Summer 2015

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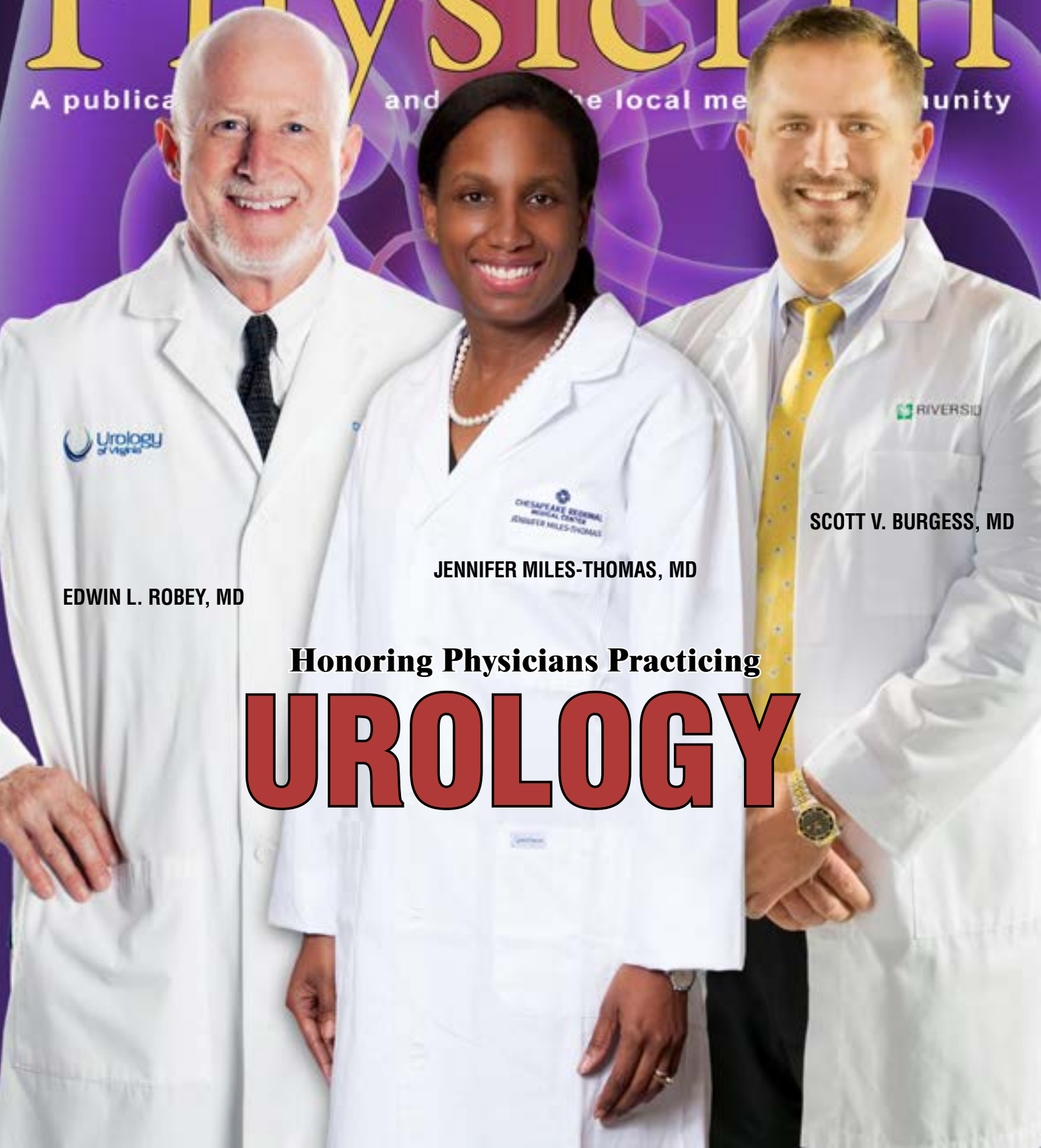


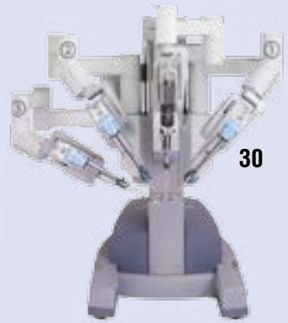
SCOTT V. BURGESS, MD

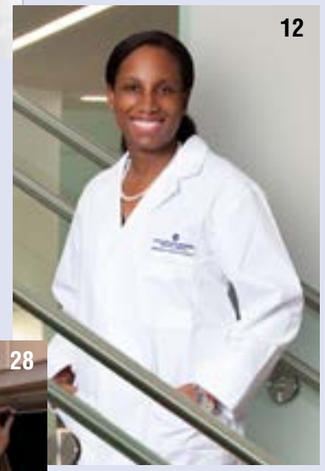
JENNIFER MILES-THOMAS, MD

EDWIN L. ROBEY, MD

Honoring Physicians Practicing

UROLOGY





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

Summer 2015, Volume III/Issue III

Recognizing the achievements of the local medical community

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WELCOME
to the Summer 2015 Edition

In this issue, we recognize the physicians in our community who care for the patients – both men and women – who suffer from the same, but also distinctly gender-specific, urologic diseases. To introduce the topic, we have a look back at some of the early 'technology' used by the first diagnosticians.

Our cover honorees – as always, chosen by our Physician Advisory Board from among nominations submitted – are representative of the exceptional quality of urologic care available in Hampton Roads.

In this issue, we also look at the continuing challenges of hospitalist medicine, non-surgical intervention for pain relief, Regenerative Medicine and CMS efforts to ease the fast approaching transition to ICD-10. We also include the last in our series on the future of health care, and as you'll see from the table of contents, several other articles of interest.

Holly Barlow
Publisher

You'll also find promotional features (see pages 30 and 36), describing the work being done by local physicians Available as two- to eight-page profiles, these promotional features provide a more expansive opportunity for doctors to share their specialties, philosophies and successes. *Hampton Roads Physician* maintains a staff of experienced medical writers and photographers who work with these practices to ensure the end product has a life far beyond the pages of this magazine. These articles are written so they can be reprinted as stand-alone marketing pieces as well. If you are interested in learning about costs etc., please contact the publisher, Holly Barlow, by email at holly@hrphysician.com or by phone at 757.237.1106.

Finally, we're thinking ahead to our next issue. We're very excited about the topic – which we're calling Rising Stars. It encompasses all medical specialties, and is intended to recognize physicians who aren't necessarily new to medicine, but who may be new to our community –or recently trained to introduce the most cutting edge and innovative modalities.

This is the time to nominate the researcher whose work has made major contributions to medical science – the surgeon performing first-of-its-kind procedures – the practitioner implementing a new treatment regimen. There are many such pioneers in our community – our Fall issue will bring them to light!

Bobbie Fisher
Editor

Deadline for Nominations is September 2

Warmest thanks and good health to all of you.

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.
Please contact us if you are interested in serving on the 2016 Advisory Board.

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.

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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
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Dr. Obeng provides a full spectrum of health care services for adults with an emphasis on preventive care at Nansemond Suffolk Family Practice.

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

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Associate Professor of Department of Urology and Pediatrics
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Elizabeth Yeu, MD
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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.

UROLOGY

Past, Present and Future

The study of urine has a long and storied history. The analysis of urine through the technology of the urine wheel soon led to uromancy, the art of divination using urine. The 'prophets' (as they were known) employed different methods for predicting the donor's future: some considered the urine's color a reliable predictor, others its taste. Frequently, the prophet would observe the urine immediately after it hit the divination bowl. If the donor's urine had large bubbles that were spread far apart, that signaled a large inheritance. However, small bubbles packed tightly together signified illness, loss or death. Young women about to wed visited these prophets to find out if the marriage would be successful, and when pregnant, in hopes of learning the sex of their baby.

Urine has also been used as a way to identify pure evil. As the witch hunts of Europe reached their fever pitch in the 16th and 17th centuries, the guilt of an accused witch was determined based on whether or not the cork popped out of a bottle containing a combination of her urine and metal objects like pins and nails – inspired no doubt by Pliny the Elder, who in addition to prescribing fresh urine for the treatment of sores, burns, scorpion bites and other maladies, recommended that Romans spit unto their urine immediately – to prevent anyone from cursing them.

Urology is the branch of medicine that focuses on the surgical and medical diseases of the male and female urinary tract system and the male reproductive organs. The word comes from the Greek 'ouron' (urine) and 'logia' (study of).

An excerpt from "The Early History of Urology[1]," which appeared in the February 1937 *Bulletin of the Medical Library Association*, reads as follows:

> We rarely find that the name and designation of a branch of medicine bears as little relation to its content, concept and extent as is the case in urology, for the original meaning of the word gives no inkling that it applies to one of the most important surgical fields in medicine, one that not only comprises the knowledge of the entire internal and external pathology and therapy of the urinary apparatus but also touches neighboring fields that indeed extends directly into their domain. Nevertheless, the word 'urology' is clearly indicative that the entire modern development of this branch of science with its complicated methods and remarkable achievements derives in the last analysis from the simple uroscopy as we find it practiced in the most remote periods by physicians of all peoples.
>
> The ancients used the inspection of the urine, its taste and smell, principally in order to draw conclusions as to the general state of health of the entire body, and did not attach much importance to uroscopy in purely local diseases.

This urine wheel attributed to a Woodcut circa 1500

The ancients Professor Neuburger spoke of had no microscopes or other lab equipment with which to analyze the urine. As the article mentioned, they relied on their own senses of sight, taste and smell to determine the nature and extent of illness. The medieval physicians believed that observing urine could help them gauge the health of the liver, where they thought blood was produced. They also thought urine was the key to understanding whether a patient's humours – the blood, phlegm, yellow and black bile – were properly in balance. The one piece of 'technology' they relied on was the urine wheel, pictured here.

Urine wheels usually consisted of a circle of around 20 colors, described as anywhere from 'white as well water' to the more ominous 'red as oriental saffron' to the lethal 'black as a dark horn.' They were often quite decorative, with graphic illustrations of suffering patients handing a flask of urine to their physician in the middle of the circle.

Fortunately, today's methods of diagnosing and treating urologic diseases are far removed from the technology of the urine wheel, and the specialists treating these conditions are highly trained and skilled physicians, far beyond even the imagining of the early practitioners.

And if the authors of the 1937 article were amazed at the "complicated methods and remarkable achievements" in (then) modern urology, they would no doubt be astounded by the work being done by urologists today.

Of major concern in urology today is the anticipated shortage of urologists. The discoveries in diagnosis, treatment and technology that have advanced the field and its subspecialties will be of little value if there are not experts to employ them.

In the Spring of 2013, a spate of articles appeared in lay and medical publications alike, forecasting a disturbing lack of urologists to treat the needs of an aging population. But the shortage was anticipated well before 2013. In 2011, the *New England Journal of Medicine* included urology among the "severe, increasing shortages" anticipated for specialties that care for older adults.

An article in the June 4, 2013 issue of *Urology Times* stated, "Researchers predict that the number of urologists in the United States will fall sharply over the next 12 years, dropping by almost 30 percent by 2025 as compared to 2009... The urologist shortage threatens effective health care in the United States." The authors of the study featured in the article attribute the shortage to cuts in graduate medical education positions dating back to the 1980s, and an aging urologist workforce. The AUA is carefully considering strategies to resolve the shortage, but still predict that by 2025, there will be 20,000 fewer urologists in the US.

Fortunately for the people of Hampton Roads in 2015, our community is blessed with many exceptionally skilled and highly trained urologists like the three on our cover, who were chosen by our Physician Advisory Board to represent their field and its subspecialties. *Hampton Roads Physician* is pleased to honor Drs. Scott Burgess, Jennifer Miles-Thomas and Edwin Robey, each of whom exemplifies the quality of medical care and expertise that define our area. ■

References

1. By Professor Max Neuburger, Dr. med et phil, Vienna, translated by David Riseman, MD, ScD, Philadelphia, Bulletin of the Medical Library Association (Vol.24, No.3)

SCOTT V. BURGESS, MD

Riverside Urology Specialists

Like many physicians, Scott Burgess says he decided on a career in medicine when he was very young – although not many can say they had made the choice by the time they got to kindergarten. "I never considered doing anything else," Dr. Burgess says. The decision to become a surgeon took a little longer – until the fourth grade.

He never waivered, and by high school, he was in the Conley scholarship program, and guaranteed acceptance into medical school. He worked as a student research fellow in the division of cardiothoracic surgery from 1992 to 1994, and as a research assistant in the division of general surgery from 1992 to 1998, at the University of Missouri-Columbia School of Medicine, where he also earned his BS in biological sciences and his doctor of medicine.

The choice of urology for his specialty came at the end of his second year of med school. "I had just finished the year when my father became severely ill," Dr. Burgess remembers. "I took a month off to help take care of him, and when I got back to school, I needed to find something to do for the month remaining. Most rotations when you're a third year student are two months, but all I had was one month. I already knew I wanted to be a surgeon, so I chose a two-week rotation in ENT and a two-week rotation in urology."

He wasn't sure what urology entailed at that point, he remembers, but found he was drawn to it, in part because "the attendings were very nice, very laid back – and they were all still married to their first wives!" Between the camaraderie of the urologists, the appeal of their lifestyle and his very real fascination for the work, Dr. Burgess found his niche. He served a general surgery residency from 1998 to 2000, and a urology residency from 2000 to 2004, both at William Beaumont Hospital in Michigan. In 2003, he was a Willet Whitmore Memorial Scholar at Memorial Sloan Kettering Cancer Institute. He completed his fellowship in endourology/laparoscopy at Tulane University Health Sciences Center in 2005.

Dr. Burgess joined the Riverside Medical Group in 2005. His caseload includes female as well as male patients, although the majority of his practice is treating men. With its large military population, he says, Hampton Roads has given him the opportunity to treat men and women alike who have traveled all over the world, and thus exposed to many different substances that can allow urologic disease to develop – including Agent Orange.

The focus of his practice these days is laparoscopic and robotically assisted surgery for cancer patients. In fact, he estimates fully 75 percent of his practice is devoted to cancer cases – kidney cancer, bladder cancer, and of course, prostate cancer. "For better or worse, in Southeastern Virginia, we have an older population, and many of them get cancer," he says. "But with robotic minimally invasive laparoscopic surgery, and the improvements in technology and instrumentation, we're able to offer patients invasive procedures that are now done non-invasively. We can take out a big kidney through two tiny holes, one the size of my pinky nail and the other just three inches long." The benefits of performing these procedures robotically and non-invasively are many. Hospital stays are shortened, pain is decreased, and quality of life is restored sooner.

For prostate cancer patients, the benefits are even greater. Ten years ago, Dr. Burgess instituted the robotic prostatectomy program, and two years ago, Riverside Urology upgraded to the newest version of the daVinci robot. Now his prostatectomy patients are often home in about 20 hours, requiring no blood transfusions and needing much less postoperative pain modalities.

The daVinci robot ensures a far greater degree of precision, Dr. Burgess explains, and thus he's able to preserve his patients' sexual function and bladder control as well. "The daVinci technique magnifies the tiny nerves and blood vessels 10 times," he says, "so our accuracy is precise. It also allows for far less post-op scarring because we can make the incisions so much smaller than other prostate surgery methods currently in use."

