Our Team is Ready

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In less than a month, physicians will have a new resource to tap into when Florida Hospital for Women opens in January 2016.

Florida Hospital is recognized as a pillar in the Central Florida community, having built and maintained a reputation of excellence by serving the region’s health care needs for more than a century. Beyond providing quality care, the system and its doctors are recognized nationally as leaders in health care for volumes, outcomes and innovation.

The new hospital will be a natural extension of this leadership position. With gynecology and breast programs recognized by U.S. News & World Reports and the National Accreditation Program for Breast Centers, respectively, this facility will help Florida Hospital realize its vision to create a comprehensive tertiary women’s hospital with destination programs promoting both health and healing. Further, it brings established obstetric, wellness and specialty care services to women of all ages and life phases seamlessly under one roof at a brand-new, advanced facility.
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In 2016, more than 86,000 women and girls will be diagnosed with a gynecologic (GYN) cancer. Of those who are diagnosed, more than a third will lose their battles. This is where the Women’s & Girl’s Cancer Alliance (WGCA) comes in. WGCA is the only organization in Central Florida that educates and advocates for good gynecological health for both women and girls by providing programs and support to those who are diagnosed with GYN cancers.

Dr. Robert Holloway, Gynecologic Oncologist at Florida Hospital Cancer Institute, recognizes the stress reducing effects of WGCA's programs: “WGCA is the most impactful resource for women newly diagnosed with a gynecologic cancer. The knowledge and experience they generously share with our patients significantly relieves stress and enhances their recovery.”

WGCA encourages women to schedule an annual well-woman exam and have regular breast cancer screenings. Many of the symptoms of GYN cancer are subtle and often attributed to something else. Early detection is the key to surviving cancer.

WGCA celebrates survivors at their annual Teal Magnolia Luncheon on April 2nd, 2016 at the Westin, Lake Mary and again at their Mother’s Day 5k on May 8, 2016 at the Oviedo Mall.

SOME OF WGCA’S PROGRAMS
- Lunch Bunch, WGCA’s inaugural program, has helped more than 6,000 survivors since its inception. Happening across five Central Florida counties, Lunch Bunch offers survivors the opportunity to connect and support each other in a non-medical setting.
- Girl Talk focuses on age-appropriate education for women and girls in high school and college. The goal is to teach young women and girls to take control of their GYN health.
- Bags of Hope, re-launching in 2016, provides patients a tote bag filled with items that offer comfort during their treatment.

For more information visit WGCancer.org.
Planning for Partial Retirement —
What to Do Now to Prepare for the Transition

By Jeff Holt, VP, CMPE

When talking to my physician clients about their exit strategy many times they seem to think their only options are to never retire, or to be completely done with taking care of their patients.

**THERE IS ANOTHER OPTION!**

If you want to keep working, only on a less demanding schedule, you’re not alone. Many people these days are considering a “partial retirement.” According to a University of Michigan study, 20 percent of those ages 65 to 67 consider themselves partially retired, while in 1960 this group was nonexistent.1

The reasons for this trend vary –

- Some partial retirees need to prolong income to support their lifestyle.
- Others simply enjoy their work and don’t want to stop.2

Can you participate in this trend? Possibly—but it takes planning. To help you clarify your goals and how to reach them, consider drafting a partial retirement plan.

The process of retiring, especially partially, is complicated for medical professionals, largely because of their practices. If you’re the owner of a private practice, a partial retirement must be planned well in advance, and generally is more successful if there is a planned duration.3 But whether you’re negotiating with partners to scale back, looking for possible buyers to take over your practice or considering moving into an entirely different part-time job, planning is crucial.

Consider the following questions and discuss them with your business and life partners. Then share the answers with your accountant and/or financial professional.

- Do you want to change jobs, or stay at the same job and reduce hours?
- Have you made a financial plan that takes into account the reduced compensation resulting from fewer hours?
- Have you spoken with your financial advisor to prepare for partial retirement?
- Have you communicated your plans to your life partner and your business partners?

Once you’ve discussed these questions with all the players, the next step is to sit down with your accountant or financial professional and draft an actual plan for your proposed retirement.

This plan should cover –

- Financial matters, including how much you expect to earn and how that will cover your living expenses.
- Work responsibilities including scheduling, such as on-call hours, regular hours worked and patients taken on.
- The expected duration of this arrangement.
- How a change in work habits will affect the ownership of the practice.
- A clearly stated plan for the eventual transition to complete retirement.4

All of the above goes double if you’re in a solo practice and plan to eventually sell or hand down your practice to the next generation. Preparing a business for sale takes years if you want to get the best price, and both you and your patients will benefit from long-term planning.

Timing is critical for a successful transition to partial retirement, and knowing what your plans are today for tomorrow and beyond will help to eliminate any related stress.

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Jeff Holt is a Senior Healthcare Business Banker with PNC Bank’s Healthcare Business Banking and can be reached at (352) 385-3800 or Jeffrey.holt@pnc.com.
A New Era in Women’s Health Care Is Ushered in by Opening of Florida Hospital for Women in 2016

By Heidi Kettler

In less than a month, physicians will have a new resource to tap into when Florida Hospital for Women opens in January 2016.

Florida Hospital is recognized as a pillar in the Central Florida community, having built and maintained a reputation of excellence by serving the region’s health care needs for more than a century. Beyond providing quality care, the system and its doctors are recognized nationally as leaders in health care for volumes, outcomes and innovation.

The new hospital will be a natural extension of this leadership position. With gynecology and breast programs recognized by U.S. News & World Reports and the National Accreditation Program for Breast Centers, respectively, this facility will help Florida Hospital realize its vision to create a comprehensive tertiary women’s hospital with destination programs promoting both health and healing. Further, it brings established obstetric, wellness and specialty care services to women of all ages and life phases seamlessly under one roof at a brand-new, advanced facility.

ELEVATED COMMITMENT TO WOMEN’S HEALTH CARE

Florida Hospital for Women is not just a physical location but also a philosophy that is being integrated across the health system.

“We’re integrating our commitment to women’s health throughout the eight central region Florida Hospitals as well as our comprehensive network of outpatient and ancillary centers. From cardiac care to ERs to primary care and management of chronic conditions, like diabetes, we’re looking at how, clinically, women need to be treated differently,” said Marla Silliman, Senior Executive Officer, Florida Hospital for Children and Florida Hospital for Women.

Florida Hospital for Women will be the flagship of the health system’s women’s health initiative that included previous construction of Winter Park Women’s Health Pavilion, the Women’s Institute at Florida Hospital Celebration Health and expansion of Florida Hospital Altamonte.
“All of these things built up to the culmination of the new Florida Hospital for Women tower and demonstrate our commitment to women’s health,” Ms. Silliman says. “Florida Hospital cares for a lot of women, so this is very exciting for us. This women’s tower, which encompasses health and wellness, as well as inpatient services, is a gift we are giving back to the community.”

INTRODUCING THE NEW FLORIDA HOSPITAL FOR WOMEN

The new Florida Hospital for Women is a 12-story, 332 bed hospital on the Florida Hospital Orlando campus. This state-of-the-art hospital designed specifically for women will be supported and extended by a network of dedicated programs and facilities at campuses throughout Central Florida, enabling Florida Hospital to uniquely position itself to serve the needs of the women in this community as well as serving as a destination for specialty care.

Florida Hospital for Women will feature:

- 332 Beds
  - 72 Post-partum beds, including a dedicated high-risk unit
  - 84-Bed Neonatal Intensive Care Unit (NICU)
  - 72 Post-surgery beds for gynecology & oncology
  - 100+ Beds for future growth
- 14 Labor and delivery suites
- 13 Operating rooms with robotic capabilities

“We are entering a new era of health care, focusing not only on healing but also on women’s health and wellness.” Said Kari Vargas, Vice President Florida Hospital Orlando.

