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I am pleased to bring you another issue of Florida MD. Although the Affordable Care Act and Medicaid have helped, thousands of Central Floridians do not receive proper and preventative health care. Fortunately there is Shepherd’s Hope to fill the gap for thousands of uninsured residents. Even if you can’t donate your time, please join me in supporting this truly wonderful organization.

Best regards,

Donald B. Rauhofer
Publisher

HELP ANSWER PRAYERS OF UNINSURED PATIENTS

Despite the recent open enrollment phase of the Affordable Care Act which ended on February 15th, a staggering coverage gap will still remain for 1-in-4 Central Floridians. Half of a million men, women, and children in our community cannot afford to purchase health insurance and, therefore, will remain uninsured in 2015. How can Florida MD readers help? Support Shepherd’s Hope, a faith-based nonprofit providing free medical services for uninsured and underserved residents through five health centers in Central Florida, by becoming an active medical provider volunteer.

More than 75% of people who lack coverage come from working families who hold low wage jobs. Some do not qualify for benefits, and others have been impacted by Florida’s decision to limit Medicaid eligibility. Sadly, many must choose to pay for rent and food, rather than healthcare (which, to them, has become a luxury).

Shepherd’s Hope is a nationally recognized, innovative healthcare model that leverages multi-faith partnerships, hospital & diagnostic providers, and healthcare advocates with teams of medical and support volunteers. By operating under the guidelines of the Volunteer Healthcare Provider Program through Florida’s Department of Health and the Florida S.S. 766.28 Sovereign Immunity Law, licensed medical providers are protected and, thus, encouraged to help answer the prayers of uninsured patients.

In 2013 alone, Shepherd’s Hope provided 20,000 patient visits and medical services to the uninsured, thanks to the dedication of 2,400 volunteers who collectively donated 50,000 hours. Shepherd’s Hope requests your medical expertise to continue its free services for those in need of evaluation, diagnosis, and treatment. Please consider volunteering at a Shepherd’s Hope center for just one night a month! Learn more at http://shepherdshope.org/volunteers or by calling Gina Johnson at (407) 876-6699 ext. 233.

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info@floridamd.com

Publisher: Donald Rauhofer
Photographer: Donald Rauhofer / Florida MD
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Florida MD is published by Sea Notes Media LLC, P.O. Box 621856, Oviedo, FL 32762. Call (407) 417-7400 for more information. Advertising rates upon request. Postmaster: Please send notices on Form 3579 to P.O. Box 621856, Oviedo, FL 32762.

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When hypertrophic cardiomyopathy is suspected, turning to a Center of Excellence for diagnosis and treatment is well advised. In the Orlando Metropolitan Area, there is one center – Central Florida Cardiology Group P.A. The oldest cardiology group in Orlando, it has been providing excellence in cardiac care since 1948.

Fifteen cardiologists, five physician extenders and a complement of highly trained clinical support staff provide comprehensive adult cardiology services. Their specialization in noninvasive/invasive diagnostic procedures and therapeutic interventions include angioplasty, comprehensive imaging, such as echocardiography and nuclear cardiology, and cardiovascular perfusion. CFCG also provides clinics for patients whose illness is being managed by a defibrillator, pacemaker and/or Coumadin.
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Cardiologist Marcos S. Hazday M.D., F.A.C.C., is the specialist focused on the management of hypertrophic cardiomyopathy (HCM). He has led the HCM center of excellence since 2009 when he joined the practice. Through the years, Dr. Hazday has helped scores of patients successfully manage the symptoms of this heart condition and lead fuller lives.

The HCM center of excellence is one of many specialty areas within Central Florida Cardiology Group (CFCG). Its great diversity of advanced expertise is one of the traits that set it apart from other practices, according to cardiologist Scott J. Pollak, M.D., F.A.C.C.

“Our practice offers everything in cardiology. All of our physicians are board certified and dedicated to staying on the cutting edge. We participate in clinical research, and we give patients access to first-line technology, including investigational devices,” says Dr. Pollak, who specializes in electrophysiology. “That we continue to operate as a private practice, rather than as part of a hospital, is an important distinction.”

Dr. Pollak joined the practice in 1987 to work alongside fellow alumni of Emory University School of Medicine, where interventional cardiology training is world renowned. Classmates include interventional cardiologist Andrew S. Taussig, M.D., F.A.C.C., F.C.C.P., and cardiologist Hall B. Whitworth Jr., M.D., F.A.C.C.

HCM CENTER OF EXCELLENCE

It is estimated that some 700,000 people in the United States have hypertrophic cardiomyopathy, making it one of the most common forms of genetic heart disease and relatively common in the general population.

Although most cardiologists are familiar with the condition to one degree or another, patients are best served in a center that specializes and is familiar with multiple presentations of this disorder. For this reason, HCMA recommends that those with HCM be evaluated at a center of excellence. American College of Cardiology/American Heart Association (AHA) guidelines reflect this opinion.

Most affected individuals probably have a normal life expectancy without disability or the necessity for major therapeutic interventions, according to Dr. Hazday. On the other hand, in some patients, HCM is associated with disease complications that may be profound, with the potential to result in disease progression or premature death.

HCM centers of excellence achieve the designation because of their high degree of exper-
Myocardial Perfusion Imaging study is performed to evaluate symptoms of chest pain in this patient.

Dr. Hazday, whose board certifications include electrophysiology and nuclear cardiology, sees an average of 8 to 10 patients per week.

Following American College of Cardiology Foundation/AHA guidelines, Dr. Hazday and the cardiac surgeons he teams with are familiar with the contemporary management of HCM. His patients have access to all diagnostic and treatment options, including comprehensive transthoracic echocardiogram (TTE), cardiac magnetic resonance (CMR) imaging, surgical septal myectomy, the management of atrial fibrillation (AF)/atrial flutter and implantable cardioverter defibrillators (ICDs) and genetic testing and counseling.

Patients come to the Central Florida Cardiology Group HCM center from as far away as Tallahassee, Melbourne, Boca Raton, Port Richey, Winter Haven and Daytona, so diagnosis and consultation is packaged into a single visit. The first visit involves a family history, advice about screening other family members and testing that includes a stress test, cardiac MRI and a Holter monitor.

“In general, once we obtain this testing, we have a very good idea of how to treat the hypertrophic cardiomyopathy. We try to expedite the work up as patients could be from out of town,” says Dr. Hazday.

**A COMPLEX DISEASE**

Hypertrophic cardiomyopathy “is one of the most heterogeneous diseases there is and its manifestations are very capricious,” says Dr. Hazday.

Because none of its symptoms is unique, HCM can be misdiagnosed. Angina may incorrectly suggest aortic stenosis or coronary artery disease. Shortness of breath could be from multiple factors including diastolic dysfunctions, valvular heart disease and physiological deconditioning.

HCMA defines hypertrophic cardiomyopathy as “a primary and usually familial cardiac disorder with heterogeneous expression, unique pathophysiology and a diverse clinical course, for which several disease-causing mutations in the genes’ encoding proteins of the cardiac sarcomere have been reported.”

The major abnormality of the heart affected by HCM is an excessive thickening of the muscle (hypertrophy) that occurs without an obvious cause. The thickened muscle is stiff and relaxes poorly. This requires higher-than-normal pressures for the heart to expand with the inflow of blood. This limits the amount of blood the heart can hold and in turn the amount of blood ejected with the next contraction.

