

FloridaMD

JANUARY 2018 • COVERING THE I-4 CORRIDOR



Central Florida Inpatient Medicine

*Hospitalists Shifting
the Paradigm to Meet
Patients Needs*

Specialists You Trust

Urology



Justin Emtage, MD

Dr. Emtage is a board-certified urologist with interests in innovative treatments for advanced prostate cancer and other genitourinary diseases. A co-investigator for multiple clinical trials, he stays abreast of the most advanced urological treatments and diagnostic methods through ongoing research. An honors graduate of Boston University School of Medicine, Dr. Emtage went on to complete an advanced fellowship in urologic oncology and robotic surgery at City of Hope National Medical Center in California.

Specialties

- Robotic prostatectomy
- Urinary incontinence
- Enlarged prostate (BPH)
- Vasectomy
- Nephrectomy - partial and radical
- Voiding disorders
- Prostate, kidney and bladder cancer



Eduardo Hernandez, MD

Dr. Hernandez is a urologist with interests in prostate cancer, its early detection and treatment protocols, robotic prostatectomy and robotic-assisted partial nephrectomy. Recognized for academic and clinical excellence at the Ponce School of Medicine in Puerto Rico, he went on to complete an advanced robotic urology fellowship as part of one of the world's top robotics programs at the Global Robotics Institute at Florida Hospital Celebration Health.

Specialties

- Robotic prostatectomy
- Vasectomy
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- Urinary incontinence

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JANUARY 2018

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I am pleased to bring you another issue of *Florida MD* and I hope your new year is happy, healthy and prosperous.

The emotional and physical trials and tribulations of parents and families with a child who is mentally and/or physical disabled. Where can they go and who can help them and their child? Since 1955 UCP of Central Florida has offered support, therapy and education for thousands of children with a wide range of disabilities. They continue to grow and provide much needed services. Please join me in supporting this wonderful organization.

Best regards,



Donald B. Rauhofer
Publisher



UCP OF CENTRAL FLORIDA

UCP of Central Florida is a not-for-profit charter school and pediatric therapy center providing support, education and therapy services for children, with and without disabilities, ages birth through 21. More than 3,000 children and their families receive services annually. There are seven campuses located throughout Central Florida in three counties – Orange, Osceola and Seminole.

The charter schools serve students of all abilities including children with cerebral palsy, Down syndrome, autism, spina bifida, speech delays, visual impairments and other developmental delays. UCP now embraces an inclusion education model allowing all children – with and without disabilities – to learn, grow and excel together in the same setting. Research illustrates that inclusion education strengthens socialization skills, test scores and acceptance of others for both students with and without special needs.

For more information, go to www.ucpcf.org.

COMING NEXT MONTH: The cover story focuses on HealthSouth Hospital in Altamonte Springs. Editorial focus is on Cardiology, Heart Disease and Stroke.

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STILL WAITING TO GO DIGITAL?

Points to Consider!

By Jeff Holt, CMPE, VP, Senior Healthcare Business Banker with PNC Bank



As you move toward transforming your medical or dental practice from paper to electronic health records (EHR), chances are you can think of plenty of reasons not to do so:

- Paper records are how you've always done it — why rock the boat?
- You can barely keep up with your patient load, let alone devote time to fundamental process changes.
- Your staff may resist.
- Who needs the expense?

Compelling objections? Maybe. But holdouts raised similar objections to the typewriter, telephone, personal computer and virtually every major development in history. With the medical/dental world moving inexorably to EHR, converting your practice may be about when, not if. Get ahead of the trend to stay competitive and potentially reap results that are helpful to you — and your patients.

CONTAINING COSTS

There are undeniable hardware and software costs associated with switching to digital, not to mention the time costs of learning new systems. However, adhering to traditional practices also comes with expenses that add up over time — from printers and ink to paper forms and mailing costs.[1]

When it comes to counting costs related to time spent learning the technology, remember that, once you and your staff get up to speed on the new processes, you may find yourselves among the 79% of providers who, according to the U.S. Department of Health and Human Services, say their practices are more efficient thanks to EHR.[2] Additionally, 75% of providers say they receive lab results faster, and 82% say sending prescriptions electronically is more efficient.