The new hospital also will focus heavily on education and prevention. In fact, the first floor will house dedicated programs and resources for education and wellness for women, including high-risk breast cancer clinic, lactation center and educational support programs for women and their families.

LEADING A MOVEMENT

Leading the way since 2014 has been Dr. Boardman, M.D.Sc.M., Chief Medical Officer for Florida Hospital for Women. Her responsibilities include working throughout Florida Hospital campuses, in both outpatient and inpatient settings, to increase physician awareness of emerging women’s health perspectives. She also is engaged in identifying opportunities to improve medical treatment by incorporating evidence-based therapies specific to women.

“We’re not focusing on one part of the physician population; physicians across all specialties see women,” says Dr. Boardman. “We’re looking at a variety of clinical outcomes and comparing women and men and other parameters – race, ethnicity, language spoken, all the things that weigh into patient interaction – to improve screening and getting patients the health care they need and by extension their families.”

Dr. Boardman brings to her position a passion for women’s health as it relates to clinical care, education and research. As a professor of Obstetrics and Gynecology at the University of Central Florida College of Medicine, she understands the importance of training the next generation of physicians and of providing ongoing education to those providers currently in practice. “Because Florida Hospital for Women is committed to furthering our understanding of how, where and at what points in women’s lives different services are needed, we are focusing on both provider and patient education across all specialties of medicine from primary care to medical and surgical specialty care to palliative care.”

“In order to better target clinical services, it is also critical to compare clinical outcomes across
a variety of populations. To that end, we have begun the process of looking at outcomes such as readmission rates following a heart attack or screening rates for colon cancer by gender, race and ethnicity, language and socioeconomic status,” says Dr. Boardman. “The downstream effect of this work is to improve care by understanding those differences.”

**OBSTETRICS**

Florida Hospital has provided superior health care for women since 1908. The first nursery and obstetrics program dates back to 1940, and since that milestone Florida Hospital Orlando has become a regional transfer center for high-risk pregnancies and babies in need of neonatal intensive care unit (NICU) services or pediatric specialty services.

The hospital is dedicated to safety and education not only within the Florida Hospital System but also for the entire Central Florida obstetrics community. With education and training as a pillar of the obstetrics program, Florida Hospital Orlando physicians and nurses worked collaboratively to create the Multi-Profession Obstetric Simulation Program (MOST). This advanced simulation technology and training for emergencies, such as shoulder dystocia and post-partum hemorrhage, increases safety in actual emergencies.

In addition, doctors on the team voluntarily participate in fetal heart rate courses every two years as a commitment to the hospital’s culture of safety. “These are rare complications, but when they occur, they can be life-threatening. Our goal is to help prepare every obstetrician for these events to ensure the best outcome for the mother and baby,” said Dr. Ashley Hill, Program Director for MOST.

The Labor and Delivery Unit at Florida Hospital for Women will have an obstetric hospitalist or laborist model that provides 24-hour-a-day, seven-days-a-week attending coverage. “This group of physicians and midwives solely dedicated to the laborist program will provide continuous coverage of the labor floor and underscores our commitment to strong patient safety,” said Lori Boardman, M.D., Sc.M., CMO, Florida Hospital for Women. “Our team is committed to providing the highest level of care for mom and baby and to support that every step of the way.”

For high-risk pregnancies, the Comprehensive Fetal Medicine Program uses a collaborative approach to ensure the highest level of care. It is comprised of board-certified, high-risk obstetricians, maternal fetal medicine specialists and a pediatric specialists program. The Level III NICU is physically incorporated into the new women’s hospital to maximize positive outcomes when issues arise and every second counts.

Florida Hospital has been proud to provide emergency transfer services by helicopter for the past 15 years. Its Emergency Transfer Center is available for physicians in the event they have a delivery that requires a Comprehensive Fetal Medicine Specialist, Level III NICU or a pediatric sub-specialist during or after delivery.

As a regional leader, Florida Hospital Orlando currently accepts more than 500 at-risk mothers annually from across the state of Florida. Many of these mothers are transferred from smaller hospitals without NICUs. Some come from as far as the Caribbean. This program allows for direct communication between our hospitalists and the referring physician, thus ensuring the best care and treatment plan for the patient post-partum.

With the opening of Florida Hospital for Women, Florida Hospital will be able to expand its transfer program, meaning more women who are experiencing such issues as placenta previa will have safer deliveries and better outcomes.

As Dr. Hill explains, “The new hospital will be high-tech and high-touch. We are proud to serve as the tertiary center for mothers and their babies experiencing complications. Our team has the training to ensure the highest level of expertise to deal with high-risk pregnancies and provide the best possible outcome.”

“Florida Hospital’s maternal fetal medicine is as amazing medically as it is emotionally and spiritually. The new women’s hospital will structurally make it even better for families,” said Dr. Rachel Humphrey, Director of the Maternal-Fetal Program at Florida Hospital.

Rooms are structurally architected to intimately involve families and their caretakers. The process is a comprehensive and collaborative one. Before a high-risk woman, under care in the maternal fetal medicine program, goes into labor, the high-risk obstetrician, neonatologist, specialists and nurses meet regularly to review all pending cases. Additionally, team members meet with the mother and set up tours and educational classes to prepare the parents for what’s to come. When it’s time for delivery, the multi-disciplinary team comes together to make the most informed decisions.

In cases of C-sections, mothers can only typically have one family member in the operating room. In the new facility, families will have the option of live video streaming in a “family room,” so mothers can involve more family members in the birth. Additionally, families delivering in the new hospital will experience more comfortable stays in family- and breastfeeding-friendly rooms created for maximizing bonding with their new babies.

A major initiative, according to Dr. Boardman, is to reduce the rate of C-sections among both first-time mothers and women who have had a previous C-section. Another significant initiative will be to better identify and treat postpartum depression. A mother-baby partial hospitalization program focused on treatment and ongoing support is currently in the planning stages with the goal of implementation by early 2017.

**ADVANCED GYNECOLOGY AND WOMEN’S CANCER**

Ranked 13th nationally by U.S. News & World Reports, Flor-
WOMEN’S CANCER

Advanced cancer experts at Florida Hospital Cancer Institute realize that cancer is happening at every stage of life, and they are seeing cancers, such as ovarian, breast and colorectal cancers, at much earlier ages.

According to Dr. Robert Holloway, Medical Director Gynecologic Oncology at Florida Hospital Cancer Institute, “a female’s risk of cancer increases with menopause.” As women pass the age of 40, risks for breast cancer increase, and as they experience the hormone changes of menopause and enter their 50s and 60s risks of gynecologic cancers also increase.

The good news is that regular screenings increase chances for early detection and survival. In many of the cases for ovarian and colorectal cancer, the cancers present with no signs and symptoms, so these screenings and physician check-ups are an integral part of diagnosing cancer at early stages.

Unfortunately, studies have shown Central Florida women are putting their health on hold as they care for their families. Discussions with women reveal that the obstacle is less about economics and more about lack of time and fear of screenings, according to Vargas. “Women put others’ health and well-being ahead of their own. We know breast cancer is a fairly preventable disease, but it starts with each woman taking preventive action.”

Major initiatives in oncology at Florida Hospital include education, screenings, identifying at-risk women and genetic counseling. The health system offers several programs aimed at influencing women in making their health a priority. Florida Hospital offers unique outreach vehicles that visit groups of women to provide lifesaving education, screenings and services.

“If we can help women take good care of themselves and treat their own health as a priority, everybody wins,” said Dr. Boardman. “Why? Because a woman’s health impacts her partner, her family, and her community.”

Florida Hospital’s gynecology programs are created and designed to span a women’s lifetime and in partnership with their doctors focused on specialized, comprehensive care.

“Florida Hospital for Women is a destination for specialty care and will include services focused on several areas of community need, including menopause management and incontinence treatment”, according to Dr. Boardman.