HCM can be diagnosed at any age, from birth to age 80. Occasionally, it is the cause of a stillbirth or develops during infancy, with heart failure, which may be fatal.

However, the phenotype may not express until a period of rapid growth, according to Dr. Hazday. He primarily sees the condition in patients between ages 20 to 30. The average age of diagnosis within the HCMA database is 35 years.

The condition in children and adolescents is usually identified after a heart murmur is detected during a sports physical exam or a screening after an adult in the family is found to have the condition.

“At least half of the diagnoses are made when symptoms appear. We would like most to be made on clinical grounds, during a sports physical, for instance. As it is, we are seeing only the tip of iceberg,” Dr. Hazday says.

When HCM results in significant complications, there are three relatively discrete but not mutually exclusive pathways of clinical progression:

- Sudden cardiac death due to unpredictable ventricular tachyarrhythmias, most commonly in young asymptomatic patients.
- Heart failure characterized by exertional dyspnea (with or without chest discomfort) that may be progressive despite preserved systolic function and sinus rhythm or in a small end stage with left ventricle remodeling and systolic dysfunction caused by extensive myocardial scarring.
- Atrial fibrillation, either paroxysmal or chronic, also associated with various degrees of heart failure and an increased risk of systemic thromboembolism and both fatal and nonfatal stroke.

Source: 2011 ACCFAHA Guidelines for the Diagnosis and Treatment of Hypertrophic Cardiomyopathy
Careful evaluation of a patient with HCM is needed to determine the root cause.

While presentations of hypertrophy vary, the left ventricle is almost always affected, and in some patients the muscle of the right ventricle also thickens. Microscopic examination of tissue thickened by HCM shows myocardial disarray.

Treatment of patients with HCM requires a thorough understanding of the complex, diverse pathophysiology and natural history and must be individualized to the patient. Risk stratification for sudden cardiac death should be performed for all patients, including those without symptoms.

The selection of patients for referral to an HCM center of excellence is typically the judgment of a patient's managing cardiologist. The cardiologist who refers a patient to the Central Florida Cardiology Group HCM center becomes an important partner, working collaboratively to improve patient outcomes.

INDEPENDENT PRACTICE THRIVES

Since it was founded in 1948 by Elwyn Evans, M.D., CFCG has provided leadership in patient care, and its cardiologists have been involved in many firsts throughout history:

• The first in the country to transmit and receive electrocardiograms over the telephone.
• Primary operators of the first cardiac catheterization laboratory in Orlando.
• Providers of the first cardiac ambulance and the first cardiac rehabilitation center in the state.

• Instrumental in providing the third coronary care unit in the country at Florida Hospital, in addition to the Florida Heart Institute.
• Among the first in central Florida to use the external defibrillator, the external pacemaker and the endocardial pacemaker.
• Leaders in the use of echocardiography, dilation of coronary arteries, balloon pump insertions, electrophysiology studies, nuclear cardiology and mitral and aortic balloon valvuloplasty.

Today CFCG thrives in part by responsibly responding to the health care needs of an ever-expanding population. Physicians and physician extenders are added and facilities are opened as needed.

Prashanta A. Laddu, M.D., F.A.C.C.; and Michael P. Potts, M.D., F.A.C.C., are the newest cardiologists, having joined in 2014. The practice has four conveniently located offices in Orlando, Lake Mary, Oviedo and Sand Lake.

A 5,000-square-foot catheterization lab was added to the Orlando location, which allows group cardiologists to perform a variety of outpatient cardiovascular procedures, including:

• Abdominal aortograms and lower-extremity angiographies
• Cardiac catheterizations
• Peripheral vascular interventions: percutaneous transluminal angioplasty and stents
• Renal artery angiographies

CFCG recently gained staff privileges at Orlando Regional Medical Center.

Two noteworthy recognitions are a nod to CFCG internal operations:

• The American Heart Association as a Fit-friendly Worksites Gold Award winner
• Angie’s List as a Super Service Award winner.

LEADERSHIP IN INTERVENTIONAL CARDIOLOGY

Central Florida Cardiology Group is “cutting edge as far as interventional cardiology,” says Dr. Andrew Taussig.

“We have participated in a great deal of clinical research, including being leading enroller in a series of stem cell studies for heart disease. In one study, the patient’s own stem cells were used...
Marcos S. Hazday, M.D. and Brian K. Dublin, M.D. review the angiographic findings and plan of a patient with an abnormal stress test who underwent coronary angiography in the CFCG lab.

Dr. Taussig was one of the first in Florida to have interventional cardiology training, when he joined CFCG in 1984. He had just completed a fellowship at Emory led by the late, great Andreas Greuntzig. A pioneer in the treatment of coronary artery disease, Dr. Greuntzig developed the concept of a balloon catheter to dilate coronary arteries, which led to the first coronary artery balloon angioplasties.

Dr. Taussig also is among the most experienced cardiologists in the country who have performed transcatheter aortic valve replacement (TAVR) having participated in the implantation of some 200 transcatheter aortic valves.

**TRANSCATHETER AORTIC VALVE REPLACEMENT TRIAL**

The United States Food and Drug Administration (FDA) cleared the Edwards SAPIEN TAVR in 2011 for patients with severe symptomatic aortic stenosis who are inoperable for open aortic valve replacement. Before FDA approval, the only treatment option for these individuals was use of medications that are limited to symptom management and do not stop the progression of the disease.

The procedure replaces a heart valve using a catheter into the heart. It requires only a small incision in the thigh or sometimes between two ribs. TAVR candidates tend to be older and have serious comorbidities.

Since their start, the team has performed 200 TAVR procedures that have produced outcomes “that are among the best in the coun-
try,” he says. “It’s a nice thing, and I am very proud of that.”

Even with their risk factors, the one-year survival rate for TAVR is well above 80 percent. “The vast majority of our patients have phenomenally improved quality of life.” He recalls the 99-year-old male patient, who was able to bowl and drive again and is now 101.

Recently, the TAVR team operated on a female in her late 50s who had three previous open-heart surgeries since age 30 and was suffering from critical stenosis and heart failure. “It was pretty astounding that she was able to go home within 24 hours. Many are able to go home in 48 to 72 hours,” Dr. Taussig says.

MITRAL CLIP INVESTIGATION

The mitral clip marketed as MitraClip was the first minimally invasive transcatheter device to repair degenerative mitral regurgitation. The FDA approved it in 2013 for patients with significant symptoms who are at prohibitive risk for mitral valve surgery.

Mitral regurgitation is a debilitating, progressive and life-threatening disease in which a leaky mitral valve causes a backward flow of blood in the heart. The condition can raise the risk of irregular heartbeats, stroke and heart failure. It is a common condition, affecting more than 4 million Americans – nearly one in 10 people aged 75 and above.

COAPT trial compares outcomes of patients undergoing mitral clip to standard medical therapy for patients with impaired heart muscle function plus functional mitral regurgitation who are not surgical candidates.

STEM CELL RESEARCH

The Autologous Cellular Therapy CD34-Chronic Myocardial Ischemia (ACT34-CMI) Trial involves the use of a patient’s own stem cells to treat myocardial ischemia. The goal is to investigate the efficacy, tolerability and safety of blood-derived stem cells to improve symptoms and clinical outcomes in patients.

