift

By Nicole J. Harrell and Beth A. Norton

If you are one of the 51 percent of small business owners who haven't heard about the new credit card rule that went into effect on October 1st, you should know that there has been a significant shift in liability for credit card fraud, and that liability likely just shifted to you.

Chances are, you recently received a new debit and/or credit card from your bank in preparation for the shift. The new card, called an EMV card, contains a microchip that stores the cardholder's data on integrated circuits rather than magnetic strips, and which is more secure than the magnetic strip cards. Cryptographic keys used in the transaction help protect against fraud at the point-of-sale, thus making the EMV cards more difficult to counterfeit.

Previously, the card-issuer bore all the risk of a fraudulent use. Now, however, the liability for all fraudulent charges will shift to the least secure, or non-EMV compliant, party. What that means is that if the bank has issued an EMV card and the card is fraudulently used, or a retailer suffers a security breach and the cardholder's information is obtained, the retailer bears all the liability for the fraudulent charges unless the retailer is using an EMV terminal.

The converse is true and the bank bears the liability for fraudulent use if the retailer is using an EMV terminal. If both parties have implemented EMV technology and fraud or a breach occurs, then the bank bears the liability.

Therefore, the surest way to ensure liability remains with the bank is to install and implement an EMV-enabled payment terminal with at least chip-and-signature capability. Chip-and-signature is most widely used now, but chip-and-PIN will be transitioned in over time.

First, practice managers should contact the practice's bank and POS device provider to learn about the process and costs associated with integrating EMV-enabled technology into your practice. Discounts on equipment may be available. Each payment card brand may also have additional guidance.

Next, given the likelihood of a breach, practice managers should engage in risk/benefit analysis to determine whether mitigating liability outweighs the cost of purchasing and implementing the EMV-enabled payment terminal and associated software. The EMV terminals still accommodate magnetic strip cards, so there is no need to maintain two terminals in order to accommodate both types of cards.

Last, if you elect to upgrade to EMV technology, your staff will need to be trained on the new devices, including the configuration and validation requirements necessary to integrate EMV with legacy systems. You will also need to make sure your IT administrator is familiar and compliant with Payment Card Industry (PCI) data security standards.

Be vigilant and watch for future changes in the ever-evolving payment technology industry, particularly if you accept online payments. They're likely the next target. ■

Nicole J. Harrell is the Chair of the Cybersecurity Response Team at Kaufman & Canoles. She routinely assists clients with planning and response to cyber breaches including the Payment Card Industry Security Standards. Nicole can be reached at (757) 624.3306 or njharrell@kaufcan.com.

Beth A. Norton is an associate in the Health Care Practice Group at Kaufman & Canoles. She can be reached at (757) 624.3210 or banorton@kaufcan.com.

PRESS-FIT FIXATION FOR TOTAL KNEE REPLACEMENTS

– A NEW APPLICATION FOR AN EXISTING TECHNOLOGY

By Scott Grabill, DO

Historically, surgeons have used cement to hold the components in place in total joint replacements. Over the last decade, we've seen improved porous metals designed to mimic cancellous bone of the human body. Recently, we have newer implants with this porous metal that can be press-fit directly against the bone, which then grows onto those implants. That's been the gold standard for hip replacements for many years, but has not been refined for use in total knee replacements until recently.

Although there have been versions of cementless prostheses with reliable ingrowth of the patient's bone to the femoral component for knee replacements, most older versions have shown higher failure rates with the tibial component fixation.

Press-fit fixation is now feasible in an increasing number of knee replacement cases. As in the hip, the press-fit prosthesis gives us the potential of a permanent fixation: it becomes part of the patient's bone because it's directly attached; there's no interface holding it in place that could break down or become loose over time. With these newer metals, we have a better likelihood of long-term ingrowth on the tibial component. Among the benefits of the press-fit technology is that it can be applied using either conventional or robotic assisted surgical techniques.

Physicians and surgeons are seeing younger and younger patients presenting with arthritis, whose active lifestyles makes them candidates for total knee replacement at a much earlier age. For these patients, press-fit knee replacement offers a more permanent method of fixation of their components, which we believe will demonstrate a lower incidence of loosening or failure requiring revision surgery.

Press-fit fixation is appropriate for most patients who are active, healthy, and without multiple comorbidities, and who have healthy bone in the knee. It may not be ideal for patients with osteoporosis or low bone mineral density, because when we press-fit the prosthesis, there is a risk of fracture, or subsiding into the bone. As people maintain more active lifestyles later into life, bone density improvements may allow this technology to be performed successfully in much older patients.