The gynecologic division treats advanced gynecologic issues, such as pelvic floor disorders, benign tumors and other issues affecting women of all ages. One in every three women will experience a pelvic disorder and 10 percent of all women will require surgery. This statistic may even be higher, because many pelvic disorders, such as incontinence or overactive bladder, are left untreated, because they are embarrassing. Dr. Bella Kudish, a Board-Certified Urogynecologist, reports, “Pelvic disorders are so prevalent that the money spent on pelvic disorders annually is equivalent to that spent on diabetes.”

Women often suffer silently from incontinence and genital prolapse. An integrated pelvic program will provide comprehensive diagnostic and treatment services for women with pelvic floor disorders in a confidential and supportive environment. Dr. Boardman said.

Florida Hospital’s Pelvic Floor Program uses a comprehensive approach that includes board-certified, robotically trained urogynecologists, urologists, colorectal surgeons and pelvic rehabilitation specialists to treat incontinence, organ prolapse and other conditions affecting the bowel and bladder.

“Our goal is to provide comprehensive, individualized treatment plans for women experiencing conditions affecting their bladder and bowel function. Our team is ready to assist with patients experiencing common to complex issues, offering the latest in diagnostics and surgical techniques,” said Dr. Rakesh Patel, a Board-Certified Urogynecologist.
Women with ovarian, uterine, cervical and vulva cancers receive care from leading experts in gynecologic oncology surgery with a heavy emphasis on the minimally invasive surgical approach. The program at Florida Hospital has been considered a forerunner in gynecological robotic surgeries since 2006.

In fact, 60 percent of gynecologic cancer surgeries, or more than 700 procedures annually, are performed as minimally invasive robotic surgeries. More impressive, 96 percent of the 5,000 annual benign gynecologic surgeries are minimally invasive, requiring stays less than 24 hours and leaving minimal scars.

Florida Hospital is developing survivorship programs to assist patients after cancer and heart disease. “We understand the impact of cancer and cardiac treatment on women’s long term physical, emotional and sexual health,” said Dr. Boardman.

NATIONALLY RECOGNIZED COMPREHENSIVE WOMEN’S SERVICES UNDER ONE ROOF

Florida Hospital has created a unique, iconic women’s program culminating in the new women’s hospital in 2016.

“We looked beyond reproductive-based issues to what impacts women’s health across the lifespan,” said Dr. Boardman. Input from obstetricians, neonatologists, and nurses, as well as the community was integral to Florida Hospital for Women’s creation.

As described above, the new facility will focus on the lifespan of a woman through purpose-built programs for pregnancy, well-woman and specialty care. It will provide a space that is friendly to patients and conducive to well being from prevention to education to treatment.

“We work diligently so that Central Florida women don’t have to go anywhere else to get the best care,” said Dr. Holloway. “We are also seeing women travel from across the state, region and even country to receive our high level of care. We have become a destination.” Florida Hospital has brought experts together to offer Central Florida patients the highest chances for survival, and the resulting level of care is ranked among leaders nationwide and globally as well.

“Florida Hospital for Women will lead the way in delivering care that meets the unique medical needs of women today, with the goal of improving the health of future generations and the health of the Central Florida region,” Vargas said.

For more information or to register to attend the grand opening celebration of Florida Hospital for Women January 21st at 5:30 pm., visit HerHospital.com.
Pulmonary Manifestations of Rheumatoid Arthritis

By Daniel T. Layish, MD, FACP, FCCP, FAASM

Rheumatoid arthritis (RA) is a systemic autoimmune process classically known for chronic symmetrical erosive synovitis. It is generally progressive. Lungs are the site of a myriad of non-articular manifestations of RA. Other non-articular manifestations can include subcutaneous nodules, vasculitis, pericarditis, mononeuritis multiplex, and episcleritis

Pleuropulmonary manifestations of RA include:
1. RA associated interstitial lung disease (ILD)
2. Pulmonary nodules
3. Large and small airway obstruction
4. Pleural disease
5. Vascular disease (including vasculitis and pulmonary hypertension)

In addition, pleuropulmonary infections can occur (related to RA itself as well as drug-induced immunosuppression) and drug-induced pulmonary toxicity can occur related to medication use to treat rheumatoid arthritis. Furthermore, in a given patient, multiple pleuropulmonary syndromes can overlap (for example interstitial lung disease and pleural thickening). Prevalence of RA associated respiratory disease is difficult to estimate because of variations in study population and different techniques utilized to detect disease (HRCT versus pulmonary function tests versus autopsy, etc). In many cases, pleuropulmonary involvement can be subclinical, which further complicates epidemiologic assessment. Overall, the most common pleuropulmonary manifestations of RA appeared to be interstitial lung disease (ILD) and pleural disease.

RA related ILD can include various histologic patterns including nonspecific interstitial pneumonia (NSIP), usual interstitial pneumonia (UIP), organizing pneumonia (OP), lymphocytic interstitial pneumonia (LIP), desquamative interstitial pneumonia (DIP), and acute interstitial pneumonia (AIP). Patients with RA related ILD that are most likely to benefit from aggressive immunosuppression include younger patients, patients with histopathologic patterns other than UIP, and/or evidence of physiologic and/or radiographic progression over the proceeding three to six months.

Pleural disease is most common in patients with longstanding RA, but can precede joint disease. It is more common in men and coexists with rheumatoid nodules and ILD in up to 30% of patients. RA related pleural disease can often be subclinical. It can include exudative inflammatory pleural effusions. Rheumatoid nodules can develop necrosis and cavitation and rupture into the pleural space with creation of a bronchopleural fistula. Other manifestations include chyliform or “cholesterol” pleural effusion as well as “trapped lung.” Empyema also needs to be considered in the differential diagnosis of these immunocompromised patients when they present with a pleural effusion.

Upper airway obstruction can occur in RA because of cricoarytenoid arthritis, less common causes include vasculitis involving the recurrent laryngeal or vagus nerves, which can then cause obstruction due to vocal cord paralysis. Upper airway disease is more common in women and in longstanding RA. Unfortunately, symptoms of upper airway obstruction can often be absent until significant airway obstruction occurs and the patients can present with stridor. It is important to remember that because RA can be complicated by cervical spine instability, intubation should be performed by highly experienced clinicians with care to avoid excessive neck flexion.

Small airway dysfunction is known to occur in up to 24% of non-smokers with RA. Small airway abnormalities can be seen on HRCT in many patients who did not have physiologic evidence of airway obstruction. This phenomenon is of unclear clinical significance. Obliterative bronchiolitis (OB) is a rare (and usually fatal) condition characterized by progressive concentric narrowing of membranous bronchioles. OB has been associated with both RA itself and drugs utilized in the treatment of RA. OB appears to be more common in women.

Follicular bronchiolitis (lymphoid hyperplasia of bronchus associated lymphoid tissue) can also occur in rheumatoid arthritis (either alone or in combination with NSIP). On HRCT, this can cause centrilobular or peribronchial micro-nodules (less than 3 mm) with branching linear structures, which can include bronchial dilation and bronchial wall thickening. Bronchiectasis has also been reported in up to 30% of patients with RA and can occur without evidence of ILD.

Rheumatoid nodules are the only pulmonary manifestations specific for RA. Rheumatoid lung nodules occur more often in patients with a longer duration of disease and concomitant subcutaneous rheumatoid nodules. They are usually located in subpleural areas or interlobular septa, range in size from a few millimeters to several centimeters and may be single or multiple, solid or cavitary. Rheumatoid nodules can cause hypermetabolism on a PET scan (even in the case of nonmalignant rheumatoid nodules). Rheumatoid nodules can resolve spontaneously and complications such as bronchopleural fistula are infrequent.

Caplan’s syndrome refers to a combination of RA and occupational dust exposure (pneumoconiosis). This can cause rapid development of multiple basilar nodules with mild airflow obstruction. Caplan’s syndrome can also be complicated by the development of progressive massive fibrosis.