“The hope is that the patient’s own stem cells will stimulate the growth of new blood vessels and circulation system for the heart. If it proves to regenerate blood vessels, it could lead to treating patients with their own stem cells in conjunction with other treatments,” says Dr. Taussig. “This trial offers a possible treatment for patients who have exhausted all other treatment options and still do not have an acceptable quality of life.”

Dr. Taussig cautions that the trial isn’t for everyone. Those who are able to undergo conventional procedures, such as angioplasty, stents or coronary artery bypass surgery to improve blood flow to the heart, are not eligible for the study.

A PILLAR OF THE CARDIOLOGY COMMUNITY

Central Florida Cardiology Group has been a staunch advocate of medical education and advancement.

Dr. Taussig recalls when the vision for the new School of Medicine at the University of Central Florida (UCF) was unveiled in 2008 by its current dean, Deborah German. The base of community support was so great that $6.4 million was raised, and the medical school became the first in the United States to offer full four-year scholarships to an entire class in 2009.

As a Charter Class Scholarship donor, CFCG provided the funding for one student in the first class and a second student the following year. “We worked hard to make sure we have a medical school in this community,” says Dr. Taussig.

For its support, CFCG was awarded the UCF President’s Medallion Society Award.

CFCG has since been a clinical partner with the medical school, providing quality clerkship experiences for third- and fourth-year medical students and clinical opportunities for pre-clinical medical students. Some CFCG cardiologists serve as assistant professors and mentors, and efforts are under way to develop a cardiology elective.

CFCG practitioners also take pride in the independent status of their group and leadership role as a sponsor of Association of Independent Doctors (AID). The professional association advances understanding of the vital role independent practices play in keeping health care costs competitive.

Dr. Taussig, who is a member of AID board, notes that the cost of procedures performed in the hospital are three to four times higher than when they are performed in non-hospital settings, e.g., physician offices. “All the mergers with hospitals are not good for patients or doctors,” he says.

AID advocates for a competitive environment, allowing for comparative pricing for drugs and procedures. “We think that once a hospital has a corner on the market, it becomes a monopoly. It’s important that the public and the industry know what’s going on.”

REFERRALS ARE WELCOME

Central Florida Cardiology Group is on call 24 hours a day for lesser emergencies at (407) 841-7151 or (800) 647-2657. Appointments also may be scheduled by calling (800) 647-2657. For more information, visit www.cfcg.com.
THE FEDERAL RESERVE HELD ITS FIRST OF 8 MEETINGS SCHEDULED FOR CALENDAR YEAR 2015 LAST WEEK. THE STATEMENT RELEASED FOLLOWING THE 2-DAY GATHERING INDICATED THAT "THE (FED) JUDGES THAT IT CAN BE PATIENT IN BEGINNING TO NORMALIZE THE STANCE OF MONETARY POLICY." PAST COMMENTS BY CHAIRPERSON JANET YELLEN SUGGEST THAT "PATIENT" INDICATES NO CHANGE IN SHORT-TERM INTEREST RATES IS LIKELY FOR AN ADDITIONAL 2 MEETINGS, I.E., DON'T EXPECT AN INCREASE IN RATES BEFORE THE MID-JUNE 2015 FED CONFERENCE (SOURCE: FEDERAL RESERVE).


NOTABLE NUMBERS FOR THE WEEK:


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The Westmed Vibralung Acoustical Percussor® is a new airway clearance device that couples acoustic energy from a loudspeaker directly to the airways through a mouthpiece. This sonically vibrates the boundary between airway secretions and the airway surface at or near various Resonant Frequencies (RF). The Vibralung generates random noise as well as three programmed sequences of frequencies over range from 5 to 1,200 Hz. This represents a new paradigm in airway clearance technology called Electro-Mechanical-Acoustical Airway Clearance (EMAAC).

The programmed sequences are sinusoidal tones that repeat in a four tone pattern, at a tempo of about 360 beats per minute, gradually rising approximately three octaves over the course of a 10 minute therapy session. There are three programmed sequence ranges available, low, medium and high. These match the resonant frequencies (RF) of the airways (from the largest to the smallest). The wider airways have a lower RF while the narrower airways have a higher RF:

- Low frequency (5 to 200 Hz)
- Medium frequency (5 to 600 Hz)
- High frequency (5 to 1,200 Hz)

The concept of Vibralung is to expose the airways to a multitude of different RFs for effective airway clearance. Aerosol therapy can be given along with Vibralung through a special nebulizer. The handheld transducer creates the oscillatory sound waves which are interfaced to the patient’s airway through a Y adapter and mouthpiece. The Y adapter provides separate gas flow pathways for inhalation and exhalation to minimize rebreathing of carbon dioxide and allow Positive Expiratory Pressure (PEP) to be applied. The straight mouthpiece and the Y adapter are designed to prevent the soundwaves from being dampened before they enter the airways through the mouth.

To use the device, the patient breathes normally through the mouthpiece attached to the handheld transducer. Therefore, the effectiveness of this therapy is independent of patient effort. In addition, the device works during both the inspiratory and expiratory phases of the breathing cycle. This reduces treatment time and increases efficiency of therapy. The use of “random noise” at the beginning and end of the incremental advancing frequency sequence provides another means of exposing the lung to the broadest possible range of acoustic frequencies. A single treatment session lasts for 10 minutes; it can be repeated 2 to 4 times per day depending upon the needs of the individual patient.

This therapy may be helpful for a variety of respiratory conditions including cystic fibrosis, chronic bronchitis, pneumonia, bronchiectasis, muscular dystrophy, post-operative atelectasis or neuromuscular diseases that inhibit effective cough, mucokinesis, airway clearance and expectoration.

The device is also battery operated. This therapy might be especially attractive in cases of burns, chest wall injuries, rib fractures, recent surgical wounds etc. because the percussor does not make contact with the chest wall.

Vibralung was cleared for marketing by the FDA in May 2014. It appears to be an exciting new option for airway clearance therapy.

Daniel Layish, MD, graduated magna cum laude from Boston University Medical School in 1990. He then completed an Internal Medicine Residency at Barnes Hospital (Washington University) in St. Louis, Missouri and a Pulmonary/Critical Care/Sleep Medicine Fellowship at Duke University in Durham, North Carolina. Since 1997, he has been a member of the Central Florida Pulmonary Group in Orlando. He serves as Co-director of the Adult Cystic Fibrosis Program in Orlando. Dr. Layish may be contacted at 407-841-1100 or by visiting www.cfpulmonary.com.
INTRODUCING

Vibralung Acoustical Percussor

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A Paradigm Shift in Respiratory Care
Can you hear it? It’s the new sound of the Vibralung® Acoustical Percussor, and it’s starting a revolution in Airway Clearance Therapy (ACT). The Vibralung Acoustical Percussor applies vibratory sound waves over a wide range of frequencies (5 to 1,200 Hz) to vibrate the column of gas in the tracheobronchial tract. As a result, mucus is loosened and separated throughout the airways to promote safe, effective and gentle ACT like no other alternative.

The Gentler Approach to ACT
The Vibralung Acoustical Percussor is a gentler form of ACT than oscillatory PEP devices, or those that make contact with the external chest wall. It may be especially useful for airway clearance therapy when other means like vests and hand-held chest percussors cannot be used. It’s the ideal choice whenever airway clearance is the goal and patient comfort is preferred.