Whatever the condition he treats, Dr. Burgess says, he enjoys the aspects of urology that allow him to build long-lasting relationships with his patients. "We have patients with chronic incontinence or chronic infections, and we manage six or seven different types of urologic cancers that require vigilant follow up," he says, "and if I take out someone's prostate, that patient is mine for life." Many of them tell him that he's not like any surgeon they've ever met. "I tell them that's because of my family," he says. "My grandparents on both sides were missionaries to India, and my parents both university professors. So I have a bit of pastoral history and a bit of education/teaching history that I bring to bear."

The other trait he brings to bear with his patients is one he describes as almost indispensable for a urologist: a highly developed sense of humor, which is evident when he describes what he does "when I'm not doing doctor stuff: I like to play golf, which I'm really bad at, and I like to barbecue, which I'm really good at!" But most of all, he says, "I just like hanging out with my wife and my two daughters, Charlotte and Clara." ■

JENNIFER MILES-THOMAS, MD

Urology of Virginia
Medical Director of the Pelvic Health Program at Chesapeake Regional Medical Center

When Jennifer Miles was a three-year old growing up in Cleveland, she was diagnosed with meningitis, which meant that she spent a lot of time seeing a lot of doctors. They made an impression on the little girl, and it wasn't long before she decided to become a physician herself. She admits she didn't really understand what that entailed at such a young age, but says, "I believe we're all here for a reason, and medicine is mine. I think our steps are ordered."

Her admission to medical school was guaranteed in high school, and following graduation, her steps took her to VCU/MCV on a full scholarship named for Jean L. Harris, the first African American woman to graduate from MCV. She earned her Doctor of Medicine at Northwestern University's Feinberg School of Medicine in Chicago.

Urology wasn't her first choice of specialty, she recalls. "When I was in high school, Ben Carson was very popular, and I decided I wanted to be a black female neurosurgeon." After a few rotations in neurosurgery, she changed her mind. She discovered that as she was shadowing urologists, the wives of patients would approach her and ask about their own symptoms. "They'd never seen a woman urologist before," Dr. Miles-Thomas says, "because at that time, fewer than five percent of all urologists were women."

That was the case when Dr. Miles-Thomas decided to pursue urology. "A lot of women didn't go into urology because it was so male dominated, but it was a culture I was comfortable with," she explains, "and I love a challenge." Her next steps led her to Johns Hopkins, where she completed her internship in general surgery in 2002. She completed the remainder of her medical education at the James Buchanan Brady Urological Institute at Johns Hopkins: she was a Nagamatsu Fellow in Endourology from 2002 to 2003, a resident in urological surgery from 2003 to 2008, and completed a fellowship in female urology in 2007.

If this intense training weren't enough of a challenge, Dr. Miles-Thomas notes that during her time at Johns Hopkins, she was only the fourth female urologist in the department's history, and the first to not only be married but to have children during her residency. And she adds, "I was the first black woman at the Brady Institute since 1897."

She has practiced urology in Hampton Roads since January of 2009, treating both women and men. She estimates that roughly 30 percent of her patients

Dr. Miles- Thomas's photos provided by Hobbs Studio

are men, who are referred to her for reconstruction or stone disease. If her male patients are self-conscious about being treated by a woman, she quickly puts them at ease. "Once they meet me and see that I'm pretty laid back, they feel comfortable," she says. "And they realize I've been practicing for a good while, so there's absolutely nothing they can tell me or show me that will surprise me." The majority of the time, reconstruction is done on the penis or the urethra, and in cases of erectile dysfunction, she says, "We can place a prosthesis that can be inflated to give them an erection. If they're incontinent, artificial sphincters can control leakage."

Incontinence is far more prevalent in women than in men, and is one of the major presentations Dr. Miles-Thomas treats in her female patients. Prolapse is another. She tells her patients to think of their vagina as an empty room, with support structures on the back, the top and the floor. These structures hook the bladder up, the uterus and bowels back, and the rectum down. "Over time and after having children, those tissues can weaken and sometimes things will fall into the vaginal vault," she says. "That's prolapse." Often it can be treated by careful observation and a change in eating and drinking habits; but depending on the severity of the case, she will either suggest a pessary – a device inserted into the vagina to provide support – or perform reconstructive surgery.

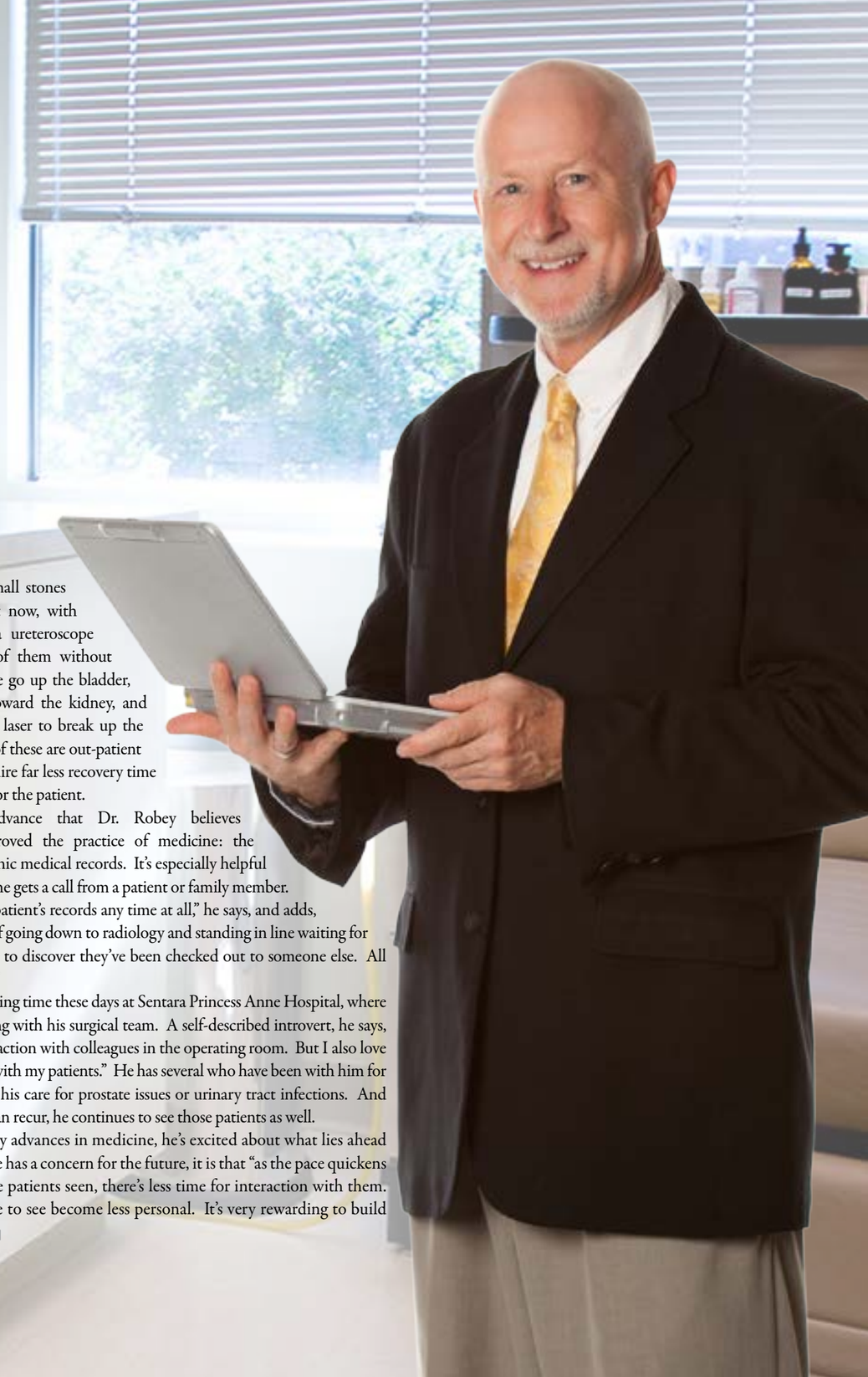
She also sees a fair number of 'tweens and adolescents. "Usually their moms will bring them for some kind of voiding dysfunction; maybe they're still wetting the bed or getting frequent UTIs," she says. "Many teenage girls who are very active – like cheerleaders – can leak when they jump. As a mother myself, I can be empathetic and realistic with these girls at the same time."

In both women and men, Dr. Miles-Thomas frequently sees cases of neurogenic bladders – patients with spinal cord injuries or MS or other neurological disorders, whose bladders will squeeze and empty slowly or inadequately – in most cases, function can be restored with medications, Botox, neuromodulation or reconstructive surgery. "Our practice also treats difficult urethral strictures with a procedure called an urethroplasty – reconstruction of the tube using tissue from the lining of the mouth," she says. "We have realized excellent short-and long-term results with low post-operative complication rates."

Dr. Miles-Thomas believes women will continue to pursue urology. "It takes a certain passion and motivation," she says – and it's clearly so for her, as for the past several years, she's commuted to her Virginia Beach office from Williamsburg, where she lives with her husband, a basketball coach at Kecoughtan High School, and their three kids. She doesn't mind the commute: "I listen to different podcasts, NPR programs, and Spanish language tapes," she says. "I like to maximize my time learning about life and the world." ■

EDWIN L. ROBEY, MD

Urology of Virginia



It may seem a far stretch from an undergraduate degree in statistics to a career in the operating room, but for Ed Robey, the route was less circuitous than it might appear. He'd always done well in math and science, and found the statistics curriculum at NC State "a real smorgasbord" – for the first two years, that is. "The courses included everything from economics to philosophy, from foreign language to genetics, from biology to chemistry – that all appealed to me," he says. But in the third and fourth years, he remembers thinking, "What am I gonna do with this? I did OK in theoretical math, but I couldn't see myself making a career of sitting around thinking about numbers all the time."

One of the first things any student of statistics hears is a quote by the American mathematician John Tukey: "The best thing about statistics is that you get to play in everybody's backyard." Dr. Robey set about to find a new backyard.

A college dorm mate was in pre-med, and that inspired Dr. Robey to think about medicine. Fortunately, his statistics curriculum had prepared him well: all he had left to take to make the switch was organic chemistry and biochemistry.

He earned his doctor of medicine at Wake Forest University's Bowman Gray School of Medicine in 1980, and served both his internship and residency in surgery at EVMS. He enjoyed his rotations in neurology and urology, but chose urology because he wanted to do surgery – and because he liked the urologists he worked with. "I was lucky enough to get a call from Dr. Paul Schellhammer regarding a urology residency," he says, and thus began his career with what was then known as Devine-Tidewater Urology, now Urology of Virginia, in 1980. He was named Chief Resident in his last year at EVMS.

Following a three-year stint as a Major in the Air Force – Dr. Robey served as a staff urologist at the 31st T.F.W. Hospital at Homestead AFB in Florida – he began applying for positions. For several years, in addition to his regular caseload, he took care of the urological aspects of the kidney transplant program, removing kidneys from donors laparoscopically. "It was quite intense," he remembers, "because removing a kidney from a healthy patient is a major procedure – but it was tremendously rewarding."

In recent years, he has pursued his interest in stone disease, and has tailored his practice to caring for the most difficult cases, which he finds equally rewarding. Because obesity, hypertension, diabetes, chronic diarrhea and other diseases can increase the risk of stone formation, it's not surprising that the incidence of stone disease is rising. Currently five percent of American women and 12 percent of American men are affected. "Heredity is another factor that plays a role in the formation of these stones," Dr. Robey notes, "as do certain metabolic imbalances, such as too little or too much calcium or oxalate. Even some medications can increase the risk of stone formation." Left untreated, these stones can lead to chronic kidney disease.

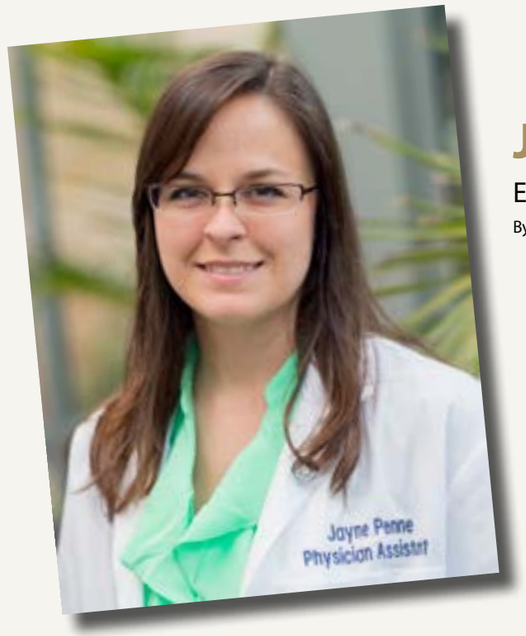
Over the course of his career, he has seen tremendous advances in the treatment of urological cases. "When I was a resident, we were doing mostly open surgery for stone disease, as well as for kidney cancer," he recalls, "but then along came less invasive ways of dealing with stones: the shock wave machine, small telescopes and lasers, then laparascopic surgery. We performed our first nephrectomy laparascopically in 1991." And of course, not long thereafter, was the introduction of robotic surgery.

"Our ability to treat patients with stone disease has improved dramatically," Dr. Robey says. "We used to have to make big, open incisions to get the small stones out of the ureter, but now, with a small telescope – a ureteroscope – we can take care of them without any incision at all. We go up the bladder, and into the ureter toward the kidney, and using a monitor, use a laser to break up the stones." The majority of these are out-patient procedures, which require far less recovery time and result in less pain for the patient.

There's another advance that Dr. Robey believes has dramatically improved the practice of medicine: the introduction of electronic medical records. It's especially helpful during off hours when he gets a call from a patient or family member. "Now we can access a patient's records any time at all," he says, and adds, "I remember the days of going down to radiology and standing in line waiting for films to be found, only to discover they've been checked out to someone else. All that is eliminated now."

He spends his operating time these days at Sentara Princess Anne Hospital, where he finds real joy working with his surgical team. A self-described introvert, he says, "I really enjoy the interaction with colleagues in the operating room. But I also love building relationships with my patients." He has several who have been with him for years, who first sought his care for prostate issues or urinary tract infections. And because stone disease can recur, he continues to see those patients as well.

Having seen so many advances in medicine, he's excited about what lies ahead for his profession. If he has a concern for the future, it is that "as the pace quickens and we try to get more patients seen, there's less time for interaction with them. That part I would hate to see become less personal. It's very rewarding to build those relationships." ■



Jayne Penne, PA-C

EVMS Internal Medicine - Primary Care

By Bobbie Fisher

When she was just entering high school, Jayne Penne started thinking about careers. She considered administration or computers, among others, but none appealed to her. Her father, an OR nurse at Virginia Beach Ambulatory Surgery Center, suggested she look at medicine. One of his colleagues, an anesthesiologist, invited her to come to the operating room and watch him perform a C-section. She was enraptured. "The baby was cute," she concedes, "but I was much more interested in the procedure. I knew immediately I wanted to be in the medical field."

Once she made up her mind, she was eager to get to work. Not wanting the time commitment (or the financial burden) of medical school, she chose the Physician Assistant program at Shenandoah University in Winchester, Virginia, earning a Master's in Physician Assistant Studies in 2011.

After a brief stint in orthopaedics, and a longer one in urgent care, she applied for a position at the Department of Internal Medicine at EVMS. "I'd known I wanted to work in internal medicine," Jayne says. Joining the team at EVMS in 2013 was the perfect choice, particularly because she likes being part of a team, working hand in hand with other care providers.

In additional to working with the Internal Medicine team delivering primary care, she has assumed the role of coordinating another team: the EVMS Sickle Cell Program. Led by Dr. Ian Chen and Dr. Benjamin Goodman, the program takes care of more than 150 patients throughout Hampton Roads, getting them the treatment they desperately need. Penne works in conjunction with Sentara, CHKD and other home care agencies, as well as the United Way and the Urban League, coordinating care for these patients.