The decision to press fit can be easily and quickly made intra-operatively; that is, we anticipate what we'll find based on a comprehensive pre-op history and physical exam, but sometimes find a different scenario when we actually examine the bone with our own eyes and hands. If the bone is healthy, we have the option of press-fitting the prosthesis, and if we find poorer bone quality, we can cement it. This decision can be made easily without having to shift gears in the OR.

The key, as always, is proper patient selection and patient education. It's vital to talk to patients before the procedure, so they understand the potential long-term benefit of press fit biologic fixation, as well as the reliability of a traditional cemented knee arthroplasty. ■

CDR Scott Grabill, DO, has served on active duty in the US Navy for 13 years. He completed his orthopaedic surgery residency at Portsmouth Naval Medical Center, and a fellowship in orthopaedic total joint reconstruction at the Cleveland Clinic. He is currently employed by Sports Medicine and Orthopaedic Center and will join the practice full-time upon leaving the Navy in 2016. smoc-tt.com

IN THE NEWS

John Aldridge, MD

John Aldridge, MD, a spine specialist with Hampton Roads Orthopaedics & Sports Medicine, will add Williamsburg to his clinic locations. In addition to his established Newport News clinic, Dr. Aldridge will begin seeing patients every Wednesday at the new HROSM Williamsburg location in New Town.

Bon Secours Cancer Institute at DePaul physicians have introduced a technology to improve the precision of radiation therapy treatments. Charles E. Ives, MD, FACS, with Bon Secours Surgical Specialists, recently surgically implanted Hampton Roads' first BioZorb, a small three-dimensional bioabsorbable marker for women with early stage breast cancer. BioZorb provides a target for aiming radiation therapy precisely at the tumor site, which helps minimize any damage to healthy tissue. BioZorb is a small coil that holds six tiny clips arranged in a precise three-dimensional array. The device is sutured directly into the tumor resection site and the 3D array remains over time while the coil holding the clips dissolves. The marker of the tumor bed also makes it easier to do follow up using routine mammograms.

Bon Secours Hampton Roads is proud to announce that two of its medical centers have earned the Platinum Performance Achievement Award for 2015. Bon Secours DePaul Medical Center in Norfolk, and Bon Secours Maryview Medical Center, located in Portsmouth have received the American College of Cardiology's National Cardiovascular Data Registry (NCDR) ACTION Registry– Get With The Guidelines (GWTG) Platinum Performance Achievement Award for 2015. Bon Secours DePaul and Bon Secours Maryview are two of only 319 hospitals nationwide to receive the honor.

Marylou S. Anton

Bon Secours Hampton Roads announces that Marylou S. Anton, MSN, RN, OCN, has joined Bon Secours to serve as Administrative Director of Oncology Services. Anton is recognized for her highly accountable management experience in oncology services, clinical care, management, research, fiscal responsibility and education, as well as her motivational and supportive managerial techniques and collaboration. An Oncology Certified Nurse (OCN), she brings more than 35 years of nursing and oncology experience to her new role.

Bon Secours Hampton Roads announces that Tonya L. Nafzger, MSN, RN, ONC, is joining Bon Secours as Administrative Director for Orthopaedics, effective July 27, 2015. In her new role, Nafzger will serve Bon Secours DePaul Medical Center, Bon Secours Maryview Medical Center and Bon Secours Mary Immaculate Hospital. She has more than ten years of nursing leadership and management experience. She is a Certified Orthopaedic Nurse through National Association of Orthopaedic Nurses (NAON).

Tonya L. Nafzger

Bon Secours Hampton Roads announces that the Bon Secours DePaul Outpatient Infusion Center has relocated to the Bon Secours DePaul Medical Plaza. The new, 7,270 square foot center is located adjacent to Bon Secours Cancer Institute at DePaul in Norfolk. The new center offers patients a very comfortable and therapeutic environment. By relocating next to the radiation therapy department at the Cancer Institute, where many of patients have treatments, they have the enhanced opportunity to work as a team and ultimately enhance coordination of care.

Bon Secours Hampton Roads Health System held a groundbreaking for a new medical plaza on the campus of Bon Secours Health Center at Harbour View. The project is a $20 million investment, and once completed, the 58,000-square-foot, two-story facility will offer a comprehensive, outpatient cancer institute that will serve one of the most rapidly growing communities in Hampton Roads. Construction is anticipated to be complete by September 2016. "The new Bon Secours Harbour View Medical Plaza will have a tremendous impact on the service and care for people with cancer in the western Hampton Roads community," says Michael K. Kerner, CEO, Bon Secours Hampton Roads Health System.