Consider the Many Advantages of the Vibralung Acoustical Percussor
- Easy to operate; battery-powered, lightweight and portable, can be used almost anywhere
- Requires only minimal patient effort with normal breathing
- No patient discomfort; no contact with the external chest wall
- Treatment times are quick and efficient
- Unique coupling of acoustical energy (sound waves) directly to the airway gently vibrates the airway surface to loosen secretions
- Sole therapy or adjunct to other methods/devices
- Optional simultaneous aerosol delivery
- Incorporates delivery of PEP (Positive Expiratory Pressure)
- Works during both phases of the breathing cycle

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Cardio-Oncology: An Important New Specialty to Improve Patient Outcomes at the University of South Florida and Moffitt Cancer Center

By Michael Fradley, MD, and Roohi Ismail-Khan, MD

While cardiovascular disease and cancer remain the most common causes of death in the United States, improved therapies for both conditions have improved mortality dramatically. In fact, there are now more than 14 million cancer survivors living in the United States alone. Despite these advances in cancer treatment, many of these therapies have cardiovascular sequelae that can also cause short- and long-term morbidity and mortality. In addition, many patients with cancer also have pre-existing cardiovascular disease which can impact their ability to receive and tolerate optimal cancer treatment. Up to 30 percent of patients receiving cancer therapy experience cardiovascular complications.

Given the complexities of treating cancer patients, collaboration and communication between cardiologists and oncologists is essential. As a result, cardio-oncology, a new specialty within cardiology, has been developed to provide more specialized care to cancer patients. Cardio-oncology is a multidisciplinary field focusing on the prevention, early detection and management of cardiovascular disease in both cancer patients and survivors. The University of South Florida, Department of Cardiology and the Moffitt Cancer Center have partnered to create a comprehensive academic cardio-oncology program to provide more effective and specialized cardiovascular care to cancer patients in the state of Florida and beyond.

It has been recognized since the 1970s that exposure to anthracyclines, an important class of chemotherapeutic agents used to treat a variety of malignancies including breast, sarcoma and leukemia/lymphoma, can lead to left ventricular dysfunction and heart failure. These complications may not become apparent for up to 25 years after completion of therapy and is manifested by myocyte damage and cell death. This irreversible injury with cardiac structural changes is classified as cardiotoxicity type 1 however the underlying mechanism remains unclear. In contrast, cardiotoxicity type 2 is reversible cardiac dysfunction without myocyte structural changes. Cardiac function usually normalizes with cessation of therapy. This complication is typically associated with the HER2 targeted agents trastuzumab and pertuzumab as well as the tyrosine kinase inhibitor sunitinib. Despite the general recognition of these toxicities, there is still little understanding of the mechanism of the ventricular dysfunction associated with these agents or the appropriate methods for monitoring, prevention or treatment. Dedicated cardio-oncologists are necessary to advance medical knowledge about these complex therapies.

While much of cardio-oncology had initially focused on the diagnosis and management of left ventricular dysfunction and heart failure, it is increasingly recognized that other cardiovascular complications can occur as a result of cancer therapies. These include accelerated coronary artery, vascular and valvular disease as well as arrhythmias. Several prominent studies have highlighted these “novel” cardiotoxicities and have increased awareness in the medical community about cardiovascular disease in oncology patients.

A recent study in the New England Journal of Medicine (2013) evaluated coronary events in women with breast cancer who were receiving radiation therapy. The rates of major coronary events increased linearly with the mean dose of radiation to the heart by 7.4% per gray with no apparent threshold, and the increased risk started within the first 5 years of exposure and continued for 30 years after therapy. Radiation therapy to the chest is a common treatment for several malignancies in addition to breast including lymphoma and esophagus and further studies are necessary to fully evaluate the cardiovascular risk associated with radiation for these tumors.

A different study from the New England Journal of
Medicine (2014) demonstrated that the tyrosine kinase inhibitor ibrutinib significantly improved survival in patients with advanced chronic lymphocytic leukemia compared to standard therapy. Safety analysis indicated a significant increase in the rate of atrial fibrillation in patients treated with ibrutinib. At the same time, there is also an increased risk of bleeding in patients treated with this pharmaceutical agent. Therefore, anticoagulation is considered a contraindication. Clearly this leads to management dilemmas since patients with atrial fibrillation are at increased risk for thromboembolic stroke. Cardio-oncologists will be necessary to appropriately mitigate the risk of stroke in these patients that develop atrial fibrillation while ensuring they continue to receive the most effective oncology therapy available.

It is evident that collaborative cardio-oncology programs are necessary to provide the best possible care to cancer patients. The USF/Moffitt Cardio-Oncology Program is the only academic program of its kind in the region. The mission of the USF/Moffitt Cardio-Oncology Program is to manage and treat cardiovascular disease in oncology patients allowing for the delivery of effective cancer therapy. This will be accomplished via three areas of focus – patient care, education and research. Each of these areas are necessary to ensure that patient outcomes continue to improve in the future.

PATIENT CARE:

**Risk Assessment Prior to starting Cancer Treatment:** Before the patient is to undergo medical or surgical treatments for cancer, it is important to understand the risk for developing or exacerbating cardiovascular disease. The Cardio-Oncology team will work closely with the oncologist to provide a comprehensive evaluation prior to cancer therapy to minimize any potential cardiovascular complications and ensure appropriate therapy is delivered.

**Monitoring for Cardiac Complications from Cancer Therapy:** The USF/Moffitt Cardio-Oncology program will use advanced techniques in cardiovascular imaging to detect heart dysfunction due to cancer therapy at an earlier stage. When patients are actively receiving chemotherapy or have previously completed chemotherapy and/or radiation therapy, they will benefit from close monitoring for hypertension, coronary artery disease, congestive heart failure, valvular heart disease, pericardial disease, and arrhythmias. With early recognition and treatment, many complications of chemotherapy and/or radiation therapy can be managed successfully.

**Cardiac Risk Assessment in Cancer Survivors:** There is increasing evidence that survivors of cancer face higher risks of cardiovascular disease, especially in patients who have received anthracyclines, targeted therapy such as Trastuzumab (Herceptin), Tyrosine kinase Inhibitors (TKIs), as well as radiation therapy. A multi-faceted approach to reduce cardiac risk will be offered to our patients that are referred to this program including lifestyle modifications and, when needed, medical therapy

RESEARCH

Research will be conducted to better understand the cardiac toxicity of current cancer therapies with an emphasis on improved diagnosis and treatment strategies. In addition, novel agents in clinical and pre-clinical studies have the potential to damage the heart (cardiac toxicity). This program will work in close cooperation with the Clinical Trial Program (Phase I/II) to offer and administer advanced diagnostic tests to determine cardiac safety in the clinical setting.

EDUCATION

Education is key to the success of any program. Resources will be developed for patients to better understand cardiovascular disease and the potential toxicities of their cancer therapy which will empower them to be advocates for their health. Similar programs will be developed for health care providers so that they can offer the most optimal care to their patients and recognize situations that require evaluation by the more advanced cardio-oncology program.