She understands well the challenges of caring for sickle cell patients, as well as the challenges the patients themselves face. "We're dealing with people who don't trust medicine, who don't trust providers, who don't trust labs – who don't trust anyone," she says. "But when I first started meeting them and understood more about their disease and how little help there is for it – it wrapped its arms around me and didn't let go. These are young people whose lives have been horrendous, with all the prejudices they've encountered. Many develop severe morbidity from the disease, and experience pain crises, strokes, heart failure, ulcers and kidney disease."

She is not only dedicated to caring for her patients; Jayne is equally determined to raise awareness about the prevalence of sickle cell disease in Hampton Roads, and to draw attention to the clinic. When the opportunity arose to submit a scholarly article for *Today's Wound Clinic* journal, the physicians' schedules didn't allow time to work on it, so Penne wrote it herself. Sickle Cell Disease & Wound Care: Lower Extremity Ulcers in "Crisis" was published in the April 16, 2015 issue.

She'll continue to write about the Sickle Cell program if the opportunity presents itself, but she doesn't plan to rely solely on the printed page to raise awareness. She's spearheading a run/walk for December, to be held at Norfolk's Ocean View Park. "It's called a Tacky Sweater 5K," she says, "and it's my hope that having people come together in a fun, shared activity will get information out to more patients, and attract the attention of people in the area who might know others who need the care we provide."

Until then, she'll continue to advocate for her patients, by working with EVMS Psychiatry to develop a support group for them, and with Pain Management to develop better treatment protocols. And she hopes at some point to be part of the team that establishes a day hospital. ■

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.

INPATIENT MEDICINE

The role of the hospitalist continues to expand - and so do the challenges

By Bobbie Fisher

In the August 15, 1996 issue of The *New England Journal of Medicine*, Robert M. Wachter, MD and Lee Goldman, MD wrote an article describing the growth of managed care in the American health care system at that time as "explosive," leading to "an increased role for general internists and other primary care physicians." In their article, "The Emerging Role of 'Hospitalists' in the American Health Care System," Drs. Wachter and Goldman defined the role of these specialists, and coined the name by which they are known today.

These authors were almost prescient in understanding how hospitalists – physicians who practice inpatient medicine exclusively – could assume the care of hospitalized patients, relieving overburdened primary care doctors with less and less time to make hospital rounds; and – by devoting themselves solely to hospital work – how they might function to facilitate the transition to the implementation of the Affordable Care Act.

"Hospitalists were created to respond to a need," says Lisa Huang, DO, a Board certified internal medicine physician who works with Bayview Physicians Group at Chesapeake Regional Medical Center. "The traditional internal medicine doctor had to round on patients, then go to the office to see patients, respond to any hospital-based emergency, and return to the hospital to see patients in the evenings. It put a tremendous strain on the doctor."

Hardik Vora, MD, MPH, Medical Director of Hospital Medicine at Riverside Regional Medical Center, elaborates: "When they were working that traditional schedule, going back and forth from the hospital to the office, it was challenging, especially when they had a full clinic schedule and had to respond to ER/hospital calls in the middle of the night. Physicians were burning out."

When Dr. Wachter and Dr. Goldman coined the term 'hospitalist,' they envisioned a model where doctors would work exclusively in the hospital, taking some of the burden of the primary care physician. The goal of the model, says Peter Paik, MD, Medical Director of the Hospitalist Group at Bon Secours' Maryview Medical Center in Portsmouth, was "to provide more continuity of care, so that physicians who are in the outpatient setting could focus on that, rather than having to run back and forth to the hospital. Hospitalists can focus on the patient from the moment he or she is admitted."

Such focused care has greatly benefited acutely ill patients, who need access to their doctors 24 hours a day, says Colin Findlay, MD, Chief of Hospital Medicine at Sentara Medical Group: "These patients are generally sicker, and as hospitals are increasingly dealing with only the most acute phase of care, it becomes more and more important to care for patients as quickly as possible."

Thus, hospitalists have become an important aspect of any hospital's safety improvement plan. "It's an essential mission of every hospital to minimize the risk to its patients," Dr. Findlay says. "Hospitalists focus on things that improve patient safety."

The role of the hospitalist is not to do everything, these physicians caution; rather, the hospitalist needs to be an effective team captain, coordinating the patient's individual needs and calling for specialists when indicated.

Hospitalists work at a specific hospital, often affiliated with various primary care practices. Tamara Jones, MD, is a Board certified internal medicine physician, and a hospitalist who works with the EVMS Internal Medicine Group at Sentara Norfolk General Hospital. She explains the benefit of the hospitalist to the PCP: "Because we work exclusively at the hospital, we're available at all times during our working day to meet patients and their families, to order and follow-up labs and other tests, and to respond immediately to problems that might arise, in the moment. And we can see patients as many times a day as is medically necessary."

The role of the hospitalist is not to do everything, these physicians caution; rather, the hospitalist needs to be an effective team captain, coordinating the patient's individual needs and calling for specialists when indicated. Because all of their cases are inpatients, these physicians have particular expertise in dealing with the myriad issues such patients face.

Lisa Huang, DO

Colin Findlay, MD

Tamara Jones, MD

Peter Paik, MD

Hardik Vora, MD

And because hospitalists work solely in the inpatient setting, they have enhanced knowledge of their hospital's operating procedures, greater familiarity with hospital staff and a sense of stewardship over the facility's resources, all of which lead to greater efficiency. Indeed, studies continue to show that when hospitalists assume inpatient care, hospital stays are shorter and health care expenditures are lowered.

There are benefits for hospitalists, as well – more flexible schedules mean more time to spend with patients, without the worries that come with managing an individual medical office practice. In an office, when patients are scheduled every 20 minutes, there is always the sense of urgency to get from one patient to the next. "In the hospital, if I need to spend 90 minutes with a patient or family, I can do it," Dr. Jones says, but concedes that can sometimes result in 14-hour days.

Fourteen hour days and longer are often par for the course for hospitalists, because they know the relationships between them and their patients is absolutely crucial – and they know they must be established and solidified quickly. Building relationships with patients on short notice can be a challenge. Often when they're admitted to the hospital, it's under acute and very stressful situations, Dr. Huang notes, "so we have to create that bond so patients can trust us to take care of them while they're there."

It takes a certain skill to build that trust in a short period of time, and that's something that can't always be learned in medical school. "But the fact is, we're there in the hospital all day, and we can take more time with each patient," Dr. Paik says. "We can sit down and chat with them and with their families, and not necessarily always about medicine or their care. That allows us to really connect with patients."

Equally important as building a relationship with a patient is establishing a good working relationship with the patient's primary care physician. Each hospital has its own protocol for communicating with its patients' PCPs, but these hospitalists emphasize that this is a vital element of successful treatment and transition. If a patient's stay is lengthy and complex, the hospitalist will generally call the primary care physician more often, sometimes even daily, to confer. If the stay is less complicated and the patient's course uneventful, the hospitalist will forward dictated notes regarding the hospitalization at the time of discharge.

The role of the hospitalist doesn't end there, however. "We take responsibility for ensuring our patients transition home safely and effectively," Dr. Findlay confirms. "All patients need intensive coordination of care between their hospital stay and their resources at home." If patients don't have a primary care physician, Dr. Paik says, "we find them one – even if they don't have insurance."

There are some hospital programs that have started post-discharge clinics, Dr. Vora notes. "These are especially appropriate for patients who don't have a primary care physician or can't get an appointment with their PCP right away," he says. "In the current health environment, they can have to wait as much as two months or more. So we will often give these patients our contact information so they can call us if they have questions. We are definitely there to help them through that phase."

The American Board of Physician Specialists (ABPS) was the first physician certification body to recognize the emerging importance of hospitalist certification. In 2009, the ABPS developed the nation's first board certification for hospital medicine, the American Board of Hospital Medicine (ABHM). Not merely a subspecialty of internal medicine, hospitalist certification through ABHM carries all the standing and prestige of a distinct and vital medical specialty.

The American Board of Internal Medicine (ABIM), recognizing the multi-faceted value of these specialists and the growing number of physicians who were concentrating their practice on inpatient medicine, developed a certification program called "A Focused Practice in Hospital Medicine" to accompany Board-certification in internal medicine. In addition to meeting the criteria to be Board certified in Internal Medicine, a physician is required to earn additional credits in Practice Improvement Modules and then sit for a separate test in hospital medicine. EVMS' Dr. Tamara Jones will sit for the exam in October, and will become the first hospitalist in Hampton Roads to earn the certification.

The American Board of Family Medicine (ABFM), in conjunction with the American Board of Internal Medicine, has similarly established a Recognition of Focused Practice in Hospital Medicine program, in response to the growing number of ABFM-certified family physicians who are primarily caring for patients in a hospital setting.

"About 80 percent of practicing hospitalists are internal medicine physicians," Dr. Vora notes, "while 10 to 15 percent are family physicians and about five percent are pediatricians." However, he notes, there are increasing numbers of surgeons, orthopaedists, OB/GYN physicians and others who are going into hospital medicine. There's even a word for surgeons, Dr. Jones says. "They're called surgicalists." ■

The Ever-changing LEGAL LANDSCAPE OF PRIVACY BREACHES

As doctors, you are heroes. You are noble protectors who always work for the good of your patients. You protect our health, but also our privacy. In fact, one of the most significant facets of the physician/patient relationship is trust, which is largely based on confidentiality. Naturally, then, one of the most difficult tasks you might confront in your profession is having to tell a patient that there has been a breach of his or her private health information. That undertaking becomes even more daunting when you are made to consider the legal ramifications of the breach. Not only must you consider the notification requirements and possible repercussions of the federal HIPAA law, but state law imposes potential liability as well.

As far as federal law is concerned, not all instances of unauthorized access or loss of control over protected health information (PHI) is a "breach", as defined by HIPAA. For example, losing a laptop with PHI is not a breach if it was properly encrypted. Therefore, the first step in determining what, if any, HIPAA notification needs to be made, is to determine whether there has been a "breach" at all.

According to the updated HIPAA standard, there is a presumption that notification is required for all unauthorized uses, acquisitions, or disclosures except when: 1) the physician conducts a risk assessment and establishes that there is a low probability that PHI was compromised; or 2) one of the limited existing exceptions to the definition of breach applies.

The risk assessment analyzes four primary factors. If after performing the risk assessment there is doubt whether or not notification is required, the new rules favor notification.

Once you have determined that notification is warranted, you must then determine what kind of notification is required, the timing, method, and recipient. For example, notification must be made without unreasonable delay and should be sent in writing to the last known address of the patient. You would also need to notify the Secretary of Health and Human Services by submitting a log at the end of the calendar year. If the breach involves greater than 500 patients, however, you might also be required to notify the media and the Secretary immediately. An investigation by the Office of Civil Rights (OCR) may follow.

HIPAA isn't the only legal hurdle you will have to overcome. The Virginia courts have recognized a claim in tort for breaching the duty not to disclose information gained in the course of treatment without a patient's authorization. In one case, a patient was awarded $100,000 for the humiliation, embarrassment and hurt caused by a healthcare provider's disclosure. It is important to keep this, along with potential liability in an OCR investigation, in mind when notifying or communicating with a patient regarding a breach.

The legal requirements for dealing with a breach of PHI may appear daunting, but with assistance, you can navigate your way through it, reestablish trust with your patients, and reclaim hero status once again. ■

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CMS and AMA
Announce Efforts to Help Providers Get Ready For ICD-10

With less than three months remaining until the nation switches from ICD-9 to ICD-10 coding for medical diagnoses and inpatient hospital procedures, The Centers for Medicare & Medicaid Services (CMS) and the American Medical Association (AMA) are announcing efforts to continue to help physicians get ready ahead of the October 1 deadline. In response to requests from the provider community, CMS is releasing additional guidance that will allow for flexibility in the claims auditing and quality reporting process as the medical community gains experience using the new ICD- 10 code set.

Recognizing that health care providers need help with the transition, CMS and AMA are working to make sure physicians and other providers are ready ahead of the transition to ICD-10 that will happen on October 1. Reaching out to health care providers all across the country, CMS and AMA will in parallel be educating providers through webinars, on-site training, educational articles and national provider calls to help physicians and other health care providers learn about the updated codes and prepare for the transition.

"As we work to modernize our nation's health care infrastructure, the coming implementation of ICD-10 will set the stage for better identification of illness and earlier warning signs of epidemics, such as Ebola or flu pandemics." said Andy Slavitt, Acting Administrator of the Centers for Medicare and Medicaid Services. "With easy to use tools, a new ICD-10 Ombudsman, and added flexibility in our claims audit and quality reporting process, CMS is committed to working with the physician community to work through this transition."

"ICD 10 implementation is set to begin on October 1, and it is imperative that physician practices take steps beforehand to be ready," said AMA President Steven J. Stack, MD. "We appreciate that CMS is adopting policies to ease the transition to ICD-10 in response to physicians' concerns that inadvertent coding errors or system glitches during the transition to ICD-10 may result in audits, claims denials, and penalties under various Medicare reporting programs. The actions CMS is initiating today can help to mitigate potential problems. We will continue to work with the administration in the weeks and months ahead to make sure the transition is as smooth as possible."

The International Classification of Diseases, or ICD, is used to standardize codes for medical conditions and procedures. The medical codes America uses for diagnosis and billing have not been updated in more than 35 years and contain outdated, obsolete terms.

The use of ICD-10 should advance public health research and emergency response through detection of disease outbreaks and adverse drug events, as well as support innovative payment models that drive quality of care.

CMS' free help includes the "Road to 10" aimed specifically at smaller physician practices with primers for clinical documentation, clinical scenarios, and other specialty-specific resources to help with implementation. CMS has also released provider training videos that offer helpful ICD-10 implementation tips.

The AMA also has a broad range of materials available to help physicians prepare for the October 1 deadline. To learn more and stay apprised on developments, visit AMA Wire.

Get Ready For ICD-10 Frequently Asked Questions

Q1. What if I run into a problem with the transition to ICD-10 on or after October 1st 2015?

A1. CMS understands that moving to ICD-10 is bringing significant changes to the provider community. CMS will set up a communication and collaboration center for monitoring the implementation of ICD-10. This center will quickly identify and initiate resolution of issues that arise as a result of the transition to ICD-10. As part of the center, CMS will have an ICD-10 Ombudsman to help receive and triage physician and provider issues. The Ombudsman will work closely with representatives in CMS's regional offices to address physicians' concerns. As we get closer to the October 1, 2015, compliance date, CMS will issue guidance about how to submit issues to the Ombudsman.

Q2. What happens if I use the wrong ICD-10 code, will my claim be denied?

A2. While diagnosis coding to the correct level of specificity is the goal for all claims, 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

CMS also detailed its operating plans for the ICD-10 implementation. Upcoming milestones include:

- Setting up an ICD-10 communications and coordination center, learning from best practices of other large technology implementations that will be in place to identify and resolve issues arising from the ICD-10 transition.
- Sending a letter in July to all Medicare fee-for-service providers encouraging ICD-10 readiness and notifying them of these flexibilities.
- Completing the final window of Medicare end-to-end testing for providers this July.
- Offering ongoing Medicare acknowledgement testing for providers through September 30th.
- Providing additional in-person training through the "Road to 10" for small physician practices.
- Hosting an MLN Connects National Provider Call on August 27th.