L-R: Bobby Bray, Bon Secours Hampton Roads, Board of Directors; Sister Rita Thomas, CBS; Joseph M. Oddis, CEO, Bon Secours Maryview Medical Center;Cynthia Reynolds, CEO/SVP, Bon Secours Virginia Foundation; Sister Christine Webb, CBS; Michael K. Kerner, CEO, Bon Secours Hampton Road; Honorable Linda Johnson, Mayor, City of Suffolk; Arthur Collins, Chair, Bon Secours Hampton Roads Board of Directors; Kevin Barr, CEO, Bon Secours Ambulatory Services; Judith Blevins, MD, Radiation Oncologist; Bradley Prestidge, MD, MS, radiation oncologist and Regional Medical Director for Radiation Oncology, Bon Secours Cancer Institute; Teresa Crist, Director Radiation Oncology, Bon Secours Virginia; Mary Lou Anton, Administrative Director, Oncology Services, Bon Secours Hampton Roads; Kevin Shephard, Vice President, Ambulatory Services, Bon Secours Virginia; Chris Jones, Virginia House of Delegates; Tim O'Brien, Administrative Director, Ambulatory Services

Bon Secours Hampton Roads Health System is pleased to announce that the nuclear medicine department of Bon Secours Mary Immaculate Hospital has received an extension to its initial accreditation by the American College of Radiology (ACR). The extension is for three years and is effective through September 2018. "With this re-accreditation, the ACR recognizes that we are providing the highest levels of image quality and patient safety for our nuclear medicine patients," notes Darlene Stephenson, CEO of Bon Secours Mary Immaculate Hospital. "It also affirms that we are compliant with all ACR practice guidelines and technical standards."

Bon Secours Health Center in Suffolk was recently recognized by the National Accreditation Program for Breast Centers (NAPBC) for its high standards in care for patients with breast cancer. Named for a longtime resident of Portsmouth and Nansemond County, the Millie Lancaster Women's Center at Harbour View provides comprehensive services for women's health, such as 3D mammography, ultrasound, bone densitometry, Reclast® infusion for osteoporosis, and other wellness initiatives. Patients at the Center can take advantage of the many resources on the campus of Bon Secours Health Center at Harbour View, including physician offices, advanced imaging, radiology, outpatient surgery, sports medicine and medical acupuncture.

Bon Secours Maryview Medical Center has implemented an innovative three-step process in conjunction with the local Portsmouth Fire, Rescue and Emergency Services (PFRES) as part of a new initiative to improve first response methods for stroke victims. This joint effort has significantly reduced time to treatment for stroke and other neurological emergencies by doing an initial assessment and blood specimen collection in the field prior to a patient's arrival at Bon Secours Maryview's emergency department. Early hospital notification by PFRES allows the emergency department staff to be prepared to rapidly assume care of the patient.

Bon Secours Medical Group is proud to announce that patients can now conveniently schedule appointments online from their computers, tablets or smartphones. Bon Secours Medical Group is working hard to make receiving healthcare easier through convenient locations and now online scheduling."

Bon Secours Virginia was named by Working Mother magazine as one of the 2015 Working Mother's 100 Best Companies for outstanding leadership in establishing policies, programs and corporate culture that supports working moms, including child care, flexible work arrangements, paid parental leave and advancement of women.

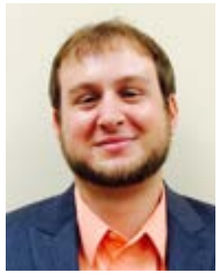
CHESAPEAKE REGIONAL HEALTHCARE

Chesapeake Regional Medical Center will now be one of a collection of sub-brands under Chesapeake Regional Healthcare, the new system name."We now consist of several entities and offer a specialty physician group along with multitude health care and wellness services," says

IN THE NEWS

Peter F. Bastone, Dr. PH, President and CEO. "This change does not mean our founding principles will disappear. It just gives us room to expand our patient-centered offerings in this fast-paced and ever-changing health care environment." The hospital continues as one of the only independent hospitals left in the state of Virginia.

Chesapeake Regional Medical Center received the American College of Cardiology Award for High Standards in Cardiac Care. It is one of a select few hospitals nationwide to receive the Platinum Performance Achievement Award for 2015. The award recognizes CRMC's commitment to 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.)



Scott Brubaker

Comber Physical Therapy is pleased to announce that they now offer a Parkinson and neuro program that includes the "LSVT BIG" Protocol. Scott Brubaker, PTA, (physical therapy assistant), is certified in the LSVT BIG program and will be spearheading this endeavor and it will bring a great deal of amazing results to the community. Comber Physical Therapy is the only outpatient clinic in Williamsburg to provide such a program.