Drug-induced lung disease in the setting of RA is beyond the scope of this article, but drug reaction should be considered in the differential diagnosis of physiologic and radiographic abnor-
malities in patients with RA. RA can also cause thoracic cage abnormalities, which can impact pulmonary function. RA appears to increase the risk of venous thromboembolic disease slightly (even after controlling for other risk factors). There also appears to be a slightly increased risk of developing lung cancer in patients with RA when compared to the general population.

Primary pulmonary vasculitis is quite rare. Pulmonary hypertension can be related to underlying vasculitis. Clinical manifestations can be similar to those of idiopathic pulmonary arterial hypertension. Secondary pulmonary hypertension (WHO Group 3) can occur in the setting of RA related ILD.

Given the multiple pleuropulmonary manifestations of RA, the monitoring and management of these patients can be quite challenging and often will involve close collaboration between a variety of specialists including a pulmonologist and a rheumatologist. Pulmonary infection can be a major contributor to morbidity and mortality in patients with RA. Vaccination against Pneumococcus and influenza should be considered in all patients with RA. Pneumocystis prophylaxis should be considered in some patients with RA (depending on their level of immunosuppression).

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. He may be contacted at 407-841-1100 or by visiting www.cfpulmonary.com.

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

COMING UP NEXT MONTH: The cover story focuses on pancreatic surgery available at UF Health Cancer Center – Orlando Health. Editorial focuses on Digestive Disorders and Diabetes.
In 2010, 36 states had obesity rates of 25 percent or higher, and 12 of those had obesity rates of 30 percent or higher. Obesity is a medical condition in which excess body fat has accumulated to the extent that it may have a negative effect on health, leading to reduced life expectancy and/or increased health problems.

**WHAT DOES IT ACTUALLY MEAN TO BE OVERWEIGHT OR OBSESE?**

At their most basic, the words “overweight” and “obesity” are ways to describe having too much body fat.

The most commonly used measure of weight status today is the body mass index, or BMI.

- BMI uses a simple calculation based on the ratio of someone’s height and weight (BMI = kg/m²). Decades of research have shown that BMI provides a good estimate of “fatness” and also correlates well with important health outcomes like heart disease, diabetes, cancer, and overall mortality.

**HEALTHY BMI RANGES FOR ADULTS**

*What’s considered a healthy BMI?*

- For adult men and women, a BMI between 18.5 and 24.9 is considered healthy.

*Obesity complications:*

Overweight is defined as a BMI between 25.0 and 29.9; and a BMI of 30 or higher is considered obese. Obesity has been linked to a number of health complications, some of which are life-threatening:

- Type 2 Diabetes
- Heart Disease
- High Blood Pressure
- Certain Cancers (Breast, Colon, and Endometrial)
- Stroke
- Liver and Gallbladder Disease
- High Cholesterol
- Sleep Apnea and Other Breathing Problems.

Successful weight-loss treatments include setting goals and making lifestyle changes, such as eating fewer calories and being physically active. Medicines and weight-loss surgery also are options for some people if lifestyle changes aren’t enough.

**SET REALISTIC GOALS**

Setting realistic weight-loss goals is an important first step to losing weight.

*For Adults*

- Try to lose 5 to 10 percent of your current weight over 6 months. This will lower your risk for coronary heart disease (CHD) and other conditions.
- The best way to lose weight is slowly. A weight loss of 1 to 2 pounds a week is do-able, safe, and will help you keep off the weight. It also will give you the time to make new, healthy lifestyle changes.
- If you’ve lost 10 percent of your body weight, have kept it off for 6 months, and are still overweight or obese, you may want to consider further weight loss.

**LIFESTYLE CHANGES**

Lifestyle changes can help you and your family achieve long-term weight-loss success. Example of lifestyle changes include:

- Focusing on balancing energy IN (calories from food and drinks) with energy OUT (physical activity)
- Following a healthy eating plan
- Learning how to adopt healthy lifestyle habits

Over time, these changes will become part of your everyday life.

*Calories*

Cutting back on calories (energy IN) will help you lose weight. To lose 1 to 2 pounds a week, adults should cut back their calorie intake by 500 to 1,000 calories a day. All patients with a BMI greater than 25 who would benefit. For individuals with a body mass index (BMI) >30 kg/m² or a BMI of 27 to 29.9 kg/m² with comorbidities, who have failed to achieve weight loss goals through diet and exercise alone, we suggest pharmacologic therapy be added to diet and exercise (from weight loss should receive counseling on diet, exercise, and goals for weight management. For patients with a BMI ≥40 kg/m² who have failed to lose weight with diet, exercise, and drug therapy, we suggest bariatric surgery. However recently FDA approved gastric balloon for the treatment of obesity. This type of weight loss treatment can help you lose weight without invasive surgery. One type of gastric balloon is known as Orbera™. During the procedure a soft balloon is inserted into your stomach through your mouth, using an endoscope (a thin, flexible telescope)

*The FDA say the new dual balloon device offers a non-surgical option that can be quickly implanted, is non-permanent and can be easily removed.*

The device comprises two balloons that are inserted into the stomach and inflated without the need for surgery. The device is meant to be a temporary measure and should be removed after 6 months. Removal is also via a non-surgical procedure.

“... Likely works by occupying space in the stomach, which may trigger feelings of fullness, or by other mechanisms that are not yet understood.”

The Dual Balloon does not alter the anatomy of the stomach.

To help achieve and maintain weight loss, patients implanted with the Dual Balloon are advised to follow a medically supervised diet and exercise plan both while the device is in place and
then for 6 months after it is removed.

The device is inserted during an outpatient visit. The procedure lasts no more than half an hour and is performed while the patient is under mild sedation.

A trained physician inserts the deflated balloons using an endoscope. This is a tube with a camera on the end that goes into the mouth, down the throat and into the stomach. The camera allows the physician to guide the placement of the deflated balloons.

Once in the stomach, the physician inflates the balloons by filling them with a sterile salt solution and then releases them and removes the endoscope.

The device is for obese adults whose body mass index (BMI) lies in the range 30–40 kg/m². It is intended for patients who have not been able to lose weight through diet and exercise alone and is limited to those with one or more obesity-related conditions such as high blood pressure, high cholesterol and diabetes.

Trial participants lost 14 lbs on average

For the approval, the FDA reviewed a clinical trial of 326 obese patients aged from 22 to 60 whose BMI was in the range 30–40 kg/m² and who had at least one obesity-related condition.

The trial randomly assigned the patients to either have the Dual Balloon inserted, or to undergo an identical “dummy” endoscopic procedure but where the device was not fitted.

The results showed that at the end of 6 months, when the device was removed, the 187 patients who were fitted with the Dual Balloon on average lost 14.3 lbs (6.5 kg), equivalent to 6.8% of their body weight.

In contrast, the control group on average lost 7.2 lbs (3.3 kg, 3.3% of their body weight).

And 6 months after the device was removed, the group that had it fitted managed to keep off an average of 9.9 lbs (4.5 kg) of the 14.3 lbs they lost.

The insertion procedure may have side effects. These include muscle pain, nausea and headache. In rare instances, this may also lead to severe allergic reaction, tearing of the esophagus, infection, breathing problems and heart attack. Once the Dual Balloon is inserted, patients may also experience nausea, vomiting, feelings of indigestion, abdominal pain and stomach ulcers.

Patients who have had bariatric or other kinds of gastrointestinal surgery should not be fitted with the device, and neither should patients diagnosed with inflammatory intestinal or bowel disease, who have symptoms of delayed gastric emptying or active H. pylori infection, or who have a large hiatal hernia. Pregnant women and patients taking aspirin every day should also avoid it, the FDA advises.

Srinivas Seela, MD moved to Orlando, Florida after finishing his fellowship in Gastroenterology at Yale University School of Medicine, one of the finest programs in the country. During his training he spent a significant amount of time in basic and clinical research, and has published articles in Gastroenterology literature.