In accordance with the coming transition, the Medicare claims processing systems will not have the capability to accept ICD-9 codes for dates of services after September 30, 2015, nor will they be able to accept claims for both ICD-9 and ICD-10 codes.

Also, at the request of the AMA, CMS will name a CMS ICD-10 Ombudsman to triage and answer questions about the submission of claims. The ICD-10 Ombudsman will be located at CMS's ICD-10 Coordination Center. ■

What is Regenerative Medicine?

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

Far too often, we see patients with conditions for which we have limited treatment options, in both scope and efficacy. Once in a lifetime, real scientific advances are made that change everything for the patient and the physician. Regenerative Medicine is a real game-changer, in that it potentially allows physicians to heal patients in ways only once imagined.

Due to advancements in immunology, cellular biology, molecular engineering and refinements in existing technologies, science is discovering the previously inaccessible reformative power of the patient's own cells to rebuild damaged or diseased organs, tissue, or bone. Diseases like heart disease, diabetes, and arthritis may one day be completely cured, instead of controlled.

You are familiar with the donation of organs for transplantation into ill patients for the purpose of saving their lives. Perhaps you have used autologously donated bone marrow for the treatment of leukemia and other types of cancers. These types of procedures were the genesis of today's Regenerative Medicine.

In the early days of stem cell research, the cells were collected from aborted human embryos, with all the attending ethical and moral issues. Today, stem cells are donated by patients from their own bone marrow. Alternatively, amniotic stem cells are collected from placentas of babies born by C-section in accredited hospital collection centers. Parents consent to this before fetal delivery, and are paid for the amniotic fluid, which is then sterilized and frozen for later use.

Regenerative Medicine is divided into several subspecialties: **Rejuvenation, Regeneration and Replacement**.

Rejuvenation involves using the body's cells to heal itself. Just as the skin can repair itself, so can more complex tissues, like the heart and lungs.

Regeneration requires the delivery of cells or cell products, by injection, to certain areas of the body, to stimulate healing of diseased or damaged tissues or organs. Stem cell or platelet-rich plasma (PRP) are used to heal musculoskeletal conditions, such as arthritic joints, damaged cartilage, partially torn ligaments and tendons, bursitis, and degenerative discs in the lower back.

In the early days of stem cell research, the cells were collected from aborted human embryos, with all the attending ethical and moral issues.

Replacement involves replacing damaged or diseased organs with healthy cells, tissues or organs from living or deceased donors. This includes being able to grow healthy organs in a laboratory for implantation into the patient's own cells, effectively ending organ shortages, the issue of organ rejection and the challenge of patient immunosuppression.

Regenerative Medicine uses autologous or amniotic stem cells, which can develop into many types of cells through a process called differentiation. Autologous stem cells cannot be rejected, and some studies show that one out of every three people could benefit from treatment with Regenerative Medicine. 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. ■

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Hospital Medicine and Retina Vascular Disease

By Alan L. Wagner, MD

You may wonder, what do *Hampton Roads Physician's* article on hospital medicine and my specialty of retina vascular disease research and ocular oncology have to do with one another? As it turns out – a lot!

Twenty four percent of adult patients with known diabetes say that they had been hospitalized in the preceding year. The risk of hospitalization increases with age, how long the patient has had diabetes, and the nature and extent of any other sequelae of the disease. A patient with diabetes is three times more likely to be hospitalized than those who don't have diabetes. If we look at all the people admitted to the hospital, 12 percent didn't realize that they had diabetes, or unusually high blood sugars. These are the very patients who are at risk for blindness without warning from diabetes – and one of the reasons the job of the hospitalist is so vital.

Hospitalists see their patients more than once during the day, and may have more opportunity to observe the warning signs of diabetic eye disease – which remains the leading cause of blindness and disability in adults in the first world. However, in the outpatient setting, the silent and progressive damage to the retinal vasculature that is preventable can go unnoticed.

The root cause of much of this physiologic mayhem comes from above normal blood sugars. Not "high" blood sugars, just above normal blood sugars! However, it's really not the elevated blood sugar itself that does the damage. Higher than normal blood sugars cause the immune system to become abnormally and broadly activated, leading to inflammatory changes in the vascular endothelium. As inflammation increases, the endothelium of the eyes, brain, heart, nerves, and kidneys become targets, leading to thrombosis. For similar reasons, platelets become far more active and sticky, compounding the problem. In addition, the elevated blood sugars cause increases in multiple inflammatory pathway associated proteins/markers (interleukins, tumor necrosis factors, growth hormones, advanced glycated End products, etc.). We see the same sort of proteins and damage in patients with arthritis. However, this time it's the blood vessels that are targeted for destruction.

Hospitalists and their teams can serve as a tremendous educational resource for patients and their families by explaining to them that it doesn't take very high blood sugars to cause these changes that can lead to blindness. The landmark Diabetes Control and Complications Trial revealed that patients with normal blood

sugars were able to reduce their risk of complications from diabetes by almost 50 percent. This is in line with what we already know about reducing the risk of diabetes associated coronary disease, renal disease, neuropathy, and strokes. In other words, we can show the patients and their families that there really is a big pay-off if they control their diabetes.

Hospitalists do so much good for patients while they're in the hospital. I encourage our ambulatory care colleagues to also be proactive, by reminding their patients of the critical need to normalize blood sugars, get regular eye examinations, and seek consultation with an eye specialist – particularly if they have or show signs of developing diabetes. As a memory tool, feel free to use our practice's take-home message for all of our at-risk patients: "Save your sight by feeding your eyes normal blood at a normal pressure!" ■

Alan L. Wagner, MD, FACS founded the Wagner Macula & Retina Center in 1987. He completed medical school at Vanderbilt University School of Medicine, residency at EVMS and a fellowship at Weill Cornell University Medical Center. wagnerretina.com

GOOD DEEDS

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

EMILY LIEB, MD

Medical Director, Bon Secours Care-A-Van

The statistics are unsettling: according to a June 2015 report posted on Virginia.gov, nearly a million Virginians still lack health insurance. In Hampton Roads, almost 15 percent of all residents under the age of 65 are among the uninsured – a population of 240,000. Many of these are children, and many are overweight or obese adults. Without insurance, vaperforms.virginia.gov states, citizens often are unable to pay for the medical care they need and frequently forego preventive measures that would make that care unnecessary.

In four cities throughout Hampton Roads, one Bon Secours physician is leading a program that reaches out to these citizens, providing medical care and treatment to those unable to pay for it. Emily Lieb, MD, a Board certified family medicine physician, is Medical Director of the Bon Secours Care-A-Van, overseeing a staff of physicians, a nurse practitioner, a registered nurse and patient navigator, a licensed practical nurse and Spanish speaking interpreter, and others. The Care-A-Van is a mobile health care clinic that collaborates with community partners, including free clinics, local health agencies, and numerous faith-based community organizations, to provide free medical services to those in need.

Dr. Lieb, a graduate of the University of Virginia School of Medicine, practiced family medicine in Charlottesville, and later worked in urgent care until she and her husband, Dr. David Lieb, an endocrinologist with EVMS, settled in Hampton Roads. It was after their three children were born that her neighbor, the previous medical director of the Care-A-Van, asked if she'd be interested in taking over. "We'd known each other at UVA," Dr. Lieb says, "and we had worked together at a migrant farmers' camp. I took a few days to think about it, but I knew it was the right fit for me."

The Care-A-Van visits locations throughout Newport News, Norfolk, Portsmouth and Suffolk – all cities that house a Bon Secours hospital. No one is asked to pay, and with few exceptions, no one is turned away (the exceptions: those who have primary care physicians, have Medicaid, or arrive late when the clinic is full). There is no geographical limitation: patients come from as far away as North Carolina and Western Tidewater to receive care.

These patients have any number of challenges: they are uninsured, they have transportation barriers, they come from unstable living conditions, they have received fragmented care, and they often have very limited health literacy. Some are students, some are jobless, some are immigrants and some are indigent. All are in need of medical care, and all lack the resources to pay for it.

"We serve 12 different locations throughout our service area," Dr. Lieb says, "in an attempt to reach as many as possible. Often we partner with churches, which post our monthly calendar and offer us the use of their meeting rooms to see patients." Many patients come to the Van through word of mouth, referral from social services, or upon discharge from jail.

The Care-A-Van provides lab services, EKGs, PAP smears, minor procedures, flu shots, and, as Dr. Lieb says, "Just about anything you'd see your family doctor for, we can do on the Van." If a patient's presentation is beyond the Van's capabilities, she will arrange for hospital care, even calling an ambulance for transport, if indicated.

While the majority of the patients are seen for management of chronic diseases, Dr. Lieb has diagnosed stroke, patients with cardiac chest pain, even cancer. There are often twenty or more patients a day, and if there are two providers on the Van, they can see even more.

Last year, Dr. Lieb says, the Care-A-Van treated 4,125 people. She expects that many or more this year. ■

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.

RIVERSIDE

RIVERSIDE UROLOGY SPECIALISTS:

SERVING THE PENINSULA FOR MORE THAN EIGHT DECADES

….by any name, Riverside Urology Specialists is the premier provider of urologic care on the Virginia peninsula

Nearly nine decades ago, in roughly 1929 – so long ago that no one remembers the exact date for sure – a medical practice known as Hampton Roads Urology was established on the Virginia peninsula. The physicians who founded the practice were too busy offering long-needed medical and surgical care to their patients to note the day and time for posterity.

Using the lithotriptor, Dr. Shultz prepares to remove a kidney stone.

Today, the inheritors of that practice are continuing the tradition of excellence that earned Hampton Roads Urology a reputation for providing the highest and most innovative urologic care available. They do so under a different banner: eight years ago, when the practice affiliated with Riverside Medical Group, they proudly changed the name to Riverside Urology Specialists – although they acknowledge that some patients still occasionally use the old name.

By any name, Riverside Urology Specialists is the largest urologic practice on the peninsula, with offices in Newport News, Williamsburg and Gloucester, treating patients who present with nearly every condition or disease that can affect the very complex human urinary tract system and reproductive organs. Their patients include both men and women, and range in age from the early teens on up to the elderly.

The 'specialist' designation is particularly apt for this group: while each physician is thoroughly trained in every aspect of urology, each has specific interests and areas of expertise within the many urologic presentations. They consider it one of the strengths of their practice, and routinely refer patients to a partner when appropriate. They frequently collaborate on complex cases in order to ensure their patients receive the best, most comprehensive care.

Kidney Stones.

Kidney stones are one of the most common disorders of the urinary tract, and research indicates that their incidence is rising, particularly among women. "Southeastern Virginia is often referred to as 'the stone belt,'" says Dr. Henry Prillaman. "There are a variety of factors that contribute to that, one being our climate. Particularly at this time of year, dehydration can cause the urine to become more concentrated, which creates the environment for stones to develop."

There are medications that can alleviate the discomfort of stones, but for patients who require surgery, Riverside Urology Specialists has a comprehensive program that includes all of the current minimally invasive procedures. One is the lithotriptor, which pulverizes the stones by passing shock waves through a water-filled tube, with the patient lying on a table. This causes the stones to fragment into pieces small enough to expel in the urine. For larger, more complex stones, the urologists can go directly into the kidney through the skin and remove stones percutaneously. Each patient is assessed and the treatment plan individualized based on the size and location of the stone(s).

"The best thing about stone care today is that over time, it's become much less invasive," Dr. Prillaman says. "Stone disease is miserable for the patient, but with these techniques, people are bouncing back quicker than ever."

Care for stone disease doesn't end when the stones are gone: the next step is teaching patients how to keep them from returning. "There are four tenets of stone prevention for calcium stones," Dr. Roger Schultz explains: "Drink more water, eliminate salt, avoid foods rich in oxalate and add lemons to the diet."

For some patients, even adhering to those tenets isn't enough to keep stones away. In those cases, Dr. Schultz says, "We'll do a 24-hour urine collection to see what's being produced in the urine, to proceed from there." They also send the stones to the lab for analysis, says Dr. Karl Pete, "and then we modify treatment based on their composition. There are several types of stones: the majority are calcium or oxalate, and the others are uric acid, struvite or cystine stones, those formed as a result of certain medication." And, he adds, while stones tend to run in families, they are to a great degree random."

BPH – benign prostate hypertrophy.

Also known as an enlarged prostate, this condition affects men as they age, and often causes urinary symptoms. Medications can be effective, but in certain situations, surgery is indicated. In the past, that meant a hospital stay of one to three days, and the patient required a catheter for several days thereafter. Recovery time was significant. "Today, we're using vaporization techniques on an out-patient basis, which give the same result," Dr. Steven Marks says, "and at most, patients need a catheter only overnight. They're back to work in a day or two. The procedure is a big hit with men!"

Prostate cancer.

For patients with low-volume, low-stage cancer, the first option is active surveillance, but "We're not just watching," Dr. Richard Rento emphasizes. "We're doing regular PSA and rectal exams, and when indicated, further biopsies."

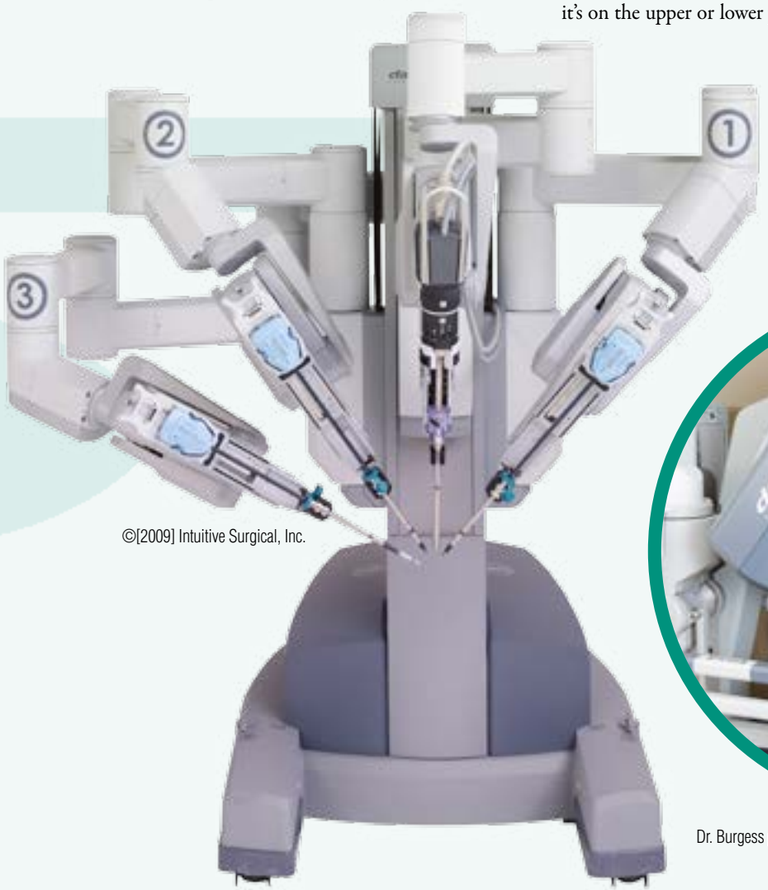
Prior to the 1990s, the only surgical option was an open procedure that required a long hospitalization and painful recovery, including a lengthy period of urinary incontinence and erectile dysfunction. Laparoscopic radical prostatectomy resulted in less blood loss and pain, shorter hospital stays, lower risk of complications. But the turning point was the introduction of robotic surgery. "Robotics allows us even greater precision during the surgery; and from the patient's standpoint, there's far less blood loss, less pain, fewer days in the hospital and fewer days with the catheter," Dr. Rento says. In fact, the first daVinci robot was brought to the peninsula to treat prostate cancer patients, and two years ago, says Dr. Scott Burgess, Riverside acquired the newest version of the daVinci.