Children's Hospital of The King's Daughters Health System has named three new vice presidents. Paul Morlock joins CHKD Health System as Vice President of Human Resources and Occupational Health. Karen Mitchell, RN, has been promoted to Vice President of Patient Care Services. Mitchell will serve as Chief Nursing Officer. Tamika Harris has been selected to serve in a newly created position as Vice President of Facilities and Support Services.

Paul Morlock

Karen Mitchell, RN

Tamika Harris

Chesapeake Regional Health Foundation Board of Directors welcomes Mark A. Compton, Joseph "Joey" Barnes, Dr. Anthony Cetrone and Louise Quales. The group presents the annual Bra-ha-ha®, which raises funds to provide mammograms and other related breast services for the area's uninsured women. Mark Compton is the founder and partner of Compton McCulley, a boutique wealth management firm located in Norfolk.

Mark A. Compton

Joseph "Joey" Barnes

Anthony Cetrone, MD

Louise Quales

Jeremy Hoff, DO

Dr. Jeremy Hoff of Hampton Roads Orthopaedics & Sports Medicine is one of only a few providers on the Peninsula now using pharmacogenetics to increase precision when prescribing medication. Pharmacogentics involves taking a DNA cheek swab to determine how genetic differences cause people to have different responses to the same drug. This information provides Dr. Hoff the ability to choose the best medication and adjust dosage according to each patients genetic profile. It also allows for potentially lower medication interactions for patients on medication from multiple providers.

This year will mark the 15th Anniversary of Lake Taylor's "Rehab Reunion." October is National Physical Therapy Month. To celebrate, Lake Taylor Transitional Care Hospital will host its 15th annual Rehab Reunion (Oct. 22), when the Norfolk facility invites recent rehab "graduates" to come back to the facility for a picnic and fellowship with hundreds of other "classmates" and Lake Taylor rehabilitation staff, nurses and therapists. It's an afternoon of fun memories, good food, renewed riendships, and celebrating many happy returns to good health.

IN THE NEWS


Timothy O'Brien

Timothy O'Brien, administrative director for Ambulatory Operations for Bon Secours Hampton Roads Health System, has been honored with Inside Business' annual Top 40 Under 40 designation. O'Brien joined Bon Secours as an administrative intern in 2008, quickly emerging as a leader specializing in strategic growth and physician alignment. He was promoted to chief of staff/assistant to the CEO in 2012 and to his current role in December 2014. He is responsible for directing operations for the Bon Secours Health Center at Harbour View, Bon Secours Health Center at Virginia Beach and Bon Secours Amelia in Norfolk.

Riverside Health System is pleased to bring the Operation Family Caregiver Program, an evidence-based program of the Rosalynn Carter Institute for Caregiving (RCI), to Virginia. The OFC program in Virginia is a collaboration between the Riverside Center for Excellence in Aging and Lifelong Health (CEALH) and the Virginia Wounded Warrior Program (VWWP), a Virginia Department of Veterans Services (DVS) program. The program will be offered in Hampton Roads and Northern Virginia, home to more than 425,000 veterans. OFC provides support to the families of newly returning service members and veterans. It is free, confidential, and tailored to each individual family. It is the only program like it serving military families.

Riverside Health System added cutting edge technology to its arsenal for treating cancer patients. On August 3, 2015, Riverside Regional Medical Center's Radiosurgery Center treated the first patients with the newly-installed Leksell Gamma Knife® Perfexion™ stereotactic radiosurgery system – one of only 300 systems in the world. The Gamma Knife delivers an isolated, high dose of radiation causing little or no surrounding tissue damage. The Perfexion™ system dramatically streamlines workflow, expanding the treatable volume through faster set-up and treatment for patients with brain tumors, abnormal blood vessel formations, and a host of other neurological conditions.


Stephen W. Shield, MD

Stephen W. Shield, MD has been elected Chairman of the Board of Allergy Partners, P.A. With 129 allergists in 24 states, Allergy Partners is the nation's largest single-specialty practice dedicated to the treatment of allergies and asthma. Dr. Shield, a 1988 EVMS graduate, has been in practice in Hampton Roads since completing his fellowship in allergy/immunology in 1993, and joined Allergy Partners in 2010. He continues to maintain offices in Williamsburg and Newport News.