The importance of the Cardio-Oncology program cannot be overstated. With the improvement of cancer therapy, patients are thankfully living longer and surviving their cancer diagnosis. With the introduction of this program, we hope to help patients enjoy this additional quantity in time by improving the quality of their life by avoiding additional cardiac complications or toxicities.

Michael Fradley, M.D., is the director of the joint cardio-oncology program at the University of South Florida and Moffitt Cancer Center. He is an assistant professor of medicine in the division of cardiovascular medicine at the University of South Florida Morsani College of Medicine. He is board certified in internal medicine, cardiology and cardiac electrophysiology. His research interests include cardiovascular complications of cancer therapy with a particular focus on arrhythmias on oncology patients.

Dr. Roohi Ismail-Khan, MD is a medical oncologist specializing in breast cancer in The Center for Women’s Oncology at Moffitt Cancer Center. She finds the field of breast medical oncology an exciting one as advances in treatment and the delivery of targeted therapies improve prognosis for everyone, including patients with advanced stage disease. The knowledge that breast cancer is not just one disease, but many, just as every patient is unique, also sets a new standard in personalized care.

Dr. Ismail-Khan’s research interests include the treatment of triple negative breast cancers and reducing or eliminating long-term side effects of chemotherapy to improve quality of life. She is also focused on triple negative breast cancer; an aggressive disease that responds well to therapy, but often recurs and spreads.
Do you wear a lot of hats at your office? Have you ever gone through an entire day and feel like you’ve got nothing done but aren’t sure why?

Check and check.

We’ve been there too, and we’ve seen it hundreds of times with clients at offices just like yours. You’ve got a challenging schedule. There’s a daunting to-do list buried under a few files. Next thing you know, something (marketing) is getting rushed, forgotten about or postponed.

So, how can you get more work done quickly and effectively? Here are 5 essential tips to become a more efficient practice administrator.

**ESTABLISH YOUR DAILY AND WEEKLY PRIORITIES**

Take some time either before or right when you get into the office to get out a sticky pad and literally rank and write down your priorities for the day and the week ahead. Writing down a list of goals and tasks will help you instantly see what you have to do in a more clear and concise way. Want to take it a step further? Categorize the activities into 3 subsets:

- What has to get done
- What you want to do
- What you should do (but can probably wait)

This will help you decide what your employees and your physicians need most from you as well as give you something to look forward to and reaffirm what can wait until later.

**ORGANIZE YOUR DAY INTO BLOCKS**

Around the DrMarketingTips office, we use Google Calendar to help organize our day into blocks of time. Block out your day and then keep the website tab open in your browser so you can reference what you should be doing and how long you have to do it. This will help keep you on task while serving as a visualization of how much you can get done in a day and what you just don’t have time for.

Of course this isn’t perfect and things do pop up on the occasion (like, every day), but it has done wonders for us, our staff and even our interns. Even though a large part of your job is putting out the proverbial fire (or dealing with a disgruntled patient, visiting with a drug rep, talking to the fire marshal, finding out why the wifi isn’t working, etc.) the calendar can still help provide a sense of order and control.

Plus, you can integrate your calendar with your smartphone so you’re never more than a few touches away… however good or bad that might be.

A sample of my personal Google Calendar.

**CLEAR AWAY LOW PRIORITIES**

Once you write down your goals and schedule time to complete your tasks, you’ll probably find a few small tasks that need to get done, but really aren’t super important for today (or this week for that matter). Before you know it, these lower priority tasks can take up your entire day leaving you feel like you didn’t get any of your major goals or tasks completed.

Our advice? See how many of your low priority tasks you can shuffle around so you don’t have to do them at all. Here’s a few ways how:

- Delegate to a fellow team member
- Consider having a conversation rather than a meeting
- Organize emails into priorities and answer the most important first

Using these quick techniques you’ll find you can typically open up 1-3 hours of your day to take on higher priority tasks – assuming you’ve got a good, competent staff and have set clear expectations for them (another post altogether).

**TURN OFF THE OUTSIDE WORLD**

Have a task you need to do but can’t get motivated for? Unplug your computer from the internet, turn off your wifi connection, put your phone in a drawer and close your office door to disappear from the outside world for a little bit.

Continued on page 16
Our renowned cardiovascular specialists helped Adrienne get back on track. Now she’s running and traveling again, living the active life she loves. Orlando Health Physicians provide expert care and partner with you to manage your health – with convenient locations throughout Central Florida. 

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Hear that? Peace. Silence. By removing the chime of instant messages, the notification of a new email and the passerby stopping to chat you’ll have no choice but to buckle down and mow through a few items on your to-do list.

Of course, this tip isn’t recommended for an extended amount of time, but it can help you eliminate distractions and put your mind 100% into what you should be doing.

Looking for more ways to attract and retain more patients? Check out DrMarketingTips.com for free articles, webinars, ebooks, audio blogs and more for your practice.

Jennifer Thompson is co-founder and chief strategist for DrMarketingTips.com, a website designed to help medical marketing professionals market their practice easier, faster and better.

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An Intro to Acute Behavioral Care

By Sajid Hafeez, MD

What comes to mind when you think of a psychiatric hospital? You may think of the clichéd straight jackets, padded rooms, and orderlies sitting behind a locked cage. While this image may sometimes persist in movies and TV shows, the modern mental health facility departed from this model decades ago. With the growing understanding of the importance of mental health, the modern day facility has a setting that is somewhere between a standard hospital and a resort spa.

Just as these facilities have abandoned the old look and setting, so too have they abandoned the old forms of treatment. Patients are no longer subjects treated by a doctor, but rather active participants on their own journey to self-betterment and stability. Often, this journey starts with education and learning what is to come along the path of self-betterment. So in that respect, a simple walkthrough can help dispel the fear that may make some hesitant to begin this process.

In acute behavioral care, there are two types of admissions: voluntary and involuntary. Involuntary happens when a therapist, a judge, a doctor, or a police officer feels that a patient is in a mental state where he or she is an imminent threat to him or herself, or others. A Baker Act is then served, which provides for transport and admission to a facility for a maximum of 72 hours. Within 24 hours of arrival the doctor gives this patient a full psychiatric evaluation. It is then up to the doctor to decide whether the patient is competent enough to consent for treatment or if the patient must be stabilized further.

If the patient is not competent, a significant other, family member, or close friend is contacted to act as an advocate on behalf of the patient’s best interests. In the absence of those, the court provides specially trained advocates to stand in until a person contact can be found. If the patient hasn’t stabilized within 72 hours, another doctor is contacted for a 2nd opinion, independent of the first evaluation. If both doctors reach the same conclusion then the involuntary is extended via the court through a “32.” A judge will then allow a certain amount of time to stabilize the patient.

There is a difference between stable and competent. Competent simply means that a person has a clear mind, understands his or her situation, and can act rationally. Stable is when that person is no longer at risk of self-harm, and has a good step into becoming mentally healthy and well.

At this moment, the patient has a choice: he or she can discharge and return to the same environment and situation as they left it, or that person can sign voluntarily, seek treatment, and return with the mental tools and skills to better handle the situations and environment that were responsible for their admission. This is the same stage in the process where a voluntary admission begins.

As mental wellbeing can be connected to physical health, the patient is given an assessment by the unit nurse, followed by a physical from the general practitioner, and lab work performed on blood samples. This is to investigate as to whether any physical ailments could be related to the mental issue with which the patient is struggling. For example, issues such as depression or bipolar like symptoms could be secondary causes of issues with the thyroid or anemia.