Dr. Rento also performs brachytherapy, the only physician on the peninsula to offer this form of targeted radiation for prostate cancer. Brachytherapy involves placing seeds of radioactive material inside the prostate, where they remain, emitting radiation for a short time or several months. These seeds don't travel beyond their destination, resulting in less damage to surrounding structures.

Kidney cancer.

Dr. Rento and Dr. Burgess perform the practice's surgical robotic oncology. In cases of kidney cancer, they are doing a large number of partial nephrectomies, or nephron-sparing procedures, removing the tumor while leaving the kidney intact. "It's been shown for the better part of 10 years that you want to save the kidney whenever possible," Dr. Burgess says. "Now we know that there are detrimental effects unrelated to kidney function when you remove an entire kidney." The criteria includes the size of the tumor, its location in the kidney, and whether it's on the upper or lower pole. Because the renal artery is clamped during the procedure, time is of the essence. The surgeons must complete the entire task within 15 or 20 minutes.

The vast majority of the time when a radical nephrectomy is indicated, it is performed laparoscopically. "The kidney is about nine to 10 cm. in size, and it's not uncommon to find tumors that are between 10 and 20 cm. on top of it," Dr. Rento says. "In those cases, we take not just the kidney, but several centimeters around that."



©[2009] Intuitive Surgical, Inc.

Dr. Burgess performs surgical robotic oncology using the da Vinci robot.

Dr. Marks discusses the treatment of urinary incontinence with a patient.

Bladder cancer.

About 85 percent of these cancers are superficial, and can be scraped away. For the 15 percent whose cancer is already growing within the wall, cystectomies are performed. Very few patients are candidates for partial cystectomy. In a radical cystectomy, the bladder and prostate are removed in male patients, and the bladder, uterus and top of the vagina in women.

The majority of bladder cancer in men can be treated through an endoscope, a telescope that goes through the penis into the bladder to resect or remove the cancer.

Urinary reconstruction includes an ileal conduit, or urostomy, through which urine flows into an external bag. The ureters are sewn to the wall of the conduit, after which a stoma is created through which urine is eliminated. A different option is continent urinary diversion, which involves creating a new bladder from a piece of bowel, stomach or right colon. The new bladder is attached inside the body.

Treatment for bladder cancer has few side effects.

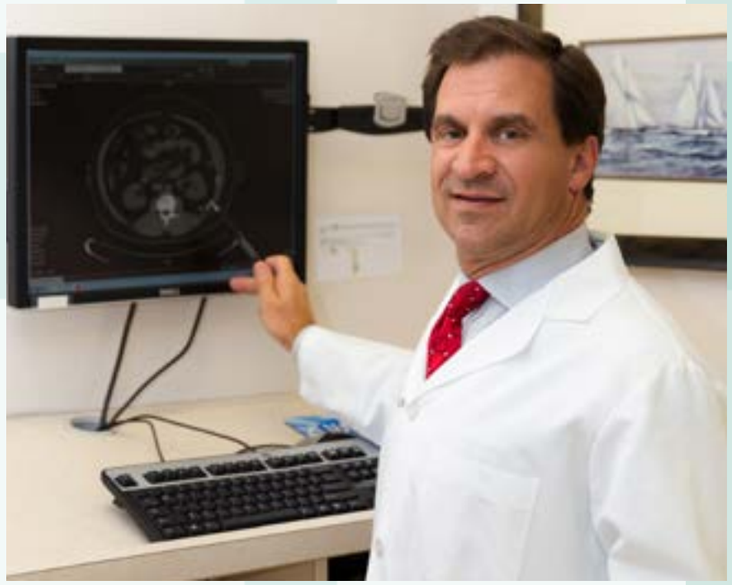
Infertility.

For some men, the decision to limit the number of children they father is a welcome and responsible one. Vasectomy, a quick and simple procedure that can be performed in the urologist's office in about 15 minutes, Dr. Marks says. "Recovery is short and easy, and relatively free of long-term side effects." In addition, Dr. Pete explains, "Vasectomy is a much safer option for men than tubal ligation is for women. Vasectomy requires only local anesthesia, whereas women must undergo general anesthesia for sterilization."

But for many men, being unable to father children creates tremendous angst. Dr. Schultz spent four years at Naval Medical Center Portsmouth, treating sailors at every stage of their reproductive lives, and acquiring special knowledge in the area of male fertility. "When couples come in complaining of not being able to conceive – typically after six months of trying – I tell the woman to consult with her gynecologist or fertility expert," he explains, "and I look at various aspects of the man's history that might impact fertility, followed by a physical exam and semen analysis. The most common thing urologists look for is a varicocele, which we can treat surgically or radiologically. It often resolves the problem, so that sperm quality improves and pregnancy ensures."

When urologic approaches to infertility have been exhausted, Dr. Schultz and his colleagues will consult with specialists in assisted reproductive techniques.

Reverse vasectomy is rarely requested these days, Dr. Marks says, although the procedure has a fairly good success rate.



Dr. Rento describes the removal of a kidney stone.

Urogynecology.

Karanvir Virk, MD, is a urogynecologist who collaborates with Riverside Urology Specialists on conditions that affect only the female anatomy, including prolapse, urinary and fecal incontinence, urinary tract infections, hemorrhagia and similar problems.

The most prevalent of these conditions are prolapse and urinary incontinence. "These are not necessary conditions of older women," Dr. Virk says. "These are pathological, and they can be fixed."

Prolapse is not always symptomatic, and doesn't require treatment unless and until it interferes with a patient's quality of life. When symptoms do appear, the first option is a pessary, a device inserted into the vagina to support the pelvic organs. Kegel exercises are often prescribed as well.

Reconstructive surgery, which is performed laparoscopically or through an incision, is done to restore the organs to their original positions. Sexual function is not affected. In severe cases, obliterative surgery is done to narrow or close the vagina to provide support, after which sexual intercourse is no longer possible.

Urinary incontinence.

Urinary incontinence, or leaking when engaged in even the briefest strenuous activity, is one of the most vexing conditions a woman can suffer, but it can be successfully treated by any of the urologists. The most common treatment is the installation of a transobturator midurethral sling, a device that acts as scaffolding, or a shock absorber, that essentially closes the urethra so urine cannot leak.

Expanding urologic care to the people of the Virginia peninsula and beyond.

From its earliest days as the first urologic practice on the peninsula, the group once known as Hampton Roads Urology has grown with both the times and the population it serves – and it continues to grow. Riverside Urology Specialists will add two additional urologists in August 2015 – Dr. John McGill and Dr. Ostap Dovirak.

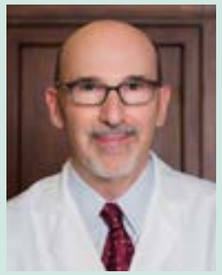
With a full complement of urologists, the practice will soon offer evening and Saturday hours to accommodate their working patients, to ensure all patients are seen in a more timely fashion, and that all receive the unparalleled treatment that is the hallmark of Riverside Medical Group physicians. ■

Please call (757) 873-1374
or visit our website:
riversideonline.com/services/urology

RIVERSIDE UROLOGY SPECIALISTS

Scott V. Burgess, MD
MD – University of Missouri School of Medicine
Residency – William Beaumont
Fellowship – Tulane University

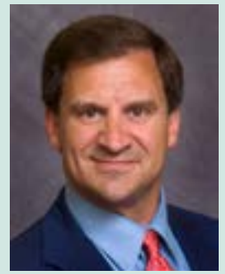
John B. Maggioncalda, MD
MD - Thomas Jefferson University
Residency - Robert Wood Johnson Medical School



Steven E. Marks, MD
MD – Wake Forest University School of Medicine
Residency – Medical College of Virginia

Karl Pete, MD
MD – Duke University School of Medicine
Residency – University of California, Davis
Residency – Medical College of Wisconsin

Henry M. Prillaman, MD
MD – University of Virginia School of Medicine
Residency – University of Virginia School of Medicine



Richard G. Rento, II, MD
MD – Dartmouth Medical School and Brown University School of Medicine
Residency – Northwestern University

Roger E. Schultz, MD
MD – Mt. Sinai School of Medicine
Residency – University of Pennsylvania

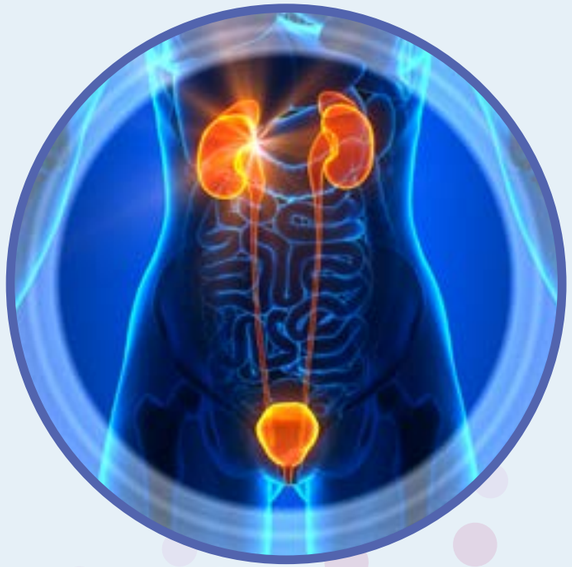
Karanvir Virk, MD
MD – University of Rajasthanin, India
Residency – St. Peter's University Hospital
Fellowship - Women's Care & Reproductive Surgery, Atlanta

CONSULTANT

JOINING RIVERSIDE UROLOGY SPECIALISTS IN AUGUST 2015

Ostap Dovirak, MD
MD – SUNY Downstate Medical Center
Residency – University of Buffalo
Fellowship – Beth Israel Deaconess Medical Center

John J. McGill, MD
MD – Feinberg School of Medicine, Northwestern
Residency – Case Western Reserve University
Fellowship – Cleveland Clinic



Women's Health:

INCONTINENCE AND PHYSICAL THERAPY

By Brittany Deuso, PT, DPT

Even if patients are hesitant to talk about it, the statistics tell the story.

Incontinence – leakages related to either the bladder or the bowel – afflicts more than 13 million people in the United States annually. For those over the age of 65, incontinence occurs in 51 percent of the population – more often in women, according to the Centers for Disease Control and Prevention.

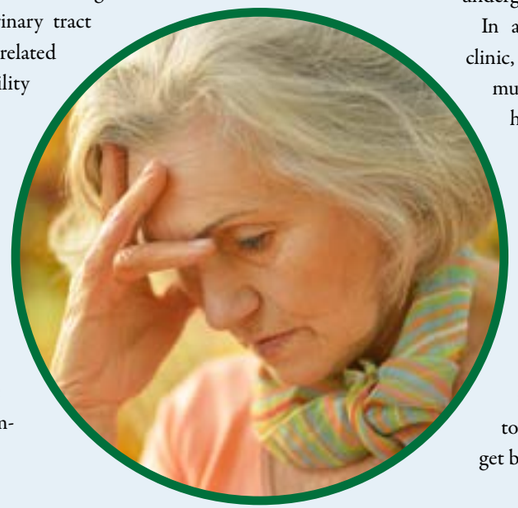
Incontinence is not inevitable with age, however, and is a treatable and often curable condition – especially when physical therapy is used as a treatment tool.

Physical therapy services aim at increasing a patient's quality of life through self-management and the use of specific strategies to reduce symptoms and improve function.

Incontinence Risk Factors

For the aging, incontinence is associated with a number of factors, including chronic conditions, such as diabetes and stroke, cognitive impairment and mobility impairment. Bladder incontinence can also be influenced by age-related changes in the lower urinary tract, urinary tract infection and other health-related conditions to include mobility impairment.

Risk factors for bowel incontinence include chronic diarrhea, inadequate fiber and water intake and chronic constipation. Health factors include diabetes, stroke, neurologic and psychiatric conditions, cognitive impairment and mobility impairment.



In addition to the financial burden, people suffering from incontinence may carry an emotional burden of shame and embarrassment that adds to the physical discomfort and disruption of their lives.

Treating Incontinence

People with incontinence suffer most commonly from stress incontinence or urge incontinence.

Stress incontinence stems from the increased abdominal pressure and weak muscles, resulting in the accidental release of urine. This happens, for example, when people laugh, cough, sneeze or jog.

Urge incontinence occurs when people must get to the bathroom right away from an immediate urge that there is no stopping.

But because people feel discomfort in talking about incontinence issues, this can lead to feelings of shame, isolation and depression. As a result, many people fail to seek treatment, either by a family doctor or physical therapist who specializes in women's health.

The Role of Physical Therapy

Physical therapy helps incontinence patients gain control of their symptoms, reducing the need for pads, special undergarments and medications.

In a private treatment room of the clinic, patients have their pelvic floor muscles evaluated. Treatment includes heat to relax the muscles, exercise to strengthen the muscles, biofeedback, and manual therapy if indicated.

On the first day of therapy, the therapist spends 20 to 25 minutes simply educating patients on what exactly the condition entails, how to "find" and strengthen the right muscles to improve their quality of life and get back in control of their urges. ■

Brittany Deuso, PT, DPT is accepting new patients at the Tidewater Physical Therapy Great Bridge Clinic in Chesapeake, VA. She provides comprehensive physical therapy treatment services and specializes in treating patients suffering from incontinence and pelvic floor pain. Deuso holds a Direct Access Certification. Find a clinic near you for your patients and learn more at www.tpti.com.

Treating patients like family

Atlantic OB-GYN

Delivers advanced care in a warm setting

By Alison Johnson

From routine pelvic exams to advanced robotic-assisted hysterectomies and fibroid removals, the team at Atlantic OB-GYN keeps two words in mind: expertise and compassion.

Practice founder Timothy Hardy, MD, F.A.C.O.G., and his partner Craig Ruetzel, MD, F.A.C.O.G., along with Melissa Waddell, Women's Health Nurse Practitioner, are dedicated to delivering warm, comprehensive, cost-effective and results-oriented care that recognizes women's busy lives.

"We never want our patients to come in here and feel small," Dr. Hardy says. "Each one of them deserves to feel well-cared for and well-informed, whether it's getting them into an appointment on time or allowing them to recover quickly from what used to be invasive and risky surgeries."

With offices in Chesapeake and Virginia Beach, Atlantic OB-GYN offers complete gynecological and obstetrical care along with inpatient and outpatient surgeries and treatments for infertility, endometriosis, female infections and sexual dysfunction.

Dr. Hardy, who founded the practice in 1990, is a leader in the region for robotic surgery. The medical team also is skilled in the field of urogynecology, which covers common pelvic floor disorders such as urinary or fecal incontinence, abnormal vaginal bleeding and prolapsed organs.

Available in-office procedures include bone density scans, breast biopsy with ultrasound guidance and insertion of intrauterine devices or vaginal contraception rings. Atlantic OB-GYN offers a full range of infertility services including evaluation and treatment including surgery. Tuboplasty, which is a surgery to repair damaged fallopian tubes, and tubal reanastomosis or tubal reversal surgery are a few of the surgical interventions that can help an infertile woman achieve pregnancy. Dr. Hardy has had up to an 80% success rate with tubal reversals. Atlantic OB-GYN also prescribes regular and emergency birth control pills.