His interests include advanced and therapeutic endoscopic procedures, colorectal cancer screening, Gastro Esophageal Reflux Disease (GERD), metabolic and other liver disorders.

Dr. Seela is board certified in both Internal Medicine and Gastroenterology. He is a member of the American Gastroenterological Association (AGA), the American Society for Gastrointestinal Endoscopy (ASGE), the American Association for the Study of Liver Diseases (AASLD), and Crohn’s Colitis Foundation (CCF).

In addition to being an Assistant Professor at the University of Central Florida School of Medicine, he is also a teaching attending physician at both the Florida Hospital Internal Medicine Residency and Family Practice Residency (MD and DO) programs. Dr. Srinivas Seela is a gastroenterologist at Digestive and Liver Center of Florida. Contact information 407-384-7388.
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ZocDoc Case Study – Correcting Online Listing Information

By Jennifer Thompson

Having your office’s information correct online is vital to ensure your potential patients are able to find you and contact you to ultimately schedule an appointment. Our relationship with Review Concierge, a review management website, has allowed us to identify where our physicians are listed and whether the information is correct or not.

Many sites such as Vitals or RateMDs allow you to claim the listing in order to maintain control over your information at no charge. Some don’t allow you to claim them, but they do allow you to ‘suggest an edit’ that is usually live within a couple of days, also for free. Other sites like UCompareHealthcare don’t offer those features and would rather you email their customer service for individual changes and they are made from there (most of the time). We recently came across a physician’s listing that was incorrect on one of the larger reputation management sites, ZocDoc.com.

WHAT IS ZOCDOC?

ZocDoc was founded in 2007 and works to simplify the doctor-patient relationship by providing physician reviews and simple appointment requests. The website pulls over five million users each month.

THE PROBLEM WITH ZOCDOC

In this particular case, the address for one of our practices was incorrect. After identifying the error, we contacted ZocDoc’s customer service to request the address be changed. We were informed that ZocDoc pulls information automatically from the internet and that they were unable to correct it… unless we were to join their service. Wait…what? Now, we are sure they provide excellent service, however it seems absurd that ZocDoc would rather have incorrect information on their website than correct it, which would ultimately be providing even better service for ZocDoc’s existing users.

This is similar to some issues we’ve run into with Yelp. Yelp has primarily been known as a site to rate your favorite restaurants or nail salons, however recently there has been significant growth in physician and private practice reviews on the website. In fact, Yelp has become the number one site to review physicians according to a recent study from Software Advice. To claim your physician on Yelp it requires a phone call to the office and entering a simple code. However, the issue comes when you have multiple physicians or locations. Generally, Yelp will allow you to claim about 15 listings under one account before they offer a sales pitch to claim more, but we found a way around that. If you have multiple locations and multiple physicians, it’s easier to just create another account with Yelp to prevent being limited to owning your information.

Currently the fee for ZocDoc’s service is a one-year contract charging $250 to $300 each month with the promise of bringing you an additional 100 new patient each week, but when all you want is your address to be correct, holding the information hostage seems a bit outrageous don’t you think?

Since we were told that ZocDoc pulls their information from the internet, we asked where the information comes from so we could ensure that it was corrected at the source (this is nothing new, several reputations websites pull from big sites like Google or Yellowpages and if they are incorrect there, they can be incorrect on several websites).

Unfortunately the response we got was that they “are not able to distinguish which sources the information came from.” Wait…what? So basically they are sharing information that may or may not be correct and they have no idea where it comes from.

One of the best ways to help ensure your information is correct throughout the internet is to have it correct on the NPI Database. This is generally one of the main sources that review sites pull their information from. Doing this is no big deal for a single physician to do, however if you are managing multiple physicians it can be a nightmare to collect personal information, like social security numbers, necessary to update the NPI Database.

SOLUTION

In an effort to “not confuse any of your patients” we were offered for the page to be deleted or for us to join their service. Since we just wanted our address correct, we elected to have the listing removed.

Although they were unable to correct our issue, we would like to mention that the customer service was extremely friendly and polite. Credit where credit is due, after all.

WHAT NOW?

Unless your office is looking to join Zoc Doc’s service and can afford the added expense, the best option is to request that the incorrect listing be removed from the website.

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.
Hip dysplasia, a common cause of hip pain in adolescents and young adults, belongs in the differential diagnosis for patients presenting with unilateral or bilateral activity-limiting pain localizing to the hip, groin, buttock or knee. Clicking or snapping may be reported; locking may occur if the acetabular cartilage has torn. Hip dysplasia may be missed on radiographs if recently updated measurement criteria aren’t applied.

Nemours is proud to offer Periacetabular Osteotomy (PAO), a single-incision surgical procedure practiced by only a few orthopedic surgeons in Florida including Dr. Ryan Ilgenfritz. PAO gives adolescents with hip dysplasia the potential to return to unrestricted activity.

By improving acetabular alignment to correct for cartilage overloading in the dysplastic hip, PAO can improve a youth’s quality of life by:

- extending the life of the natural hip
- normalizing the anatomy and function of the natural hip
- delaying or avoiding prosthetic hip replacement
- removing or reducing activity restrictions
- increasing range of motion

PAO is appropriate for correction of hip dysplasia after pelvic growth is complete, which may be as early as age 10. Although an eight-week offloading period is required after PAO to facilitate bone growth and healing, a return to unrestricted activity is usually feasible within six months.

For questions about hip dysplasia, PAO or to refer a patient for evaluation, call (407) 650-7715 or visit Nemours.org/PatientReferrals.
Telemedicine, Women, and the Law

By J. Darin Stewart, JD and Erica G. Burns, JD

Telemedicine, also commonly referred to as telehealth or cybermedicine, is a highly sophisticated form of medical treatment providing state-of-the-art medical care to patients from a distance. Telemedicine consists of physician to physician or patient communication via electronic communications, such as two-way video, email, and smart phones. Telemedicine has been utilized by physicians since the early 1960s when NASA telemetered the physiological measurements of the astronauts from their spacecraft and space suits. Today, telemedicine is used in physician offices and hospitals nationwide, including Florida Hospital.

Women are currently receiving OBGYN telemedicine services resulting in more convenient and less expensive treatment. In Georgia, Women’s Telehealth provides virtual access to obstetric care for high-risk women. These women receive expert care without having to travel or be transferred to another facility. Another company, Maven, provides telemedicine to women through a mobile telephone application. Maven allows women to seek medical advice and treatment from the comfort of their homes.

While telemedicine for women is emerging, there are legal hurdles. Telemedicine physicians serving patients in multiple states must be licensed in each state, but many states impose policies making practicing across state lines difficult. Also, telemedicine could result in greater medical malpractice liability. Diagnosing patients without any face-to-face interaction could lead to malpractice liability if the diagnosis is inaccurate, the patient relies on that advice, and is harmed as a result.

Another legal hurdle involving both licensure and malpractice is the standard of care to which telemedicine physicians will be held, and to which standard physicians must adhere when licensed in multiple states with conflicting rules. For example, in Texas, a telemedicine physician is held to the same standard as physicians practicing in the presence of the patient, but a telemedicine physician in Hawaii is held to a lower standard.

Attempting to combat legal hurdles impeding telemedicine in Florida, last year, the Florida Board of Medicine enacted regulations governing telemedicine standards. Also, in 2015, the Florida Senate attempted, but failed, to pass its bill providing specific standards for telemedicine providers and authorizing providers to use telemedicine to prescribe controlled substances, among other things.

Although the Florida legislature has yet to enact laws regulating this field of medicine, we anticipate the alignment of the law and telemedicine to benefit women and others worldwide.

References available upon request.

J. Darin Stewart, J.D., CPA is a shareholder with GrayRobinson. He represents organizations, individuals, and individual medical providers whose needs include solutions to federal and state health care regulatory compliance issues, complex financing vehicles, establishing corporate structures through which to transact business enterprises, leasing issues, and numerous corporate law issues. Darin can be reached at 407-244-5639 or darin.stewart@gray-robinson.com.