Once organic issues can be ruled out, the psychiatrist is better able to discern the root of the issue. Essentially the psychiatrist is much like a detective of the mind, carefully using clues such as clinical evidence, presentation, and collateral information from family members and outpatient providers to discern the most probable diagnosis and corresponding treatment and aftercare service recommendations.
During the patient’s stay, the multidisciplinary treatment team works with the patient to manage these treatments. The treatment milieu (environment where patients receive care) is designed to be low stress and relaxing. Patients are given access to comfortable beds, private bathrooms and showers, healthy meals, and free time to visit with family, indulge in private leisure like reading or crafts, or reflect on what they’ve learned. Throughout the day, therapists hold regular group and independent therapies where the patients are actively engaged and encouraged to talk about their struggles, while taught how to best manage them. For some people, learning new ways to cope with the stress is enough and they are ready to take the next step in their journey.

Others may find that their issue comes not just from external sources, but in the chemistry of the body. Through careful analysis, the doctor will recommend a medication or combo of medications to help stabilize the chemistry of the brain. Over the few days, the doctor may titrate the dosage up or down until it best treats the underlying issue. An important part of medication is coordination with the patient on how it is affecting that person. Does it manage one symptom, but not another? Does it make any symptom worse? Are there any adverse reactions? These are all important aspects that are routinely monitored by the nurses on the unit and reported to the doctor.

There then comes a point where the patient has become stabilized and the doctor will recommend a discharge from acute. This however does not mean that the issues are completely resolved,
Stem Cell Therapy Improving Function, Restoring Quality of Life

By Corey Gehrold

Stem cells and platelet rich plasma (PRP) therapy help make up a family of advanced orthopaedic treatments commonly referred to as regenerative medicine. These therapies have been used in a variety of medical specialties to improve a patient’s quality of life, and even restore lost function for decades.

Today, these minimally invasive, nonsurgical treatments are used at Orlando Orthopaedic Center to treat musculoskeletal injuries without surgery and help patients like George Margoles return to what matters most to them.

“The procedure was really simple and not at all painful,” he says. “Shortly afterward I was back to normal activities around the house, doing the day-to-day kinds of things; and a few weeks after that I was back on the golf course, riding my motorcycle and doing more active things without pain.”

WHA T ARE STEM CELLS?

Stem cells are the basis for the specific types of cells that make up each organ in the body. These cells are different from other cells in a few key ways:

• They have the ability to self-renew
• They can be induced to differentiate into specialized cells with specific functions

“As far as orthopaedics is concerned, we use stem cells to help promote healing of bone, cartilage, nerve tendon and connective tissue,” says G. Grady McBride, M.D., a board certified orthopaedic surgeon specializing in minimally invasive spine surgery at Orlando Orthopaedic Center.

Why do orthopaedic surgeons like Dr. McBride use stem cells? “The cells are used to create new cells in existing healthy tissue and they may help repair tissue in areas that have been injured such as a damaged or degenerative disc,” he says. “Patients consistently report positive outcomes following their stem cell treatment at our outpatient surgery center.”

The most common source to obtain adult stem cells is bone marrow because it contains hematopoietic and mesenchymal stem cells. “We use bone marrow stromal cells, which are a type of mesenchymal stem cell, that differentiate into cells to help form bone, tendon, ligament and cartilage,” says Dr. McBride.

HOW ARE STEM CELLS COLLECTED AND USED?

The most common area to obtain these bone marrow stromal cells is from the outside area of the pelvis, also known as the iliac crest. A needle is inserted into the iliac bone and bone marrow is withdrawn through the needle.

A trained nurse or technician then uses specifically designed equipment to concentrate the stem cells in the bone marrow and provides the cells back to the surgeon for implantation at the site of injury. As they divide, they create new stem cells and second-generation progenitor cells to promote healing.

For George, the stem cells were implanted in the damaged disc between spinal vertebrae in his lower back, hence the involvement of Dr. McBride, a spine surgeon at Orlando Orthopaedic Center. Most patients will see signs of improvement anywhere from 4-8 weeks following completion of the treatment protocol, although George contends he felt relief much sooner than that.

“The procedure was really nothing more than a simple outpatient procedure,” says George. “It took about a half an hour from what I recall and in a few hours I was over the mild anesthetic they had given and I did not have any real acute pain.”

HOW SUCCESSFUL ARE STEM CELL PROCEDURES?

Although the results of a clinical trial with a large number of subjects has yet to be published, patients regularly report on the positive outcomes associated with the procedure. Some limited studies have shown greater than 80 percent positive responses at 1-year follow-up.

“Of course, results vary by individual,” says Dr. McBride. “But collectively, patients report that the procedure is successful in significantly lessening the discomfort they felt prior to undergoing the procedure.” Thanks to the reduced discomfort and increased function, patients like George are back to doing what they love thanks in part to stem cells and regenerative medicine. Watch George’s full story and see what he has to say about stem cell therapy at OrlandoOrtho.com.

“My wife and I just completed a 600-mile motorcycle ride for charity and I had no discomfort and numbness in my leg which I was experiencing prior to the stem cell injection,” he says. “I found it very beneficial for those kinds of activities and after six months I really have no discomfort whatsoever.”

Watch George’s full story and see what he has to say about stem cell therapy at OrlandoOrtho.com.
The Centers for Medicare & Medicaid Services Releases Proposed Rule Recognizing Same-Sex Marriages

By Michael R. Santana, JD and Sarah Logan Mancebo, JD

On December 12, 2014, Centers for Medicare & Medicaid Services (“CMS”) published a proposed rule in the Federal Register that amends federal regulations by revising certain definitions, conditions of participation for providers and conditions for coverage for suppliers to ensure same-sex spouses in legally valid marriages are recognized and granted equal rights in Medicare and Medicaid participating facilities.

CMS issued this proposed rule to ensure consistency with a 2013 Supreme Court case (U.S. v. Windsor, 570 U.S. 12 (2013)), which held Section 3 of the Defense of Marriage Act (“DOMA”) was unconstitutional (the “DOMA decision”). The ruling specifically struck down DOMA’s definition of marriage, which stated the word “marriage” in any Act of Congress, ruling, regulation or interpretation of any federal bureau or agency meant only a legal union between one man and one woman as husband and wife and the word “spouse” could only refer to an individual of the opposite sex who was a husband or wife.

Based on the DOMA decision, CMS conducted a thorough review of its Code of Federal Regulations for all Medicare and Medicaid provider and supplier types with a specific review of terms pertaining to spouses and/or spousal relationships that rely on state law for purposes of defining these terms. Based on its review, CMS concluded (i) numerous regulatory provisions currently support the denial of federal rights and privileges to same-sex spouses; (ii) failure to implement this proposed rule will be inconsistent with the DOMA decision; and (iii) failure to implement this proposed rule will not afford equal treatment to same-sex spouses in participating facilities whose marriages are lawfully recognized.

The proposed rule seeks to resolve these inequalities and apply to Medicare and Medicaid participating providers and suppliers where current regulations defer to state law in situations that implicate, or may implicate, a marital relationship by use of the terms “representative,” “spouse,” or any other similar term that may involve a spousal relationship. The new regulations proposed in the rule, if adopted, will govern whether or not the marriage is legally recognized in the state of residence where the individuals reside or whether the jurisdiction in which the health care provider or supplier is located recognizes same-sex marriages.