The Benefits of Robotic Surgery

The use of computer-guided instruments has helped transform two common operations for women, hysterectomy and myomectomy, or removal of uterine fibroids that cause pain, bleeding and possible infertility. Atlantic OB-GYN began offering robotic surgery options to their patients six years ago when the technology first came to the Hampton Roads area. Dr. Hardy has completed several training courses with the da Vinci surgical system including most recently the advance course. In fact Dr. Hardy was the first gynecologist in Virginia to operate on the da Vinci XI robotic system, which was recently acquired at Chesapeake Regional Medical Center.

Removing the uterus and cervix once required a major abdominal incision – as big or bigger than the one made during a Caesarian section – and six to eight weeks of recovery. With robotic-assisted laparoscopic hysterectomy, surgeons can control a thin, lighted scope and other instruments through four or five tiny incisions, less than an inch apiece. They work from a computer station in the operating room.

The robot's steady, precise movements and a magnified three-dimensional view allow surgeons to maneuver easily within the abdominal cavity. Women are generally able to resume normal activities within two to three weeks, and there is a lower risk of post-operative pain and infection. For patients who don't qualify for vaginal hysterectomy, the robot is still an option.

"It is rare for me to do open surgery today," Dr. Hardy notes. "It has made a tremendous difference for women, especially if they need to get back to their jobs or families as quickly as possible. This once was a surgery that women were thankful just to survive, so things have certainly changed for the better."

About 75 percent of fibroid surgeries at Atlantic OB-GYN are performed laparoscopically with robotic assistance. Surgeons generally limit open abdominal operations to women with very large fibroids or more than 10 to 15 of the noncancerous growths. The robot allows for multi-layer stitching of the uterus rather than a single-layer closure, lowering the risk of rupture during any subsequent pregnancy. Finally, robotic surgery can help women with extensive endometriosis and pelvic pain.

Compassionate Care

Technology is just one side of the practice, however. Since obstetricians guide women through emotional and physical changes of pregnancy and gynecologists handle what many women consider embarrassing health concerns, building trust with patients is crucial.

One example is urinary incontinence, an issue that affects up to 10% of young women and up to 75% of women in nursing homes and especially those who have suffered – often unknowingly – muscle or nerve damage during pregnancy and childbirth. As with fecal incontinence, age, weight gain and smoking also are risk factors. The problem can range from an occasional leakage of urine to a complete loss of bladder control, leading to emotional distress, embarrassment and skin irritation with pain, itching and potentially sores.

"Often, women are told that this is just part of getting old and there's nothing they can do," Dr. Hardy says. "That's just not true. We can help patients who have urinary and fecal incontinence."

The range of potential therapies includes dietary changes, exercises to restore muscle strength, an implanted device that stimulates the sacral nerves and surgery to restore proper position of the bladder. "What women need to know is these are treatable conditions," Dr. Hardy says. "They don't need to suffer in silence for years and years."

Atlantic OB-GYN works hard to create a friendly atmosphere throughout a patient's experience. That starts with having a real person on the line when patients call – not a recorded message – and a kind and respectful office staff.

"We stay on time whenever possible, because we know long waits are stressful for patients," Dr. Hardy says. The practice also offers evening hours once a week for patients who can't take time off work, he adds: "We always want to mindful of their time."

An Experienced Team

Atlantic OB-GYN's team is highly trained in their specialties. Dr. Hardy completed a residency in the Obstetrics and Gynecology Department of Providence Hospital, an affiliate of Georgetown Medical Center, and holds a bachelor's degree from the University of Virginia and a medical degree from Eastern Virginia Medical School. He also completed an internship at Jersey Medical Center in Jersey City, NJ.

Timothy Hardy, M.D., F.A.C.O.G.

Dr. Ruetzel has practiced in Hampton Roads since 1992 and partnered with Dr. Hardy about two years ago. He earned a bachelor's degree at Duke University and a medical degree at the University of Texas Health Science, followed by a residency at Wake Forest University Baptist Medical Center.

Melissa Waddell, WHNP is a women's health nurse practitioner who has been with Atlantic OB-GYN for more than a decade. Ms. Waddell holds several degrees: a bachelor's in biology from Virginia Tech, a certificate in Microbiology/Immunology from Virginia Commonwealth University and bachelor and master degrees in nursing from VCU. Before joining Atlantic OB-GYN, she worked as a registered nurse in the mother/infant unit at VCU Health Systems and served as a clinical instructor-adjunct faculty member in VCU's School of Nursing.

While Dr. Hardy hopes to grow Atlantic OB-GYN's services, particularly in urogynecology, he also plans to keep the practice small. "The personal touch," he says, "is extremely important to us." ■

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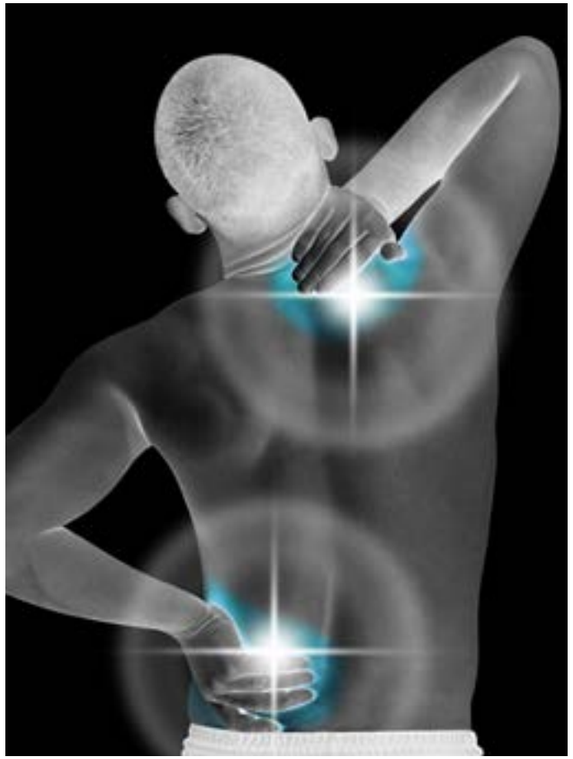
(L-R) Craig Ruetzel, MD, Melissa Waddell, WHNP, Kaitlin Cafferky, WHNP, Timothy Hardy, MD



NON-SURGICAL INTERVENTIONS FOR PAIN RELIEF

By Richard D. Guinand, DO

When many people hear the words 'disc' or 'disc herniation', they immediately think they're destined for surgery and a painful recovery. That might have once been the case, but today, it no longer is.

It's true that when a patient presents with neck or back pain, disc herniation is a potential diagnosis. And it's also true that surgery is one of the options. But it's not the only option, and it's not the first, second or even the third modality available to these patients. Before any treatment, including surgery, is considered, it's important to determine the etiology of the patient's pain.

Once a diagnosis of disc herniation (which some patients refer to as a pinched nerve or a bulging disc) is confirmed, there are four potential treatment modalities. For these patients, the goal is always to get the pressure off the nerve root. The first option is physical therapy. Many times, the physical therapist can get the nerve root free and then the pain goes away. The therapist will then work on strengthening the small muscle that attaches to the spine to give it stability, so the pain is less likely to come back. A second option is manipulation by a chiropractor or an osteopathic physician. These two options will usually be successful in 85 percent of patients.

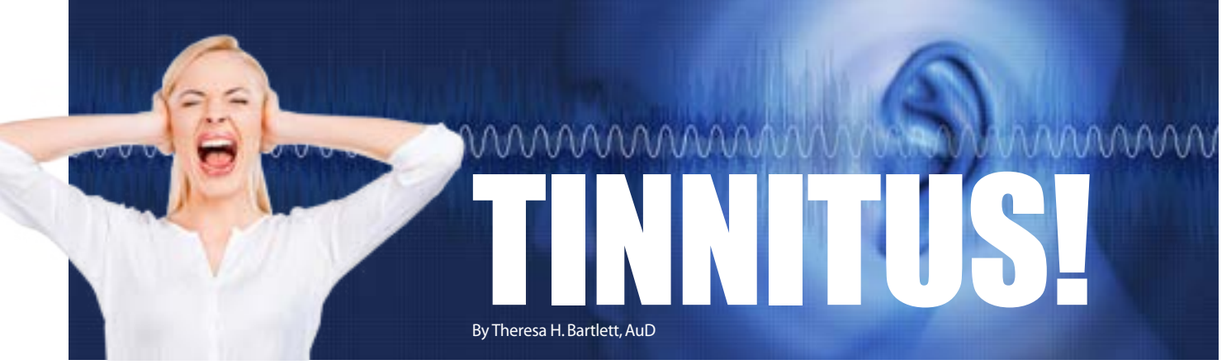
If the nerve root cannot be freed by PT or manipulation, the patient is a candidate for injection, generally an epidural steroid injection to decrease the swelling and inflammation around the nerve root. An MRI is ordered to confirm whether any other underlying spinal pathology is causing the patient's pain. Whether due to disc or arthritic pathology (or as is often the case in older patients, a combination of both), when injections are added to treatment, the success rate rises to 95 percent.

> *It's true that when a patient presents with neck or back pain, disc herniation is a potential diagnosis.*

In some cases, a second or third injection may be indicated to attain relief. Only about five percent of patients will fail all three modalities – physical therapy, manipulation and injections. It's at this point that it's appropriate to talk to the patient about surgery. Some will decline, opting instead to seek help from a pain management physician, who can prescribe and monitor pain medications.

But for those patients who do choose surgery, it's important that they are confident that they and their medical team have exhausted every other potential modality. When patients are comfortable that they have tried every nonsurgical method to eliminate or reduce their pain, they are less apprehensive and more confident facing surgical intervention – and they have a much greater chance for a better outcome. ■

Richard Guinand, DO is a Board certified family practice physician specializing in nonsurgical spine care at Sports Medicine and Orthopaedic Center, offering initial diagnosis and treatment of general orthopaedic injuries, acute and chronic back pain, worker's compensation injuries, and nonsurgical management of spine pathology.



TINNITUS!

By Theresa H. Bartlett, AuD

Do your patients complain of tinnitus? Do you refer them for further evaluation when they do? As you (and as your patients probably don't) know is that tinnitus is generally a symptom and not a condition.

Tinnitus can take on many forms: ringing, buzzing, humming, chirping, beeping, crickets, whooshing or even a pulsing sensation, generally occurring in one or both ears. It can be constant in nature, or it might be perceived as intermittent.

Tinnitus is generally associated with high blood pressure, allergies, abnormal kidney function and high frequency hearing loss. It can also be a sign of a tumor, cardiovascular problems, and a side effect of medication, exposure to high noise levels, or head and neck injuries. It is advisable to refer your patients to an audiologist for a comprehensive audiological examination when concerns of tinnitus arise.

There is currently no cure for tinnitus, but there are several treatment options that are available. It's important for people to know that there are five factors that can affect their tinnitus: alcohol, smoking, aspirin, sodium and caffeine. Some people may find that reducing the amount of one or more of these items in their diet will greatly reduce the impact of the tinnitus. Others note that if they increase their intake of one of these items, the tinnitus becomes exacerbated. Regardless, it's important to mention these five factors to patients suffering from tinnitus so they can determine any impact to their own tinnitus.

Most people who suffer from constant tinnitus note that as long as they are busy, or as long as there are other sounds in their environment, they are not as bothered by their tinnitus. It's only when there is the absence of sound, as when falling asleep at night, that the tinnitus becomes annoying and difficult to deal with. In cases like these, patients are advised never to allow themselves to be in quiet. Perhaps a radio playing in the background or a fan in the room will help to add just the right amount of ambient noise. For others, there are apps available on smartphones that will mimic sounds of nature and reduce the tension from tinnitus in quiet.

If tinnitus is associated with hearing loss, it is recommended that patients begin a trial with amplification. It's thought that tinnitus is the brain's recognition that there is an absence of high frequency stimulus. This is generally associated with the high frequency hearing loss. Therefore, fitting amplification and increasing the brain's awareness of high frequency information can also reduce the frustrations associated with this perceived sound.

These are just a few of the options available to tinnitus sufferers. Referring your patients to an audiologist who specializes in tinnitus will allow them the opportunity to learn what they can do to reduce the negative impact tinnitus may have on their lives. ■

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.

IN THE NEWS

APM Spine & Sports Physicians has been reaccredited through 2017 by the Accreditation Association for Ambulatory Health Care (AAAHC), recognizing APM Spine & Sports Physicians for providing the highest quality of care to its patients, as determined by an independent, external process of evaluation. APM is the only facility of its type in Virginia to achieve AAAHC accreditation.


Alexander Aboka, MD

Alexander Aboka, MD has been selected as a Top 10 doctor in the region for orthopaedic surgery and sports medicine by Vitals,a doctor review site that awards recognition to doctors based on the quality and number of unique patient reviews they receive. He recently obtained Board certification by the American Board of Orthopaedic Surgery.

Bon Secours Cancer Institute at DePaul has been granted a three-year reaccreditation by the Commission on Cancer of the American College of Surgeons. The cancer services are designated as a Comprehensive Community Cancer Program. To earn the three-year accreditation, a cancer program must meet more than 30 Commission on Cancer quality care standards, be evaluated every three years through a survey process, and maintain levels of excellence in the delivery of comprehensive patient-centered care.


Bradley Prestige, MD

Bon Secours Cancer Institute at DePaul has become the first radiation therapy center in Hampton Roads to offer AccuBoost®, a new, noninvasive technology for early stage breast cancer. Early stage breast cancer can be effectively treated using breast-conserving therapy, which is the surgical removal of the cancerous tissue via lumpectomy, followed by chemotherapy or radiation therapy. AccuBoost® is a mammography-guided, noninvasive radiation treatment that's employed as a boost radiation dose at the end of external beam radiation therapy. Because the boost dose directs the radiation parallel to the chest wall, the exposure to the organs below the chest wall is substantially reduced.

Bon Secours Cancer Institute at DePaul, in keeping with its commitment to providing the highest quality of patient care and to bringing state-of-the-art technology to battle cancer, now offers stereotactic radiosurgery (SRS) and stereotactic body radiotherapy (SBRT). The new technology is available using the recently acquired TrueBeam™ STx radiation therapy system for conditions of the brain and spine. This nonsurgical procedure delivers very high doses of precisely targeted radiation, resulting in fewer treatments for patients as compared with traditional radiation therapy and less radiation dose to surrounding tissue.

Bon Secours DePaul Medical Center neurosurgeons have successfully performed the region's first magnetic MRI-guided laser ablation brain surgery on a patient with a brain tumor. Ablation surgery uses energy delivered to the target area using a laser applicator. As light is directed to the target area, temperatures in the tissue rise, and the unwanted tissue is destroyed. The procedure, known as Visualase®, allows surgeons to pinpoint the tumor using MRI. "The Visualase® approach allows a less invasive approach. Patients can recover from the procedure much quicker, are discharged from the hospital after only an overnight stay and are back to normal activities much sooner than a traditional approach. " according to Joseph Koen, MD, a Board certified neurosurgeon with Neurosurgical Specialists.


Joseph Koen, MD

Bon Secours Mary Immaculate Hospital recently installed a 1.5 T GE Optima MR450 W MRI unit. "Our goal is to provide our patients with the right MRI scanner for their needs," said Andy Loiacono, MD, a Board certified radiologist and chairman of the Radiology Department. The new scanning unit offers patient comfort and exceptional images that provide the best information possible for patient diagnosis. The new imaging unit offers several new features that improve both the ability to capture better diagnostic information while improving patient comfort.