Erica G. Burns, J.D. is an attorney with GrayRobinson and also a member of the health care and corporate practice groups. She represents medical facilities, providers, and corporate entities on federal and state statutory and regulatory compliance issues, contract review and analysis, and complex business transactions. She can be reached at 407-843-8880 or erica.burns@gray-robinson.com.
Patient Advocate

[pey-shuh nt ad-vuh-kit]

*Noun.* Osceola Regional defines this as a person dedicated to improving your health care visit by focusing on your needs, ensuring your and your family's voice is heard, and you are well informed.

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Minimally Invasive Lumbar Medial Branch Neurotomy Provides Low Back Pain Relief Without Surgery

By Corey Gehrold

After suffering from spinal trauma following a car accident, everyday activities like walking and even standing for more than a few minutes, became a struggle for Mark Begley. As an active biker and runner, he was concerned low back pain would prevent him from making a full recovery; but thanks to Orlando Orthopaedic Center’s Daniel M. Frohwein, M.D. and the minimally invasive lumbar medial branch neurotomy (also known as a “rhizotomy”) he performed, Mark is able to bike, run and exercise again without any pain.

Mark met with Dr. Frohwein, a board certified anesthesiologist with subspecialty certification in pain management, several times to develop a treatment plan that would help him return to his active lifestyle without pain. Dr. Frohwein proposed a minimally invasive lumbar medial branch neurotomy procedure after Mark successfully completed the test nerve blocks which predicted the procedure would be beneficial for him. “The minute I was done with the procedure, short of the pain from the actual procedure itself, I felt a difference,” says Mark. Four days later, he was back to work and able to continue the healing process pain-free.

WHAT IS A LUMBAR MEDIAL BRANCH NEUROTOMY?

The joints located at the back of the spine between the vertebrae are called facet joints, and their job is to prevent excessive or irregular motion. These joints are susceptible to damage or inflammation from normal wear and tear, osteoarthritis, spinal stenosis or, in Mark’s case, severe trauma caused by an accident.

The nerves connecting these joints to the brain are called the medial branch nerves. A medial branch neurotomy is used to “disconnect” the nerves from sending pain signals to the brain and provide a long term treatment for relief of facet joint pain.

During the procedure, patients will be positioned lying face down while the injection site is numbed. The physician will use a fluoroscope, or live x-ray image to visualize the spine and pinpoint the location of the affected nerves. The entire procedure is performed through a needle placed along the nerves, which run along the outside of the vertebrae. A small electrical current is used to stimulate sensations in the nerves to ensure the accuracy of the procedure. Next, the targeted nerves are numbed and a radiofrequency pulse is used to heat the tissue around the tip of the needle, creating a heat lesion on the nerve to stop the transmission of pain signals to the brain.

Dr. Frohwein explains, “Facet joint pain is a significant cause of low back pain in many individuals. It is not a diagnosis that is usually demonstrated on MRI’s or X-rays of the spine. It requires listening carefully to a patient’s symptoms of low back pain, as well as a physical examination. The test nerve blocks then provide further confirmatory information that the facet joints are the primary cause of low back pain. A lumbar medial branch neurotomy removes the obstacle of pain and can allow patients to focus their efforts on further functional restoration techniques, such as physical therapy, for a long-term solution.”

In most cases, the entire procedure only lasts about an hour and the patient can return home the same day. The effects of a lumbar medial branch neurotomy can last nine months to two years, allowing patients to introduce additional recovery techniques such as anti-inflammatory medication and physical therapy to create a healing environment for the facet joints without additional discomfort.

“In Mark’s case,” says Dr. Frohwein, “the trauma of the car accident caused damage to multiple facet joints requiring a lumbar medial branch neurotomy. We were able to help him move and exercise again without pain, ultimately returning to the active lifestyle that he loves.”

RESULTS AND RECOVERY AFTER A LUMBAR MEDIAL BRANCH NEUROTOMY

A majority of patients report significant pain relief and improved mobility following the procedure and can usually begin taking additional recovery steps within three to five days.

For Mark the biggest benefit was being able to stand and walk again pain-free. “[It’s] just very simple things that a lot of people take for granted,” Mark recalls. As an extremely active runner and biker, Mark was finally able to return to the active hobbies he enjoys.

Mark was particularly grateful for the relationship he built with Dr. Frohwein throughout the healing process. “He’s one of the smartest people I’ve ever met in my life,” says Mark. “He cares about the patient. He wants to make sure that what he’s doing is right. I know he has my best interest at heart.”

Being able to simply stand and walk pain-free are just the beginning. Thanks to Dr. Frohwein, Mark can now return to work, bike and run just as he could before the accident. For Mark, there’s one word he uses to describe the results: “Unbelievable.”

COMING UP NEXT MONTH: The cover story focuses on pancreatic surgery available at UF Health Cancer Center – Orlando Health. Editorial focuses on Digestive Disorders and Diabetes.
What Every Patient Needs to Know – For the Health of Their Pocket

An Open Letter From Independent Doctors

By Marni Jameson

Educating patients about the importance of going to an independent doctor is key to keeping America’s health-care costs down. It is also essential to keeping our doctors independent. At the Association of Independent Doctors, we think a great place to start that education is right in the doctor’s office.

Hospitals spend hundreds of thousands of dollars each year marketing directly to patients, whom they then direct to employed doctors. To compete in this market, independent doctors need to tell consumers about the benefits of seeing a doctor who is not financially aligned with the hospital.

If you are an independent doctor, we encourage you to include a version of the following “Open Letter to Patients” in all your new patient packets, on your website, and in any correspondence you have with existing patients. Personalize it as you like, but do spread the word.

DEAR PATIENT:

Congratulations on choosing an independent doctor for your care. Seeing an independent doctor – rather than a doctor employed by a hospital – is one of the very best ways you can lower your medical costs and help your community.

Here’s why:

When you see a doctor employed by a hospital, the hospital bills for that doctor’s services at hospital rates. Those rates are much higher than what independent doctors charge. Plus, the hospital tacks on what’s called a “facility fee,” a fee that adds absolutely no value, but that hospitals have negotiated to help cover their overhead. This can increase your cost by three to four times.

What’s more, hospital-employed doctors answer to administrators. Independent doctors remain free of those conflicts. In our practice, our focus remains on you.

The same holds true for centers that provide services like outpatient surgery or imaging (MRIs, CT Scans, X-rays, and mammography). Going to an independent surgery or imaging center will cost you less, sometimes one-fourth the price, of going to one owned by a hospital. This is why we do our best to refer you only to free-standing, independent facilities.

Many studies that have looked at the impact of hospitals acquiring independent doctors’ practices and independent facilities have found that these mergers drive up health-care costs dramatically. Everyone pays. Patients pay more out of pocket. Workers pay higher premiums, and more of our taxpayer dollars have to go into programs like Medicare and Medicaid.

Finally, independent practices are small businesses that support their communities by providing jobs and paying taxes. When hospitals acquire these private practices, office workers lose jobs. If the acquiring hospital happens to be a nonprofit, the taxes the practice used to pay into the community go away, because nonprofit hospitals don’t pay taxes.

Most citizens know that nonprofit hospitals don’t pay income tax, but many don’t realize they are also exempt from property and sales taxes.

Unfortunately, figuring out which doctors or outpatient facilities are independently owned and which ones aren’t can be tricky. You have to ask. Often, when a hospital acquires a doctor’s practice, nothing else changes in the office – but your bill.

But rest assured, you’ve chosen wisely. Please make sure your loved ones do, too.

Sincerely,

Your Independent Doctor

One way to help patients find an independent doctor near them is to direct them to AID’s online directory of more than 500 independent doctors in every specialty www.aid-us.org/directory. It’s a healthy choice.