The proposed rule revises the following regulatory provisions for providers and suppliers:

- Hospice Care. Definitions (42 C.F.R. §418.3); Conditions of Participation – Patient Rights (42 C.F.R. §52(b)(3)).
- Hospitals. Conditions of Participation – Patient Rights (42 C.F.R. §482.13); Conditions of Participation – Laboratory Services (42 C.F.R. §482.27).
- Long-Term Care (“LTC”) Facilities. Resident Rights (42 C.F.R. §483.10); Preadmission Screening and Resident Review Evaluation Criteria (42 C.F.R. §483.128).
- Community Mental Health Centers. Definitions (42 C.F.R. §485.902); Conditions of Participation (42 C.F.R. §485.910(b)(3)).

All of the new regulations proposed in the rule revise and/or add language requiring same-sex marriages that are valid in the jurisdiction in which they were celebrated be granted equal treatment to that afforded to opposite-sex marriages.

The proposed rule was open for public comment until February 10, 2015. CMS will review timely submitted comments before deciding whether to adopt the proposed rule.

Michael R. Santana, JD, is a shareholder in the Health Care Practice and Litigation Practice Groups with GrayRobinson, P.A. Mike has represented hospitals, healthcare providers, and insurers in complex contract, insurance, business tort, construction, fraud, personal injury, professional malpractice, and landlord/tenant matters. Call him at (407) 843-8880; michael.santana@gray-robinson.com or visit www.gray-robinson.com.

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Osceola Regional Goes Red, All Year Round  Featuring Kristopher George, MD, FACS, FACC, Medical Director at Osceola Regional’s Central Florida Cardiac and Vascular Institute

It’s that time of year again.

Americans pull out their red shirts, communities increase awareness efforts and women of all ages GO RED in a sign of solidarity to support American Heart Month.

While some wait for February to make a push for heart health, Osceola Regional Medical Center is pushing to keep the conversation top of mind, all year round.

“I typically give lectures to groups of people that are interested in hearing about heart disease, coronary disease, valve disease and various treatments for each. We talk about how to detect the problem, the importance of early detection, and how to repair the problem surgically. Kristopher George, MD, FACS, FACC, Medical Director at Osceola Regional’s Central Florida Cardiac and Vascular Institute said. “We do this throughout the year not just in the month of February.”

Dr. Kristopher George’s lectures are a part of Osceola Regional’s Healing Hearts on Wheels initiative. The free, educational series brings surgeons and cardiologists out from the CV unit and into the community, for in-depth conversations on heart health.

“There are a variety of reasons why it’s important. We want people to be able to understand how to recognize a heart problem. Certain cardiac diseases can be prevented, and there are ways to reduce the risks. It’s important for them to know when to seek help and to be aware that there is excellent healthcare right in their backyard,” Dr. George said.

Located within Osceola Regional Medical Center is the Central Florida Cardiac & Vascular Institute (CFCVI), Dr. George’s home for the past seven years. A board certified cardiothoracic surgeon, Dr. George started his cardiac surgery training at George Washington University and Johns Hopkins Hospital. From there he went to work at the Cleveland Clinic before arriving at Osceola Regional in 2008. He admits he’s seen the practice go in a new direction over the past few years.

“We’re continually adding new procedures
for patients. Probably the biggest direction that we're going in is minimal invasiveness, sometimes even including the use of robotic instruments. Right now we're advancing the TAVR program. It's another option for certain patients to get an aortic valve replacement that doesn't require an incision on the chest," Dr. George said. "We're moving towards reducing incision size, while still keeping very high outcomes."

While heart treatment options seem to be ever-changing, other data has remained constant. According to the CDC, heart disease has been the leading cause of death in the United States since 1921. On a more local level, the results of a 2013 tri-county health assessment show that cardiovascular disease is the leading cause of premature death in Osceola, Orange and Seminole counties, with diabetes (a contributing factor to heart disease) listed as the most prevalent chronic disease.

Dr. George says another important constant, is his hospital's continuous success in treating local heart patients.

“What sets us apart really is our results. Perhaps the best existence of our results is that for the majority of our existence we've been a 3-star STS program,” Dr. George said.

The STS or Society of Thoracic Surgeons database is the largest clinical database in the world. A 3-star rating defines clinical excellence in cardiac surgery.

“The take home message for the people in Osceola County and the surrounding area is that they have a heart program at Osceola Regional that is in the top 13 percent in the nation and in terms of outcomes, and it's in their own backyard,” Dr. George added.

Osceola Regional is the only accredited Chest Pain Center with percutaneous coronary intervention (PCI) in the county. It has also received the Gold Seal of Approval Accreditation by the Joint Commission and is one of two Central Florida Hospital’s to receive the Top Performer on Key Quality Measures® recognition. The hospital has also received the American Heart Association’s Get With The Guidelines Heart Failure Silver Quality Achievement Award.

“We're different in a lot of ways. The CFCVI (heart institute) is geographically separate in the hospital and it all exists within one tower. The rooms in that tower are large, private rooms and all of the staffing and services within that tower are really geared towards cardiovascular systems,” Dr. George added.

Osceola Regional also has the only accredited Advanced Primary Stroke Center in Osceola County. The State-of-the-Art Electrophysiology (EP) Laboratory is the only one of its kind in the county, bringing comprehensive electrophysiology services close to patients—when and where they need it.

“We want our local residents to know that the vast majority of heart surgeries that are done around the country, including bypass surgery, valve and aortic, can be done right in their own backyard. For a person that may need such a procedure it’s incredibly convenient and critical to have that high-quality option nearby,” Dr. George said.

After a heart attack, the heart muscle can begin to die within 80 to 90 minutes after it stops getting blood. Quick treatment can restore blood flow to the heart and save a life. When it comes to matters of the heart, proximity and quality are ultimate keys to survival and recovery. Dr. George plans to keep drilling home that message long after February's Heart Month efforts have subsided.

“The end reality is that patients need to understand what they can do to prevent these problems in the first place - living a heart healthy lifestyle, knowing what kinds of food you should eat, and the kind of exercise you should have. The most important thing about heart month, as well as any other month, is the education of the population,” Dr. George concluded.

Education he’ll keep pushing, one lecture at a time.

For more information about Osceola Regional’s Central Florida Cardiac & Vascular Institute, Healing Hearts on Wheels, or to view the calendar of events, visit www.OsceolaRegional.com.

Kristopher George, MD, FACS, FACC is a board certified cardiothoracic surgeon and Medical Director at Osceola Regional's Central Florida Cardiac & Vascular Institute. Dr. George and his colleague, board certified cardiothoracic surgeon Nestor Dans, practice at Cardiac Surgical Associates of Osceola located at 720 West Oak Street, Suite 360, Kissimmee, FL 34741.

Be sure and check out our website at www.floridamd.com!

COMING UP NEXT MONTH: The cover story focuses on the recently opened Orlando Regional Medical Center tower. Editorial focus is on Orthopaedics and Men’s Health.
Burned Out? We’re Working on It. But Hospital Employment Is Not the Answer

By Marni Jameson

As a non-physician who talks to a lot of doctors, I’m often struck and saddened by how frustrated they are.