Tidewater Physical Therapy would like to welcome the following new clinicians:


Joanna Michalopulos, PT, DPT
Williamsburg


TJ Stites, PT, DMT, FAAOMPT
Suffolk


Blythe Kolb,PTA
Suffolk


Calla Selfridge, PT, DPT, CMTPT
Gloucester Point


Jinni Newing, PTA
Red Mill


Kate Henderson, PTA
Oyster Point


Amy Heron, PTA
Oyster Point


Joan Fernandez Tomas, PT
Williamsburg

If you have News you would like to share with our readers in the Fall edition, please contact the publisher at 757-237-1106 or email: holly@hrphysician.com Deadline for submissions is January 5th.

WELCOME TO THE COMMUNITY

Paul Arunava, MD has joined Sentara Medical Group. Dr. Arunava earned his medical degree from Dhaka Medical College in Bangladesh in 2002. He completed an internship in internal medicine and surgery at Dhaka College & Hospital in Bangladesh in 2003, and his residency in internal medicine at Coney Island Hospital in Brooklyn, NY, in 2009. As an internist, he provides personalized care to adult patients with chronic medical illnesses and diseases. Dr. Arunava's experience includes diagnosing, managing, and providing comprehensive treatment to patients who sometimes have serious or complex health issues. He is certified by the American Board of Internal Medicine.

Timothy J. Campbell, MD has joined Allergy Partners of Hampton Roads with offices in Newport News and Williamsburg. He earned his medical degree at Northeast Ohio Medical University in 2009. He completed his residency in internal medicine at Summa Health System in Akron, Ohio. After residency, he completed his fellowship in allergy/immunology at the Cleveland Clinic.

Lucy DeFanti, DO has joined Peninsula Pathology Associates in Newport News. She received her nursing degree from the University of Maryland and her medical degree from the Kirksville College of Osteopathic Medicine. Dr. DeFanti completed her residency in anatomic and clinical pathology at the University of Tennessee Graduate School of Medicine, where she also completed a fellowship in cytopathology. She completed a fellowship in surgical pathology at the Icahn School of Medicine at Mount Sinai. Dr. DeFanti is Board certified in anatomic and clinical pathology and cytopathology.

Ostap Dovirak, MD has joined Riverside Urology Specialists in Newport News. He earned his medical degree at SUNY Downstate Medical Center in New York City. Dr. Dovirak completed his residency at the University of Buffalo, followed by a fellowship at Beth Israel Deaconess Medical Center in Boston. He has been active in clinical research and has served as an instructor in surgery at Harvard Medical School. Dr. Dovirak speaks Ukranian, Russian and Polish. His specialty focuses include: hematuria, kidney stone, dysuria, prostate cancer and kidney cancer.

Brian Farrell, MD, PhD, a Fellowship trained neurosurgeon, has joined Riverside Hampton Roads Neurosurgical & Spine Specialists in Williamsburg and Newport News. He is a graduate of William and Mary and earned his medical degree at the University of Nebraska Medical Center, followed by his internship and residency at Oregon Health and Science University. Dr. Farrell also holds a Doctor of Philosophy. He has been published in national journals and is a recipient of the Ruth L. Kirschstein National Research Service Award Fellowship. His areas of medical focus include: image-guided and minimally invasive spine surgery, neuro-oncology, lumbar and cervical disc herniation and spinal stenosis.

Joseph Frenkel, MD has joined Bon Secours Surgical Specialists in Suffolk. Dr. Frenkel is a Board certified colorectal surgeon. He received his medical degree from George Washington University School of Medicine. He completed a general surgery residency at Boston University and a colorectal surgery fellowship at St. Francis Hospital in Hartford, Connecticut. Dr. Frenkel is a fellow of the American College of Surgeons and the American Society of Colon and Rectal Surgeons.

Scott E. Grabill, DO has joined the group of orthopaedic physicians at Sports Medicine & Orthopaedic Center, Inc. He holds a certification from the American Board of Orthopaedic Surgery (ABOS) and is a Fellow with the American Academy of Orthopaedic Surgeons. He is currently Active Duty Service and is a Lieutenant Commander with the United States Navy, Commissioned in January 1999. He plans to begin transitioning to the SMOC team in April 2016. Dr. Grabill specializes in arthroplasty

Donald Hastings, III, MD has joined Patient Choice Oceana in Virginia Beach. A Board certified family medicine physician, Dr. Hastings obtained his bachelor of science in biology from Davidson College in Davidson, North Carolina and received his doctor of medicine from Georgia Regents University School of Medicine in Augusta, Georgia. Prior to joining Bon Secours, Dr. Hastings held medical positions as an urgent care physician, family medicine residency faculty member and medical project director in China. He is professionally affiliated with the American Academy of Family Physicians and Christian Medical and Dental Associations.