Bon Secours Maryview Nursing Care Center has launched a telemedicine program, as part of a Bon Secours Health System initiative to improve health outcomes for nursing care residents and ultimately reduce hospital re-admissions. The telemedicine unit is a portable web-based communication system that is rolled into a resident's room. A physician can see the resident through the monitor, zoom in on a specific area and receive information such as temperature and blood pressure. Best practices from beta testing will be shared system-wide. "We believe this technology has a place in the long-term care setting," says Stacy Guzik, administrator, Bon Secours Nursing Center.


Eric DeMaria, MD, FACS, FASMBS

Bon Secours Surgical Weight Loss Center - Eric DeMaria, MD, FACS, FASMBS, Board certified general and bariatric surgeon, has successfully performed Hampton Roads' first endoscopic revision obesity surgery. The incisionless weight loss surgery restores the size of the stomach in former surgical weight loss patients and assists them with achieving weight loss goals once again. "Most patients who undergo bariatric surgery achieve significant and long-lasting weight loss," said Dr. DeMaria. "The new procedure offers a very minimally invasive option to help patients get back on track with their weight loss goals and work toward living a healthier life."

Bon Secours Virginia Medical Group has opened Bon Secours Grassfield Medical Associates in Chesapeake, offering residents quality primary care family medicine in a convenient location while meeting the growing needs of the community.


James Cochran, MD


Kevin Wilson, MD

Internal Medicine of Portsmouth has joined Bon Secours Medical Group. The practice has offered Portsmouth residents quality primary care and internal medicine services in a convenient location since 1989. James Cochran, MD and Kevin Wilson, MD will continue to see patients at their current location in Portsmouth.

Michael A. Campbell, MD, a Foot and Ankle Specialist at Atlantic Orthopaedic Specialists, performed the first hexapod external fixator surgery to correct a combined upper and lower leg deformity in the U.S. Although used previously in foreign countries, the surgery was only recently approved by the FDA. In May, WVEC-TV news reporter Sandra Parker covered the story of a Virginia Beach mother of two who underwent the surgery to rectify bowed legs caused by the genetic disorder hypophosphatemic rickets, or vitamin D resistant rickets. Dr. Campbell expects the patient will have straightened and slightly lengthened legs upon the completion of additional surgeries in 2016.


Alton L. Stocks, MD

Chesapeake Regional Medical Center is pleased to welcome retired Rear Admiral Alton L. Stocks, MD, as its new chief operating officer after an extensive executive search. The newest member of the executive leadership team has more than forty years of dedicated military service with the bulk of that time spent in medicine, including time as the commander of Walter Reed National Military Medical Center and Navy Medicine National Capital Area from 2011-2013. During his tenure, he oversaw the merger of Walter Reed Army Medical Center and the National Naval Medical Center.

Chesapeake Regional Medical Center is the first hospital in the state of Virginia to acquire Intuitive Surgical, Inc.'s latest model of the da Vinci® surgical robot. The system upgrade includes enhanced surgical technique capabilities, which can be used in many minimally invasive procedures across a wide spectrum of specialties. Its advancements allow patients less invasive surgical options, reduced pain and quicker recovery times."As the only independent, community-based hospital in the Hampton Roads region, we are incredibly proud to be the first in Virginia to offer this innovative and advanced technology to our community," said Peter F. Bastone, Dr.PH, president and CEO of Chesapeake Regional Medical Center. "

Gregg Eure, MD, of Urology of Virginia, recently treated his first patient with the UroLift® System, the first permanent implant to treat symptoms due to urinary outflow obstruction secondary to benign prostatic hyperplasia (BPH) in men 50 years of age or older. The UroLift System is designed to relieve symptoms caused by an enlarged prostate, while preserving sexual function. The UroLift System permanent implants, delivered during a minimally-invasive procedure, act like window curtain tie-backs to hold the lobes of an enlarged prostate open. Patients recover from the procedure quickly, and return to their normal routines with minimal downtime.

IN THE NEWS

Allen R. Jones

Dr. Allen R. Jones and the staff of Dominion Physical Therapy & Associates are celebrating their 25th anniversary. They would like to thank the Hampton roads community for allowing them to serve you.

David C. Kushner, MD

David C. Kushner, MD, medical director of radiology at Children's Hospital of the King's Daughters, was recently elected president of the American College of Radiology. The ACR, founded in 1924, is the largest North American professional medical society dedicated to serving patients and society by empowering radiology professionals to advance the practice, science, quality and safety of radiological care. Dr. Kushner is certified by the American Board of Radiology in diagnostic radiology and pediatric radiology and has held many leadership positions in national radiology organizations, including serving as president of the Society for Pediatric Radiology, which awarded him a gold medal for service to his field in 2014.

Chad Manke, MD, FAAOS, Orthopedic surgeon with Atlantic Orthopedic Specialist, and affiliated with Bon Secours Orthopedic Institute at DePaul Medical Center, is one of a few physicians nationwide to offer a minimally invasive shoulder replacement procedure. In a conventional shoulder replacement the subscapularis tendon is cut, detached from the humerus to gain access to the joint and then reattached after the implant is placed. Surgical recovery can be lengthy. If the tendon doesn't receive sufficient post- surgical healing, patients can have reduced range of motion, reduced function and ongoing pain. Further, if scar tissue builds up, it can result in "stiff shoulder."

Melinda Martin has joined Patriots Colony as its Director of Nursing, leading the campus-wide team of providers who care for residents in long-term care, rehabilitation and memory support areas. Patriots Colony is one of three Riverside Health System Continuing Care Retirement Communities (CCRC) located in Williamsburg, Ms. Martin graduated from the Riverside School of Professional Nursing as a Registered Nurse.

Mark W. McFarland, DO

Orthopaedic & Spine Center announced today that Dr. Mark W. McFarland successfully implanted SpineFrontier's A-CIFT™ SoloFuse-P™. The procedure was an anterior cervical discectomy and fusion on a 57 year old, male patient. The patient suffered from both neck pain and bilateral shoulder pain as a result of stenosis at the operative level C3-4. Prior to undergoing surgery, the patient failed conservative treatments including physical therapy and anti-inflammatories.SpineFrontier engineer Lucas Diehl explained how A-CIFT SoloFuse-P leverages the familiarity of existing techniques while providing an alternative to cumbersome plating for one-level procedures. "Its standalone design makes implantation easier. The technology was designed with surgeons in mind. It's easy. It's simple. It's consistent," said Lucas Diehl.

Jefferey R. Carlson, MD

Orthopaedic & Spine Center has announced that Dr. Jeffrey R. Carlson finished his 100th case using SpineFrontier's® PedFuse® REmind® Screws. The operation took place at Bon Secours Mary Immaculate Hospital in Newport News, VA. The procedure was an L5-S1 posterior lumbar interbody fusion on a 69 year old, male patient. Prior to undergoing surgery, the patient suffered constant pain and failed conservative treatments including chiropractic treatments and steroid injections. Dr. Carlson's milestone case represents a significant achievement in the innovative, Less Exposure Surgery (LES®) midline approach. Implanting PedFuse REmind screws via the LES midline approach minimizes tissue disruption and results in smaller incisions. It may also reduce blood loss, and surgery time while potentially speeding up the patient's recovery.

Erin Lee

Orthopaedic and Spine Center - Dr. Mark McFarland and PA Erin Lee hosted the 2nd annual 24-Hour Treadmill Run and Walkathon. Over $14,000 was raised for the Leukemia and Lymphoma Society this year! Twenty-seven teams walked and ran through the day and night to help find a cure. The event was held in the OSC Physical Therapy Center.

Pharmacy Innovations is pleased to introduce Jeff Burnham as their new pharmacist and to announce their move to a new location in the heart of Virginia Beach. Please see their ad on pg. 35 for more information.

Riverside Health System, in partnership with Williamsburg Landing, is pleased to announce that beginning June 2015, older adults throughout Williamsburg, the Peninsula and Middle Peninsula of Virginia can now access the full suite of services available through ChooseHome, Virginia's first Community-Based Continuing Care (CBCC) program. Also known as life care at home, CBCC programs provide services and benefits to independent older adults who wish to remain in their homes, but want to have access to a safety net of continuing care services and control over the cost of long-term care.

Riverside Health System expands its Telemedicine Services with Access to 24/7 Physician Care.

Riverside Virtual Visits provide access to board-certified physicians 24/7/365 using a computer or a mobile device. Through a partnership with American Well, consumers can visit riversideonline.com/virtualvisit and download the free Amwell app. This new service will allow you to create an account log in, review all the virtual doctors available, and instantly connect to a live physician via video for a non-emergency medical consultation.

Mike Rowe, has been named Executive Director of Patriots Colony At Williamsburg a continuing care retirement community, a position he will assume in mid-June. Patriots Colony is a Riverside Health System LifeCare retirement community that caters to retired and former military officers, retired federal civil employees and their spouses. Rowe's career in health care has spanned more than 30 years and includes an early stint as a Captain in the Medical Service Corps of the U.S. Air Force. After serving in the Air Force, Rowe returned to school to earn an M.H.A. in Healthcare Administration from Virginia Commonwealth University and the Medical College of Virginia in Richmond.

IN THE NEWS

Sentara Enterprises announces the appointment of Linda R. Huffer as its new President. She has responsibility for Sentara Home Health, Sentara Hospice, Sentara Infusion Therapy, Sentara DME and Respiratory Services, and Medical Transportation. Huffer holds a Masters of Business Administration degree and Bachelor of Business Administration degree in finance, both from Georgia State University.

Sentara Enterprises announces the appointment of Monica S. Hullinger as its new Vice President of Operations for Sentara Home Health and Sentara Hospice. Hullinger brings 29 years of executive-level home health experience where she has built regional leadership teams and directed all aspects of operations, clinical outcomes, growth, and profitability. She holds a Bachelor of Science degree in Business Administration from William Woods University and is currently enrolled in the MBA program at Old Dominion University.

Seriously Weight Loss, LLC is celebrating its 5th year anniversary in August! Thank you for all the support. Very grateful for the opportunity to be of help to those of you who are afflicted with the disease of obesity and to remove the stigma associated with it! See our ad on pg 49 for more information.

Jennifer F. Pagador, MD

SMOC (Sports Medicine and Orthopaedic Center) will open its new Chesapeake office in 2016 in the Oakbrooke Business & Technology Center. The new location will accommodate orthopaedics, spine, pain management and physical therapy. "Just like our office in Suffolk, we at SMOC are excited to offer all of our services under one roof in Chesapeake. This is a state-of-the-art medical building that will allow our staff the ability to make it convenient and comfortable to receive medical care," said Todd Rauchenberger, Administrator at SMOC. See our ad on page 55 for more information.

Virginia Dermatology & Skin Cancer Center will be opening one of the region's largest free-standing dermatology practices in the Hampton Roads area, August 2015. The 16,000 square foot medical office building will be conveniently located near North Military Highway in Norfolk. Dr. Brian L. Johnson, a Board certified Dermatologist and Mohs Surgeon who honorably served in the military for 24 years opened the practice in 2006. Dr. Johnson and his team have a passion for serving the medical community and are excited about the expansion which will allow for enhanced general and surgical treatment. In addition, the new building will offer a robust cosmetic-medical suite to serve the aesthetic patient population with innovative and advanced technology.

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 October 6th.

WELCOME TO THE COMMUNITY

Jessica R. Burgess, MD has joined EVMS Surgery after graduating from EVMS and completing her General Surgery Internship, Residency and a Surgical Critical Care Fellowship at EVMS Surgery. Dr. Burgess served an additional year as the Administrative Chief Resident and will join the Department's Critical Care and General Surgery division on August 1, 2015.

David D. Copp, MD has joined the staff of Sentara Medical Group. Dr. Copp earned his medical degree from the Uniformed Services University of the Health Sciences, in Bethesda, MD, after receiving his Bachelor of Science degree in Chemistry from the United States Air Force Academy in Colorado Springs. He is certified by the American Board of Surgery in General Surgery and is an Initiate of the American College of Surgeons and a member of the Society of Air Force Clinical Surgeons.

Asser El-Atfy, MD has joined Riverside Pulmonary and Sleep Specialists in Williamsburg. Dr. El-Atfy is a graduate of Alexandria University in Egypt. He completed his internship, residency and fellowship training at the University of Louisville in Kentucky. He is Board certified in pulmonology and sleep medicine. He is a Fellow of the American College of Chest Physicians and the American Academy of Sleep Medicine.

Marika Gelashvili, MD has joined the staff of Sentara Medical Group. She earned her medical degree at AIETI Medical School in Tbilisi, Georgia, and completed her internal medicine residency at Synergy Medical Education Alliance in Saginaw, MI. As a hospitalist, she strives to be an effective collaborator with specialists in the hospital, as well as primary care physicians in the community, to ensure quality care continues upon the patient's discharge from the hospital. Dr. Gelashvili is certified by the American Board of Internal Medicine.

Joseph S. Gondusky, MD has joined the Jordan Young Institute for Orthopedic Surgery and Sports Medicine in Virginia Beach. He received his medical degree from the Uniformed Services University of the Health Sciences in Bethesda, and completed his residency in Orthopedic Surgery at the Naval Medical Center in San Diego. He is Board certified in Orthopedic Surgery by the American Board of Orthopedic Surgery. Dr. Gondusky specializes in hip and knee replacement.

Robert Juer, MD has joined the staff at Bon Secours Medical Associates in Virginia Beach. Dr. Juer is a Board certified family medicine physician. Dr. Juer completed his bachelor of arts at Vanderbilt University in Nashville and received his medical degree from University of Tennessee Center for Health Sciences in Memphis. Dr. Juer completed his residency training at Naval Hospital Charleston in Charleston, South Carolina.

Taking Nominations for the Fall Edition

Rising Stars

Encompasses all medical specialties, and is intended to recognize physicians who aren't necessarily new to medicine, but who may be new to our community –or recently trained to introduce the most cutting edge and innovative modalities.

This is the time to nominate the researcher whose work has made major contributions to medical science – the surgeon performing first-of-its-kind procedures – the practitioner implementing a new treatment regimen.

Nomination forms are available on www.hrphysician.com, or by emailing a request to holly@hrphysician.com.

Deadline for Nomination Submissions – September 2nd

Tarita Pakrashi, MD, MPH has joined EVMS Jones Institute for Reproductive Medicine after completing a Reproductive Endocrinology and Infertility Fellowship at the Jones Institute. Dr. Pakrashi received her medical degree from Topiwala National Medical College in Mumbai, India and completed her Obstetrics & Gynecology Residency at the University of Cincinnati, College of Medicine. Dr. Pakrashi's clinical interests and skills include fertility preservation, reproductive endocrinology and infertility, and in vitro fertilization.

Karl Pete, MD has joined Riverside Urology Specialists. Dr. Pete practiced for nearly 10 years at WakeMed Specialty Physicians in Raleigh. He earned his medical degree at Duke University. He completed an internship and residency in general surgery at the University of California, Davis, followed by a residency in urology at the Medical College of Wisconsin. He has served as a clinical assistant professor of surgery at the University of North Carolina at Chapel Hill, and is a two-year member of the North Carolina State Health Coordinating Council.

Matthew A. Sachs, MD, MPH has joined the staff of Sentara Medical Group. He earned his medical degree from Virginia Commonwealth School of Medicine in Richmond. He earned his Masters of Public Health degree in occupational and environmental medicine from Harvard School of Public Health in Boston. He completed his residency in adult psychiatry and his fellowship in child and adolescent psychiatry at the University of Virginia in Charlottesville.