Marni Jameson is the executive director of the Association of Independent Doctors. You may reach her at marni@aid-us.org.

Be sure and check out our website at www.floridamd.com!
Caring for Your Mother as She Matures

By Scott Thomas

COULD YOU APPRECIATE THE NEARLY FREE USE OF $1,840,000?

Is your mother the surviving spouse of a wartime veteran with medical needs such as home healthcare, assisted living, or nursing costs? She may be eligible for access to a resource equal to the “use” of $1,840,000. Maybe your mother has called the Department of Veterans Affairs and was told she is “not qualified” due to assets or income. Question: would you send your mother to talk to the Internal Revenue Service without proper forms and help? Of course not, so why simply trust a voice on the other end of the phone in calling the VA? Especially since a report by a syndicated columnist wrote in 2005, only “nineteen percent of the [VA’s] answers were “completely correct.”

HOW DID WE ARRIVE AT $1,840,000 FIGURE?

Let’s assume in 2015, the rate on Bank CD is 1%. Let’s also assume your mother is in a 25% tax bracket.

$1,840,000 X 1% = $18,400 interest for the year less 25% taxes ($4,600 tax) leaving a net income of $13,800 for the year.

Currently the Improved Pension award from the Veterans Affairs program for a surviving spouse provides $13,788 tax-free benefit in a year. This benefit is indexed over time to help offset effects of inflation.

According to research in an article by Knight Ridder Washington Bureau syndicated columnist, Chris Adams, nearly 2 million veterans and their surviving spouses are missing out on as much as $22 billion a year in pension. The stated reason is that the VA doesn’t know where to find these people! Do you know where your mom is now and would you like to learn more on this subject? One resource is found at the site www.ltc4vets.org a national educational website committed to helping the families of veterans and their surviving spouses get information and get their improved pension benefits.

Very few financial advisors are going to venture into VA Benefits education or sift through the 1500+ page VA manual. So what can be done to secure a surviving spouse benefit that is equivalent to the use of nearly $2 million dollars? There are a few test items or qualifications that must be passed. 1) Was the veteran serving at least 1 day during war time period? 2) Did they serve at least 90 days and receive an honorable discharge? 3) Would a doctor say that they need healthcare help?

What if the IRS owed you a significant refund and you used the wrong form to request it and they told you, “too bad you have to wait at least another 12 months or longer in order to request your money again?” Well that is the way the VA operates on benefit requests. Get it incorrect and you will be forced to wait. By the way, you are not earning money while you are waiting and you are not getting a retroactive claim to your initial request. Sounds rough? It can be if you attempt to make a claim on your own.

What a joy it is to help a family member help their parent obtain a benefit they knew nothing about and had earned from their past service. This is NOT a welfare program and this is NOT about buying Long-Term Care Insurance. This process requires several forms and it is complex to navigate the VA forms. One key factor to being successful in obtaining the benefits is to use a highly experienced team with an accredited VA attorney to be your advocate and get you real benefits.

If you would like to have a conversation on helping your mom or dad get their benefits then contact Scott Thomas at 888-504-9908 or SThomas@ltc4vets.org.
Understanding the Legality of Involuntary Hospital Commitment

By Sajid Hafeez, MD

Unlike many medical fields, mental health has perhaps the strangest relationship with its patients in that it frequently administers services to patients who many times do not desire them. This prospect is something that can be quite disconcerting to the patients and their loved ones. This is also something that may not be completely understood by the practitioners of other medical disciplines. So to those ends, it’s helpful to have an understanding of the true nature of involuntary commitment, the legality of it, and what it means to the patient and practitioner.

Most states have allowed for a legality of sorts that allows for trained individuals to act in what they feel is in the best interest of a person who is not of sound mind. In Florida, the ruling law of this is the Baker Act, the common name for the Florida Mental Health Act of 1971. The Act allows for the immediate detainment of any individual who is deemed to be of imminent risk of harm to self or others and is deemed mentally incompetent.

Frequently, at-risk individuals are identified by police officers responding to calls who are trained to identify key criteria and transport the individual in question to the nearest Baker Act receiving facility to be assessed by a doctor. The law also allows for a physician, clinical social worker, mental health counselor, marriage and family therapist, or psychiatric nurse with a master’s degree to Baker Act anyone that the feel meets the criteria. Once a person is “Baker Acted,” so long as that patient is cleared as medically stable by a hospital, a person may be held involuntarily for 72 hours. (Similarly, a judge may order an ex-parte wherein a family may beseech the court to file involuntary commitment based on testimony without the person in question present—hence the term Ex Parte, which means “derived from the party” in Latin. The only difference between this and the Baker Act is that an Ex Parte allows for a person to be held involuntarily for 7 days.)

What confuses most is what happens once a patient is transferred to a psychiatric hospital before the allowed time period has expired. Under the law, a psychiatrist must examine this patient within 24 hours of arrival to the facility. The doctor then has the remaining time left in the Baker Act or Ex Parte to rule the patient as competent or incompetent. If the patient is found competent, he or she is given the opportunity to be transitioned to a Voluntary admission to the hospital where he or she is able to receive doctor recommended treatment until the doctor feels

Continued on page 22
that the patient has reached maximum benefit from acute inpatient hospitalization and is stable enough to proceed to a step down into outpatient care. Or, if a patient (or parent) decides that he or she has no desire to pursue stabilization, that patient (or parent) may elect to discharge from the hospital. However, if the doctor feels the patient is competent, but still in need of inpatient care, the discharge may be against medical advice (AMA), which is a way for the doctor who protect himself from liability should the patient relapse.

However, if by the end of the allowed involuntary time period the doctor feels that the patient is not of sound mind and unable to make competent decisions, the doctor may initiate what is referred to as a “32.” This is a petition to extend the involuntary commitment. When the petition is initiated, the allotted time period freezes. During this time, a second doctor is contacted to do an independent assessment. If the second doctor reaches the same conclusion that the person is not mentally competent, the petition is forwarded to the local court, which will arrange a hearing with a judge. At this hearing the doctor, patient, and or parents are given an opportunity to testify before the judge. If the judge believes the doctor's assessment is correct, he will extend the length of time that a patient can be involuntarily held at the suggestion of the doctor with the intention to provide treatment for stabilization. At this time, if the patient lacks a parent or proxy to act as the decision maker in the best interest of the patient, the court will initiate the process to provide a guardian ad litem decision maker. (This is necessary, as a person who is deemed to be incompetent cannot consent to treatment or medications and requires a proxy to act on his or her behalf.)

To those new to it, involuntary commitment can seem to be an overwhelming concept mired in a mire of uncertain legality. In reality, at its heart, it is a fairly straightforward set of rules developed to protect those whose unstable mental status leaves them vulnerable to a world that they are not, unfortunately, sound enough to understand. These laws provide the opportunity for the professionals to work toward returning these patients back to a place in life where they can once again make rational, thoughtful choices and work to improve the quality of their life.