Alexander Lambert II, MD has joined Hampton Roads Orthopaedics & Sports Medicine. Dr. Lambert earned his medical degree in 1988 at Howard University College of Medicine in Washington, DC. He performed his residency at Brooke Army Medical Center at Fort Sam in Houston, TX and his internship at William Beaumont Army Medical Center in El Paso. Dr. Lambert served in the U.S Army 1988-2002. Since 2002, he has served the Williamsburg community and has been a team physician for the College of William and Mary.

Nurudeen Lawani, DO has joined the staff of Internists at Western Branch in Chesapeake. He is a Board certified internal medicine physician. Dr. Lawani attended medical school at the New York College of Osteopathic Medicine. He also has a Master of Public Health from the University of Medicine and Dentistry, New Jersey. He completed his residency in internal medicine at Eastern Virginia Medical School. Dr. Lawani is a member of the American Medical Association, American College of Physicians and American Osteopathic Association.

Adam Luchey, MD has joined the staff of Urology of Virginia. Dr. Luchey is a fellowship trained urologic oncologist who received his medical degree from North Eastern Ohio Universities College of Medicine. He completed a fellowship at the H. Lee Moffitt Cancer Center and Research Institute in Tampa, FL. Dr. Luchey specializes in the care of patients with urologic cancers, including: bladder, renal, testicular, prostate, and penile malignancies. He will see patients in the Paul F. Schellhammer Cancer Center, a division of Urology of Virginia.

John McGill, MD has joined Riverside Urology Specialists in Williamsburg. He earned his medical degree at Feinberg School of Medicine at Northwestern University in Chicago. Dr. McGill completed his residency at the University Hospital Case Medical Center at Case Western Reserve University in Cleveland. He has been active in medical research and completed a research fellowship at the Cleveland Clinic Foundation Glickman Urological and Kidney Institute. He is a reviewer for multiple international andrology and urology journals. Dr. McGill specializes in men's health, benign prostatic enlargement, minimally invasive surgery, urologic oncology and kidney stones.

John McGuigan, MD, a fellowship trained orthopedic hand surgeon, joined Riverside Orthopedic Specialists in Hampton. Dr. McGuigan is Board certified with an orthopedic sports medicine subspecialty certification. He earned his undergraduate degree from the University of Virginia, and his medical degree from Thomas Jefferson University. He completed an orthopedic surgery internship and residency at Madigan Army Medical Center. While serving 16 years in the Army at community and combat hospitals, Dr. McGuigan was awarded the Bronze Star for his service during Operation Iraqi Freedom.

WELCOME TO THE COMMUNITY

Margaret MIynarczyk, MD, PhD has joined EVMS Maternal-Fetal Medicine. Dr. MIynarczyk completed her maternal-fetal fellowship at EVMS Maternal-Fetal Medicine and her obstetrics and gynecology residency at Loma Linda University Medical Center in Loma Linda, California. She received her medical degree from the Medical University of Lublin, Poland. She is Board certified in obstetrics and gynecology and Board eligible in maternal-fetal medicine. Dr. MIynarczyk's clinical interests include diabetes in pregnancy and fetal growth restriction.

Anil Patel,MD has joined Cardiovascular Associates. He has been practicing cardiology in Southside Hampton Roads since 1988. He is Board certified in cardiovascular disease and internal medicine.

Lauren A. Scott, MD has joined the staff of EVMS Urogynecology. Dr. Scott completed her female pelvic medicine and reconstructive surgery fellowship at the University of South Florida in Tampa, and her Obstetrics and Gynecology residency at Baylor College of Medicine in Houston, Texas. She received her medical degree from the University of Texas Medical Branch in Galveston. Dr. Scott is Board eligible for female pelvic medicine and reconstructive surgery. Her clinical interests and skills include incontinence, pelvic organ prolapse, robotic minimally invasive surgery and assessment for medical education and curriculum design.

Damian Tagliente, MD has joined Peninsula Pathology Associates in Newport News. He received a Master of Science Degree in Biological Sciences from Binghamton University in New York and his medical degree from the State University of New York at Buffalo School of Medicine and Biomedical Sciences. Dr. Tagliente completed his residency in anatomic and clinical pathology at the Mayo Clinic in Rochester, Minnesota, where he also served as Chief Resident and completed a fellowship in hematopathology. He is Board certified in anatomic and clinical pathology.