Last month, after I spoke at an American College of Cardiology summit, I was besieged afterward by doctors asking for ways they could stay independent and not succumb to hospital offers of employment.

They wanted to know, privately, if we at the Association of Independent Doctors could help them get fairer contracted rates with insurers; that is, reimbursement rates closer to what insurers and Medicare pay hospital-employed physicians for the same procedure.

Wouldn’t that be nice? We’re working on it.

They wanted help forming an IPA, so they could get better leverage and clout with payers.

We’re working on it.

They wanted to know if we could help them combat the fact that hospitals direct patients only to employed physicians, cutting independent doctors out of the referral network.

We’re working on it.

They wanted a life raft, or at least a life preserver, to help them keep cash flow up and disillusionment down.

To reassure them, we tell them, yes, at A.I.D., we are working with media, lawmakers, the judicial system, insurers, doctors and consumers on all those issues. They are big, complicated, and entrenched, but we are making a difference.

I want independent doctors, particularly those not yet members of the association, to know that someone is working for them, because I get frustrated when I read articles – two this past week – reporting that doctor burnout is on the rise.

One editorial titled “How Being a Doctor Became the Most Miserable Profession,” in The Daily Beast, opened with the cheery news that nine of 10 doctors would discourage others from joining the profession, and that over the past few years being a doctor has risen to become the second-most suicidal occupation.

Burnout, according to a January report by Medscape from WebMD, the second article that appeared in my inbox, was a problem for 46 percent of physicians – up 16 percent in just two years. The study defined burnout as a loss of enthusiasm for work, feelings of cynicism, and a low sense of personal accomplishment.

These are not qualities we want in our doctors.

Among the top reasons for burnout, were too much bureaucracy, too many hours, not enough income, computerization, impact of the Affordable Care Act, and not enough time to provide quality care.

We’re working on it.

But this much is clear: Employment is not the answer. We get that for burned out doctors, folding up their tent and going to work for a hospital seems like a good way out. But we know from those who have left independent medicine, the grass is not greener.

We know because we have many physician members who were employed by hospitals and have returned, wiser, to private practice. One internist was frustrated because her hospital employer was insisting that she see 25 patients a day rather than her average of 17, a number she felt she could see in one day and provide quality care for. When she didn’t pick up her pace, her employment contract wasn’t renewed.

Another A.I.D. member, whose practice was purchased by the hospital, quit when he went to request his vacation time, he found he didn’t have any. The surgeon, who typically worked 12 to 15 hours a day Monday through Thursday, and saw patients Friday mornings, played golf every Friday afternoon. The hospital employer had counted his Friday golf as vacation time. He is back practicing independently after sitting out a year per the terms of his non-compete clause.

Most doctors are by nature autonomous. Not too many like hospital administrators telling them how many patients they need to see, or when they can play golf. Most don’t go into practice so they can do unnecessary procedures, order unnecessary tests, and meet quotas, to please their employers and keep their jobs.

The same week I spoke to the cardiologists, and read those two doomsday articles, I got an email from a physician and A.I.D. member asking for help. The medical staff had elected him to be chief of surgery at his hospital. However, at the meeting where the board was to confirm his position, it was not approved. The board wanted an employed physician in that seat.

These injustices keep happening and will continue to happen unless independent doctors unite and speak up.

We’re working on it.

As we told this ill-treated doctor, and as we tell everyone who asks, who is frustrated about the state of health care, the only way independent doctors are going to gain ground, protect their interests and secure their professions is to develop a unified, nationwide voice that patients, hospitals, insurers, and governments listen to, take seriously and respect.

This is exactly why we formed the Association of Independent Doctors. But we can’t do this without your support. If you’re independent, and believe in our efforts, please support us by joining our cause. To become a member of A.I.D. go to www.aid-us.org. Let’s do this together.

Marni Jameson is the executive director for the Association of Independent Doctors. You may reach her at 407-865-4110 or marni@aid-us.org.
New Technologies and Treatment Paradigms In Aortic Valve Stenosis

By Kevin D. Accola, MD

Degenerative stenosis of the aortic valve has continued to increase in prevalence with the advancing aging population. Aortic valve replacement utilizing cardiopulmonary bypass and an arrested cardioplegic heart has been the gold standard since the early 1970’s. Continued advancement in surgical aortic valve replacement techniques and valve designs progressed with likewise improvement of operative results remaining the standard of care in acceptable risk patients. Historically a significant cohort of patients due to their co-morbidities were deemed extreme risk or inoperable with conventional means for valve replacement due to aortic stenosis. The expected mortality of patients with medically treated symptomatic aortic stenosis is greater that 50% within two years. Over the past decade, with increased recognition and incidence of degenerative aortic valve disease has come an enormous influx of new treatment technologies, namely transcutaneous aortic valve replacement / insertion (TAVR / TAVI). The initial pivotal trial in the United States (Edwards Lifesciences Partner Trial) not only demonstrated safety and efficacy of this technology, but initial 12 month results were superior to both conventional surgical treatment modalities as well as medical treatment in inoperable and extreme risk patients (operative mortality >15%). The Medtronic Core valve has also recently been FDA approved for clinical use in the United States. The Core Valve also underwent a multi-center US randomized pivotal trial which demonstrated similar safety and efficacy with superior results to medical treatment when compared to inoperable and extreme risk patients. Currently in the United States the Sapien and Core Valve are the two FDA approved TAVR valve options for implantation. The indications have since been extended for clinical use in high risk patients (operative mortality >8%) with symptomatic severe aortic stenosis. Currently European trials are in place to evaluate TAVR in moderate risk patients utilizing both the Edwards Lifesciences Sapien and Medtronic Core Valve.

The first FDA approved TAVR valve for clinical use was the Edwards Lifesciences Sapien Valve which became available for implantation in November of 2011. The structural heart team at Florida Hospital began preforming the TAVR procedure in March of 2012 through a coordinated effort of the Valve Center of Excellence. The initial team consisted of a collaborative effort of interventional cardiologists, cardiovascular surgeons, anesthesiologists, cath lab and operating room personnel in a specialized developed hybrid operating room. Initial TAVR implants were limited to inoperable or extreme risk patients (operative mortality estimated >15%). Shortly thereafter, transapical implantation was approved clinically as well as extending the utilization of TAVR in patients deemed high risk. We are approaching the completion of our 200th case unitizing the Edwards Lifesciences Sapien pericardial valve.
and are currently now on the second generation of this rapidly progressing technology.

In addition to the initial safety and efficacy concerns, valve structural integrity and longevity were uncertain. In a 2013 report in the Journal of the American College of Cardiology by Toggweiler et al demonstrated favorable five year outcomes with the Edwards Lifesciences Sapien Valve. They observed in 88 patients followed for at least 5 years that only moderate valve failure was observed in 3.4% of patients without development of severe stenosis or insufficiency of the Sapien Valve. Peri-valvular leak / regurgitation remains a concern, as this has demonstrated a negative impact on survival. With new prototypes available this complication has decreased substantially remaining problematic though to a lesser degree.

As continued advancements in percutaneous valve designs are developed this technology may possibly be extended to intermediate risk patients, though currently insufficient data exists and will have to be evaluated in clinical trials. This technology will continue to progress and advance as other valves are designed and enter the clinical market following further trials and FDA approval.

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