Sajid Hafeez, M.D., is a child and adolescent psychiatrist who is serving as a Medical Director of the Acute Care Baker Act Unit at the University Behavioral Center. He also served as the Center's Medical Director of the long term Residential Units: ASAPP Unit (for adolescent boys with inappropriate sexual behaviors), Solutions Unit (for adolescent boys with behavior problems), Promises and Stars Unit (for adolescent females with behavioral problems as well as victims of sexual abuse), and Discovery Unit (for children ages 5-13 with behavioral as well as inappropriate sexual problems). In addition, Dr. Hafeez also served as an Assistant Professor of Psychiatry at the University of Central Florida (Voluntary Position). He was also the Chief of the Adolescent Psychiatry Unit, an Attending Psychiatrist of the Comprehensive Psychiatry Emergency Program and of the Mobile Crisis Team at the Westchester Medical College. At Vassar Brother's Medical Center in New York. Dr. Hafeez was the Director of Outpatient Child & Adolescent and Adult Psychiatric Clinic as well as Director of Consultation and Liaison Psychiatry. Dr. Hafeez received his adult Psychiatry and Residency Training at the University of Kansas Medical Center in Kansas City. He received his Child and Adolescent Psychiatry fellowship training at the New York Medical College New York and at Children's National Medical Center of George Washington University in Washington, D.C. Dr. Hafeez can be reached at 407-281-7000 or by visiting www.universitybehavioral.com.
Telehealth Technology Expands Nemours Care for Florida Kids

By Shayan Vyas, MD, Medical Director, Telehealth, Nemours Florida

This past October, we expanded our Nemours CareConnect telehealth system to include online doctor visits for children who live in the state of Florida. Over the past year, Nemours has used telehealth technology for video consultations in partnering Emergency Departments and NICUs in the Central Florida as well as the Pensacola region — including Heart of Florida Regional Medical Center in Haines City, Indian River Medical Center in Vero Beach, Parrish Medical Center in Titusville and Wuesthoff Regional Medical Center in Rockledge.

These video consultations have delivered Nemours’ pediatric expertise right where it was needed, and patients have been grateful for the added layer of pediatric specialty expertise without the need for additional travel.

Every day, Nemours CareConnect helps us help kids in our community and beyond. Families who have experienced Nemours telehealth services in the hospital setting have found the quick, definitive subspecialty opinions to be a great emotional relief.

The expansion of Nemours CareConnect to include patient-initiated visits meets the needs of some Florida families who would otherwise go to an urgent care center or Emergency Department (ED). Nemours CareConnect is particularly appealing to those who live far from these care options, and even farther from providers who specialize in treating children.

Nemours CareConnect is a pioneering effort, and we’re working to encourage family-friendly insurance and legislative support for wider accessibility for this innovative health care resource. Telehealth may be new to patients and some physicians, but it’s well established in some areas and health care organizations. Nemours CareConnect Children’s Care is HIPAA-compliant and available for camera-equipped smartphones, tablets and desktop/laptop computers. There’s no audio or visual recording of the visit, but the family can upload photos if needed. The provider records a medical note of the visit, just as is done in an in-person visit – which will be provided to the family and the patient’s pcp.

Florida Medicaid and insurance companies don’t currently pay for telehealth appointments, and because of state licensing issues, we can only accept intrastate appointments. As a result, we are using a self-pay model for patient-initiated visits from families who reside in Florida.

WHAT PATIENTS CAN EXPECT

A parent or caregiver who needs medical care for a sick child — or who wants professional medical advice for a well-child issue — can use Nemours CareConnect at any time, even if the child is not a patient of record at Nemours. To use the service, the child registers at the website or the Nemours CareConnect app after it’s downloaded. After a flat fee is paid, the child enters a virtual waiting room until one of our providers can come online with them — usually under three minutes. The provider will review basic health information and the reason for the visit, talk with the caregiver and child, get a look at the child and review appropriate details, then make an assessment. Families will get a receipt of the telemedicine visit — which can be presented to their insurance company for possible reimbursement.

For patients in rural areas or those for whom time or transportation is a challenge, telehealth provides a valuable alternative. Most telehealth visits include about the same amount of face-to-face time with the provider that one would have in an office visit. Since Nemours CareConnect appointments are fee-for-service, the patient determines whether the almost-instant appointment availability, convenience, time savings and elimination of transportation challenges constitutes a good value.

THE PHYSICIAN SIDE OF TELEHEALTH

Nemours CareConnect provides some big advantages to the patient, but it’s definitely a win for the provider too. If the patient has been seen at Nemours before, then the whole EHR is available for the provider’s review prior to the face-to-face part of the visit. The Nemours CareConnect system can prompt the provider with EHR-based reminders, like a scheduled lab test that hasn’t been completed. Most physicians favor video communication over other alternatives, such as telephone or email, for diagnostic accuracy. In a 2015 survey of physicians, 69 percent selected video communication as the medium most likely to provide an accurate diagnosis.

At the conclusion of the visit, if no further evaluation is necessary, the clinician can prescribe a treatment, including medicine when warranted. The app uses the geo-location service in the caller’s device to find the closest pharmacy, sends the prescription and records it in the EHR. There will be no compromise on standard of care with Nemours CareConnect, so if a test — like a throat culture — is indicated before prescribing antibiotics, or the reason for the visit is something that can’t be managed remotely, the provider can assist the patient in selecting an urgent care or ED facility. If the reason for the call is more appropriately handled by 911 emergency services, the provider will assist the caller in getting help — our goal is always the best care for the patient.

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After the Nemours CareConnect provider has arranged for appropriate disposition or referral, the visit concludes with a plan for resumption of care at the patient’s medical home and transmittal of a care summary to the primary care provider.

**TELEHEALTH HAS A BRIGHT FUTURE**

We have many patients who travel hundreds of miles for follow-up appointments, and soon we’ll expand Nemours CareConnect to allow follow-up patients to check in by video, speak to their familiar provider(s) and get the same top-notch care they would had they visited in person. The time and cost savings for patients will be enormous.

Nemours CareConnect won’t ever replace in-person visits when a hands-on exam is best, but for appointments requiring only a conversation and limited imagery, it provides an alternative some patients prefer. We’ll soon have Nemours CareConnect appointments for routine and post-operative follow-ups, behavioral health, prescription refills and many more.

If you would like to have a conversation on helping your mom or dad get their benefits then contact Scott Thomas at 888-504-9908 or SThomas@ltc4vets.org.

**COMING UP NEXT MONTH:**

The cover story focuses on pancreatic surgery available at UF Health Cancer Center – Orlando Health. Editorial focuses on Digestive Disorders and Diabetes.

Be sure and check out our website at www.floridamd.com!
Florida MD is a four-color monthly medical/business magazine for physicians in the Central Florida market.

Florida MD goes to physicians at their offices, in the thirteen-county area of Orange, Seminole, Volusia, Osceola, Polk, Flagler, Lake, Marion, Sumter, Hardee, Highlands, Hillsborough and Pasco counties. Cover stories spotlight extraordinary physicians affiliated with local clinics and hospitals. Special feature stories focus on new hospital programs or facilities, and other professional and healthcare related business topics. Local physician specialists and other professionals, affiliated with local businesses and organizations, write all other columns or articles about their respective specialty or profession. This local informative and interesting format is the main reason physicians take the time to read Florida MD.

It is hard to be aware of everything happening in the rapidly changing medical profession and doctors want to know more about new medical developments and technology, procedures, techniques, case studies, research, etc. in the different specialties. Especially when the information comes from a local physician specialist who they can call and discuss the column with or refer a patient. They also want to read about wealth management, financial issues, healthcare law, insurance issues and real estate opportunities. Again, they prefer it when that information comes from a local professional they can call and do business with. All advertisers have the opportunity to have a column or article related to their specialty or profession.

2016 Editorial Calendar

JANUARY – Digestive Disorders
Diabetes

FEBRUARY – Cardiology
Heart Disease & Stroke

MARCH – Orthopaedics
Men’s Health

APRIL – Surgery
Scoliosis

MAY – Women’s Health
Advances in Cosmetic Surgery

JUNE – Allergies
Pulmonary & Sleep Disorders

JULY – Imaging Technologies
Interventional Radiology

AUGUST – Sports Medicine
Robotic Surgery

SEPTEMBER – Pediatrics & Advances in NICU’s
Autism

OCTOBER – Cancer
Dermatology

NOVEMBER – Urology
Geriatric Medicine / Glaucoma

DECEMBER – Pain Management
Occupational Therapy

Please call 407.417.7400 for additional materials or information.
Women are special. That's why we've created a comprehensive network of care specializing in women's unique healthcare needs, including a constellation of community hospitals, extended-care services and the new Florida Hospital for Women in Orlando. It's special care for special people. Because women are one of the reasons \textbf{LIFE is AMAZING}.