Selena Zheng, MD has joined Riverside Pain Medicine and Rehabilitation Specialists in Newport News. She earned her medical degree at Tongji Medical School in China, followed by a master's in rehabilitation science from the University of Minnesota. Dr. Zheng completed an internship in general surgery at Montefiore Medical Center in Bronx, New York, with a residency in physical medicine and rehabilitation at SUNY Update Medical Center in Syracuse, New York. She is a member of the American Academy of Physical Medicine and Rehabilitation and the American Association of Neuromuscular and Electrodiagnostic Medicine.

Kristy Alexander, FNP has joined the staff of Sentara Medical Group. Ms. Alexander earned her Master of Science in Nursing degree at Frontier Nursing University in Hyden, KY, in 2013. Ms. Alexander is certified by the American Academy of Nurse Practitioners and is a member of the American Academy of Nurse Practitioners.

Carla Toledo, RN, MSN, FNP-C has joined the staff at DePaul Medical Associates in Norfolk. She received her bachelor of science in nursing from Old Dominion University in Norfolk, Virginia, and earned her master's degree from the family nurse practitioner program at the University of Cincinnati in Ohio.

Margene Tranter, PA-C has joined the staff of Integrated Dermatology. Mrs. Tranter completed her PA training at EVMS. After working in Pediatric Dermatology at CHKD from 2007-2008, she moved to Hawaii and Japan before returning to Hampton Roads.

Stephanie Zeiber, MPA, PA-C has joined the staff of Sentara Medical Group. Mrs. Zeiber earned her Master of Physician Assistant Studies degree at Eastern Virginia Medical School in 2015. She has particular interests in preventative care, women's health and diabetes management. Mrs. Zeiber is a member of the American Academy of Physician Assistants, the Virginia Academy of Physician Assistants and the Emergency Nurses' Association.

Should Hunters WORRY ABOUT HEARING LOSS?

The 2015-2016 hunting season will be upon us very shortly. It really doesn't matter if you hunt deer, bear, turkey or water fowl, shooting guns can damage your hearing. Do you know which of your patients enjoy hunting? Do you discuss the impact firing guns has on their ears and hearing?

When people are exposed to noise greater than 140dB, their hearing can be permanently damaged. Most firearms create noise over 140dB. A small .22-caliber rifle can produce noise right around the 140dB level, while larger rifles and pistols can often produce sounds well over 175dB. Anyone who shoots firearms and does not wear hearing protection is at risk for permanent hearing loss. It doesn't matter if it's a single shot or multiple shots, shooting firearms without hearing protection is dangerous.

As an audiologist, I have found that most hunters who lose their hearing, lose it in the high frequency range. This loss in the high frequencies affects a person's ability to understand what people are saying to them. I have also found that in right-handed shooters, it's the left ear that sustains more hearing loss, because it's more directly in line with the muzzle of the firearm and the right ear is protected by head shadow. It would be the opposite for left-handed shooters. Most hunters with hearing loss report hearing people talking to them, but not always understanding what they're saying. They also complain that their family members are simply mumbling, and if they would speak up, there wouldn't be a problem. High frequency hearing loss can often take years to detect. Tinnitus can affect hunters also, resulting from the high frequency hearing loss.

Why not begin the discussion with your patients who hunt about the need to wear hearing protection? There are various types of hearing protective devices (HPDs), from earmuffs and earplugs to electronic devices that shut down once the firearm has been fired. Electronic HPDs can cost anywhere from $100 for earmuffs to over $1000 for high technology custom made devices. Protecting your patients' ears now can reduce their need for hearing aids later. Have your patients talk to their audiologist about the need for hearing protection and the best options available to them.

Here are some quick tips to pass along to your patients:

- Always use some type of HPD any time you use a firearm.
- Keep disposable HPDs on hand.
- Double protect your hearing when shooting big-bore firearms.
- Choose single-shot firearms instead of lever action, pump or semi-automatic guns.
- Avoid shooting in groups.
- Make sure you know your HPDs are working, and have regular hearing evaluations at your audiologist's office. ■

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.

Awards & Accolades

Celebrating the accomplishments of those who have received major honors

Jeffery J. Kuhn, MD of Bayview Ear, Nose, & Throat has received the Distinguished Service Award from the American Academy of Otolaryngology—Head and Neck Surgery (AAO-HNS). The Academy presents Distinguished Service Awards to medical professionals in recognition of extensive meritorious service through the presentation of instructional courses, scientific papers, participation on a continuing education committee, or Academy leadership position.