Kurt Strosahl, MD has joined Cardiovascular Associates, a division of Bayview Physicians Group. Dr. Strosahl has practiced cardiology in the Hampton Roads area for over 25 years. He was a member of the Cardiology Division at Portsmouth Naval Hospital for 13 years, where he served as the Navy's Surgeon General's Specialty Advisor for Cardiology for two years and Head of Cardiology for one year. He is Board certified in Cardiovascular Disease and Internal Medicine and is a Fellow of the American College of Cardiology.

Jolson Tharakan, MD has joined the staff at Bon Secours Grassfield Medical Associates in Chesapeake. Dr. Tharakan is a Board certified family medicine physician. Dr. Tharakan received his bachelor of science from Portland State University in Portland, Oregon, and completed his medical degree at St. George's University in St. George, Grenada. He performed his residency at Mount Carmel St. Ann's Department of Family Medicine in Westerville, Ohio. He has a special interest in diabetes care.

Gwendolyn Williams, MD has joined the staff of Sentara Medical Group. Dr. Williams earned her medical degree at the University of Pittsburgh School of Medicine and completed her internal medicine internship and residency at New York Hospital Queens Medical Center-Cornell University in New York. She is certified by the American Board of Internal Medicine and is a member of the American College of Physicians and the American Medical Association.

Yassar Youssef, MD, FACS, a Board certified general surgeon, has joined Bon Secours Surgical Specialists in Norfolk. Dr. Youssef performed residencies at the American University of Beirut as well as Sinai Hospital of Baltimore. He completed surgical fellowships at Vanderbilt University and University of Maryland. He has been appointed Director of Minimally Invasive and Robotic Surgery in the Bon Secours Medical Group. Before joining Bon Secours, he served as the director of robotic surgery at Sinai Hospital of Baltimore and was a professor in surgery at Johns Hopkins University. Dr. Youssef specialized in robotic-assisted and minimally invasive surgeries, scarless surgeries, general surgery, breast surgery and thyroid surgery. He has trained over 400 surgeons to perform robotic-assisted surgery.

Chris Schwizer, PA-C is the newest member of the Orthopaedic & Spine Center family. He was formerly employed as an Orthopaedic Physician Assistant by Princeton Orthopaedic Associates, in Princeton, New Jersey.

Awards & Accolades

Celebrating the accomplishments of those who have received major honors

Bon Secours DePaul Medical Center has received the Get With The Guidelines®-Stroke Gold Plus Quality Achievement Award from the American Heart Association and American Stroke Association. The award recognizes Bon Secours DePaul's commitment and success in implementing a higher standard of stroke care by ensuring that stroke patients receive treatment according to nationally accepted standards and recommendations. To receive the Get With The Guidelines-Stroke Gold Plus Quality Achievement Award, Bon Secours DePaul achieved at least 24 consecutive months of 85 percent or higher adherence to all Get With The Guidelines®-Stroke Quality Achievement indicators and achieved at least 75 percent or higher compliance with seven of 10 Get With The Guidelines-Stroke Quality Measures during 12 months of that time.

Chesapeake Regional Medical Center (CRMC) has earned a 2015 Women's Choice Award as one of America's Best Hospitals for Orthopedics for a successive year. In 2014, The National Osteoporosis Foundation reported that a woman's risk of hip fracture is equal to her combined risk of breast, uterine and ovarian cancer (NOF 2014, "What Women Need to Know"). The Women's Choice Award identifies America's Best Hospitals in Orthopedics to address the growing need for disease prevention and bone and joint care.

Chesapeake Regional Medical Center (CRMC) has earned a 2015 Women's Choice Award as one of America's Best Hospitals for Cancer Care for a successive year. CRMC is among an elite group of 331 hospitals who have earned the 2015 Women's Choice Award by meeting the highest cancer care accreditation standards of the American College of Surgeons Commission on Cancer, exemplifying excellence in clinical performance with regard to patient safety measures and for obtaining a high recommendation rate, a measure that is very important to women in choosing a hospital.

Dr. Mark Romness, MD (left), presenting award to Dr. Wilford K. Gibson, MD, FACS, FAAOS (right)

Wilford K. Gibson, MD, FACS, FAAOS, of Atlantic Orthopaedic Specialists (AOS) was recognized with the Virginia Orthopaedic Society (VOS) Career Award at the organization's annual meeting in April. The prestigious award is given to an orthopedic surgeon whom the VOS Board of Directors has evaluated to have made a pivotal contribution to those practicing in orthopedics, while honoring notable achievements during the course of a career serving patients in Virginia. Dr. Gibson practices at AOS in Norfolk.

Matt Halverson, DO, a Family Physician from Newport News, Virginia was recognized at the spring A.T. Still University Board of Trustees meeting held in St. Louis, for his contribution and ongoing support of the university's mission of providing work class health care training to its students. Dr. Halverson is a 1992 graduate of the Kirksvillle College of Osteopathic Medicine and completed his Family Medicine Residency training at Riverside Regional Medical Center in Newport News. He is in his 20th year of practice and founded James River Family Practice in 1998.

Riverside Health System - The Gardens at Warwick Forest, a Riverside Health System nursing facility, has been recognized as a 2015 recipient of the Bronze Commitment to Quality Award for its dedication to improving the lives of residents through quality care. The Gardens at Warwick Forest is the only one on the Peninsula to have received it. The program honors centers across the nation that have demonstrated their commitment to improving quality care for seniors and individuals with disabilities.

Riverside Shore Memorial Hospital Auxiliary has tirelessly supported the local hospital and the patients who seek care there. Senator Lynwood Lewis and Delegate Rob Bloxom presented the Auxiliary with a framed copy of a Virginia Senate and House joint resolution commending the Auxiliary for their dedication to the community on the occasion of the 50th anniversary of the Hospital Ball. The resolution noted that the Auxiliary raises funds for construction and renovation, scholarships and education for the team members, and equipment purchases.

Riverside Tapppahannock Hospital is among the best in the nation at providing safe, reliable and efficient care, for the third year in a row, according to Premier, America's largest healthcare performance improvement alliance. RTH is the only hospital in Virginia and one of only 20 hospitals in the country to receive a Citation of Merit for achieving top performance in five of the seven areas measured in Premier's QUEST collaborative including cost and efficiency, inpatient and outpatient evidence-based care, mortality, safety, patient experience and appropriate hospital use.

THE FUTURE OF HEALTHCARE

Balancing Act: Providing Value While Saving Money

By Alex Strauss

Peter Bastone, CEO
Chesapeake Regional Medical Center

David Bernd, CEO
Sentara Healthcare

Bill Downey, President and CEO
Riverside Health System

Michael Kerner, CEO
Bon Secours Hampton Roads

James Lind, Jr., CEO
EVMS Medical Group

Managing a modern healthcare system is an exercise in contradictions, largely because the U.S. is undergoing a sea change in the way services are accessed, delivered and paid for. On one hand, providers are expected to provide better, more efficient, more technologically advanced care than ever at a lower cost than ever. On the other hand, they are being told that they must keep patients from needing care in the first place – but that they won't be paid to do this.

But amidst all of the upheaval brought on by mandated meaningful use guidelines, ICD-10, the management and dissemination of clinical quality data, and the shift away from fee-for-service healthcare, the bottom line is still…the bottom line.

Cost Saving Strategy #1: Share Savings

"One of the biggest challenges we face is that we are one of the few independent medical centers left, so reaching the economies of scale that the big health systems have, we have had to find on our own," says Peter Bastone, CEO of the 310-bed Chesapeake Regional Medical Center. "We have looked for seamless ways to align cost savings for supplies, material, food, legal services, IT, etc., to meet this challenge"

For CRMC, fostering positive working relationships with physicians, whom Bastone sees as valued customers, is key to realizing cost savings. One approach may be co-management agreements with specialty providers. Bastone says these types of arrangements can be a win-win when it comes to compensation in areas such as the utilization of prosthetics.

"We may have eight or nine different spine prosthetics on the shelf and there is a cost differential for keeping them on the shelf as well as procurement," Bastone explains. "What I do is negotiate contracts with the companies from whom we buy the most popular products with key specialists. With a co-management agreement in place between the hospital and the specialty group, savings can then be shared with the doctor and thus lower the price for care."

While this approach may work for an individual medical center, the shared savings approach has not worked as well for the government.

"Medicare shared savings plans, for example, have not been as effective as they thought they would be," says Riverside Health System President and CEO Bill Downey. Downey hopes that bundled payments where insurance companies share savings with hospitals that save them money will be an alternative source of revenue.

Like other CEOs we spoke with whose institutions have invested heavily in IT, Downey is also hopeful that an internal information exchange system will eventually help Riverside realize savings in lowered redundancy and more efficient and effective care.

Cost Saving Strategy #2: Avoid Penalties

"We are one of the few markets in the state that does not have a government-supported hospital to help take care of the poor," points out Sentara Healthcare CEO David Bernd. "So, for us, the non-expansion of Medicaid will become a significant problem. Hospitals agreed to take cuts but didn't get the expansion."

"We essentially paid the entrance fee but we're not getting the coverage," agrees Downey.

In Virginia, the decision means an estimated 400,000 people will not have medical coverage. Because these same people tend not to seek care until they are very sick, or turn to Emergency Rooms for medical care, they unwittingly drive up healthcare costs. At the same time, these uncovered patients may end up driving down reimbursements since the likelihood of less favorable outcomes in these cases is higher.

"In the past we were paid even for readmissions. Now there are penalties for readmission after events such as AMIs, heart failure, or pneumonia," says Bon Secours Hampton Roads CEO Michael Kerner. "So now we are really trying to understand what we can do to keep patients healthier and in their homes."

For Bon Secours, that effort has led to a great emphasis on education, home care, and management of risk factors such as weight and diet. "Our readmission rates are now significantly lower than they were even a year ago," says Kerner.

Lowering readmission rates may help a health system avoid penalties but, currently, does nothing to add to the bottom line.

"Right now, when we have an individual call and follow up with the patient with a reminder or to see how they are doing, that is an unreimbursable event," notes Jim Lind, CEO of EVMS Medical Group. "For now, it's just an expenditure, an investment. I doubt this is going to be materially reimbursable until close to the end of the decade."

Cost Saving Strategy #3: Form Alliances

As new mandates and penalties, expensive technology, and dwindling reimbursements continue to drive up the cost of providing healthcare, Lind predicts that many Virginia medical practices will be forced to consolidate to save money and stay afloat.

"Small physician groups often don't have the IT infrastructure or the human resources to handle the demands," says Lind. "We have already seen a lot of consolidation in our market and I don't think it's finished. I would not be surprised if there were no more than a dozen physician groups in our market by the end of the decade."

Lind says the upside of such consolidation, beyond savings for the providers, may be higher quality care for Virginians.

But consolidation is not the only way for healthcare organizations to help each other enjoy cost savings. Clinically integrated networks such as the Sentara Quality Care Network which spans Hampton Roads and Northern Virginia and includes more than 2,400 providers, gives member practices the ability to do things such as deploy sophisticated software they might not otherwise be able to afford.

"One of the most valuable things that the Sentara Quality Care Network does is it makes sure that there is adequate sharing of information by bringing the disparate EMR systems together," says Bernd. "This has been lacking in healthcare but it is critical to help reduce expenses like duplication of tests. The instantaneous flow of information also leads to more timely diagnosis and treatment."

Quality-Focused Future

With certain critical factors that will influence Virginia's healthcare future – such as meaningful use deadlines, reimbursements, and the switch to ICD-10 – still in flux, much about the future remains murky at best. However one thing is certain: The need for quality, affordable healthcare and wellness services in the region will continue to grow.

All of the area CEOs we spoke with for this three-part Future of Healthcare series expressed a desire to continue to meet that need at the highest possible level, regardless of current or future regulatory changes. As part of that effort, the future of healthcare in Hampton Roads will likely include more mergers and acquisitions, strategic networks and alliances, more programs and processes designed to engage patients and support wellness, and increasingly integrated EMR systems. ■

DISCUSSING DIFFICULT TRUTHS*

Part Two of a Two-Part Article on Adverse Event Disclosure

By Douglas E. Penner, Esquire

In the article that appeared in the Spring 2015 issue of *Hampton Roads Physician*, we discussed the importance of disclosure. Here we address handling the disclosure meeting.

Handling Disclosure – A Step By Step Outline

Patient safety organizations and risk management are constantly attempting to identify areas of healthcare delivery that present avoidable risk of patient harm. When safety protocols work as intended, they result in "near misses." This is when the error or condition is prevented by an error detection barrier (i.e., "the system worked").

However, the system does not work every time. When relatively minor harm occurs, a discussion between patient and physician may be all that is necessary. However, for more severe errors that result in significant harm or even death, a more formal disclosure process is recommended.

1 Manage the Patient's Condition

The initial focus should be on the patient's condition and ensuring that the necessary steps are taken to address the patient's immediate clinical needs.

2 Contact Your Risk Manager, Practice Manager or Legal Counsel As Soon As Possible

These individuals will provide crucial assistance with careful and objective documentation of any medical facts in the medical record, along with preservation of any evidence, if applicable. In this immediate window after discovery of the harm, an explanation of how or why the event occurred should be deferred until an investigation is completed.

3 Prepare for the Disclosure Meeting

Convene a disclosure team to assist your preparation for the disclosure meeting. As a team, decide when and where the meeting will take place, and who will attend. Identify who will lead the discussion and review what will be discussed, avoiding any speculation. Assess whether the event was a procedural risk or medical error. Identify a liaison for continued communication with the patient or family.

4 The Disclosure Meeting

The designated individuals, usually two people, will initiate the disclosure discussion with the patient and/or patient representative. The physician providing care to the patient usually should lead the discussion, but this may not be the case in every situation. Aim for the meeting to occur within 24 hours of discovering the adverse event.

Express empathy and acknowledge the patient's/family's expressed feelings. Consistently communicate what is known or requires follow-up. Ensure patient/family will be kept informed, which means providing appropriate contact names and numbers. Clarify if the adverse event is an inherent risk of the procedure, rather than an error. Discuss future known consequences of the injury without speculating about all possible long-term consequences.

After the Disclosure Meeting

A request for a copy of the medical records frequently occurs. The patient/legal representative is entitled to a copy through the routine request process.

A record should be created of clinical facts relevant to the event discussed with the patient/patient representative. At a minimum, the documentation in the patient record should include the time, date and place of the discussion, purpose of the conversation and what was discussed (including questions posed and answers), assistance offered, and response to the conversation. Remember that in Virginia, oral statements made during a disclosure meeting and written documents related to disclosure are not protected from discovery in any legal proceeding.

Conclusion

Organizations should develop clear policies supporting disclosure and enable clinicians to meet their ethical obligations to relate adverse events to patients and families.

*This article is intended as risk management advice. It does not constitute a legal opinion, nor is it a substitute for legal advice. Legal inquiries about topics covered in this article should be directed to an attorney.

Douglas Penner is an attorney with the law firm of Goodman Allen & Filetti, PLLC. Mr. Penner specializes in hospital risk management, medical malpractice defense, health care law, and State Board licensing and credentialing matters. For more information, goodmanallen.com.

Joseph Frenkel, MD, FACS, FASCRS
Colorectal Surgeon

Dr. Joseph Frenkel is a board-certified colorectal surgeon specializing in minimally invasive colorectal surgery, including single incision procedures. He has extensive experience in the management and surgical treatment of rectal cancer and anorectal disorders of all varieties. Dr. Frenkel has contributed to eight publications and is a Fellow of the American College of Surgeons and American Society of Colon and Rectal Surgeons.

MEET YOUR NEW NEIGHBOR

Dr. Frenkel joins
Dr. Philip D. Kondylis at
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