Francine Olds, MD received an award from Top Ladies of Distinction, the Hampton Roads Chapter, which recognizes "Ordinary Women Doing Extraordinary Things." She is the recipient of many awards, including the Upjohn Distinguished Service Award at the University of North Carolina, the U.S.A.A. Science and Medicine Award and the Merck Pharmaceutical Award for Leadership in Medicine. She has also been honored as a Virginia Power Woman of Distinction and received the Hampton Roads Health Journal Reader's Choice Award, as well as being voted "Most Compassionate GYN" by her patients.

Joshua Sill, MD, Associate Professor and Medical Director of EVMS Pulmonary Medicine, was recently honored by Inside Business, the Hampton Roads Business Journal, as one of the Top 40 Under 40 honorees. The award honors outstanding young businesspeople in Hampton Roads.

Elizabeth Yeu, MD of Virginia Eye Consultants has received the 2015 Millennial Eye Award. Dr. Yeu was presented with this award at the Millennial Eye Live event held in Hollywood. This conference is geared towards future leaders in ophthalmology, designed exclusively for millennial-minded surgeons. It brings together more than 130 of the brightest millennial minds in ophthalmology and the ophthalmic industry for a highly interactive, engaging discussion of cutting-edge technology, innovation, practice styles, patient care, and more.

The New Normal
OR BACK TO THE FUTURE (PART III)?

By Thomas P. Cox, ARM; Vice President, Health Care Division, Chas. Lunsford Sons & Associates

As changes occur in the health care delivery system, some physicians have sought hospital ownership while others have sought to form large groups. We've seen this cycle fail twice before, although some argue that this time will be different because we've all learned from the past, or because of the Affordable Care Act and Accountable Care Organizations (managed care on steroids), and/or increasing technology costs.

As a health care consumer who has been working with the health care industry for 25 years, it's frustrating to watch this, while understanding that physician and patient interests are best served by independent practices: costs are lower and physicians are generally happier.

Yet the healthcare industry is riding the biggest merger wave since the 1990s. One result is increasing litigation, increasing tension between healthcare organizations and the government, particularly the FTC's Health Care Division. The FTC is reviewing all current and past hospital/hospital and hospital/physician group transactions, and other vertical alignments.

It's looking at how mergers impact price and quality. The result is an undefeated record for the FTC and a growing list of abandoned mergers. Want to defend an antitrust claim? During discovery and trial, defense costs can run over $1 million per month.

Other legal challenges include:

The return of economic credentialing allegations: in one case, Bolt v. Halifax Medical Center, the hospital and the individual members of the medical staff were deemed to be separate actors, so each needed to mount and pay for their own defense;

Physician Networks: as large groups negotiate with payers it is argued that these otherwise formerly independent providers now eliminate existing or potential competition;

Can hospitals run and properly insure medical practices: In theory hospital ownership of a physician should result in less finger pointing defending claims and more efficiencies, but as the late Yogi Berra once said, "In theory, practice and theory are the same; in practice they are not." For example a joint claim defense may mean loss of consent for a physician and more claims being settled in order to reduce defense costs; in the eyes of a jury this looks more like collusion.

This cycle started in the late 1990s, not because of the ACA, and is being driven by money: who gets it and for what? Has there really been some sort of "sea change" in health care? At the end of the day, it comes down to a doctor sitting in a room with a patient, trying to figure out what is wrong and how to fix it.

Sea change? We watched MedPartners and PhyCor crash and burn, now we have new players replicating those models. While we work through this, make sure you have a good D&O policy; a managed care errors & omissions ("E&O") policy if you are in any capitated agreement; and, if you are owned by a hospital or part of a large, physician network, have your own D&O and managed care E&O liability policies, as well as a stop loss policy. Based on a recent jury verdict, both your practice and the parent organization need the same coverage, as you will likely be held to be separate actors.

Can physicians remain independent? Yes, with access to the top 10 percent of practice administrators. These are normally six figure individuals full-time, but on a consulting basis, they can keep you independent for much less. ■

WE SEE THINGS DIFFERENTLY

The Bon Secours Cancer Institute is **home to the region's most advanced brachytherapy program**. Brachytherapy destroys cancer cells and shrinks tumors by an internal source of radiation. These sources are carefully placed inside the body where they can reach and kill cancer cells. Brachytherapy can significantly reduce the amount of time a person has to undergo radiation treatment.

Radiation oncologist **Dr. Bradley Prestidge** is an internationally recognized authority on brachytherapy treatment of prostate, breast, cervical, and other cancers. Under Dr. Prestidge's direction, our expert teams create specialized radiation treatment plans for even the most challenging cases.

Call 757-278-2200 or visit bshr.com/cancer
to learn more about brachytherapy and Dr. Prestidge.

BON SECOURS CANCER INSTITUTE