Meanwhile, the government is adding its own cost incentives to switch: By 2018, Medicare will reduce physician reimbursements by 4% for records not submitted electronically, up from 1% in 2015.[3]

IMPROVING CARE

The most compelling reason for adopting EHR may be the opportunity to provide better service and care for your patients. Electronic records can:

- Improve accuracy
- Enable you to provide the best care, whether for routine visits or emergency situations
- Help clinicians seamlessly share information, such as alerts about patient allergies and other data vital to prescription accuracy[4]

Patients are also likely to appreciate having the ability to schedule appointments electronically. In addition, patients are becoming more proactive in their own care by establishing electronic personal health records (PHR). Your ability to provide information digitally can help them maintain the PHR and keep them up to date.[5]

The advantages of EHR may outweigh the comfort of older methods. Making the leap could position your practice for the future.

Still not sure what decision to make? Contact me directly and I can offer you some options for those who may be able to assist you in making the right choices.

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Central Florida Inpatient Medicine

Hospitalists Shifting the Paradigm to Meet Patients Needs

By Katie Dagenais

In the past decade the role of hospitalists has evolved, from a role once focused on working with patients solely in inpatient facilities to the role of integrated caregiver in multiple locations helping patients to transition from one location to the next and navigate today's healthcare landscape. Today, the 135 providers of Central Florida Inpatient Medicine (CFIM) work with primary care physicians, hospitals, acute care facilities and skilled nursing facilities to ensure that patient care is coordinated with a single point of contact. Utilizing the latest in technology to streamline care, CFIM is at the forefront of shifting the hospitalist paradigm. Focused on collaboration, they strive to provide the best quality care for patients in an ever-changing healthcare world. The fastest growing specialty in the country, hospitalists are changing the way care is delivered throughout the country. At CFIM, currently based in nine hospitals and over 45 post-acute centers across three different hospital systems in Central Florida, shifting the paradigm isn't a cliché, it's a new approach to hospital medicine that is changing patient care to meet ongoing needs in a variety of environments.

Founded in 2001, CFIM is the largest private Hospitalist, SN-Fist and Transitional Care group in the state of Florida. Their hospitalist services are provided at more than 8 area hospitals in Central Florida and their skilled nursing program takes place in more than 45 post-acute facilities. Last year alone, CFIM practi-

tioners managed more than 75,000 discharges and annually they tally 300,000 patient encounters.

Prior to the introduction of the Affordable Care Act healthcare was being practiced in various silos. The Hospitals and Skilled nursing facilities had laser like focus on what was happening with their patients within the four walls of the institution. As Value Based Care was introduced through the ACA, the focus shifted more toward quality rather than quantity. New terminologies in medicine such as Transition Care and Integrated Care came to the forefront. Each institution and the healthcare providers in those institutions were responsible for the quality of care provided not only during that stay but also needed to ensure the healthcare needs of its patients were going to be met until they could transition safely back to the community.

With the rise in increasing number of physician groups who were responsible not only clinically but also financially for delivering healthcare to their patients, the preexisting silos had to be taken down. Hospitalist seemed to be the missing part in bridging the information and clinical gap in the community. CFIM set out on a mission to create an organization that could help fill in the gaps.

"When the Affordable Care Act started focusing on quality rather than quantity, healthcare was in a silo. The focus was on hospitals and not beyond those four walls," explains Krishan

Left front: Keyur Gohel, Corissa Archer, Lilian Alevato, MD, Kathleen Miller, Center: Krishan Nagda, MD Right front: Dixita Amin, Damona Emami, Brad Whitney, Michelle Pribble, Miriam Gallardo, Miriam Luker. The diverse team at CFIM hold meetings regularly to discuss initiatives revolving around Value Based Care.



PHOTO: DONALD RAUHOFFER / FLORIDA MD

Nagda, M.D., President and CEO of CFIM. “One of the big shifts is that now each provider is responsible for patients outside of that setting. It is our responsibility as hospitalists that for the next 30 days the patient has the tools that will help them stay at home and not return to the hospital. Our group plays a critical role in creating an integrated delivery model which includes everything from inpatient services to home health services to hospice services. Patients can’t do it alone and we are their navigators.”

VALUE BASED CARE LANDSCAPE

Central Florida Inpatient Medicine has been actively observing the landscape in healthcare as it continues to evolve and create different programs from Accountable Care Organizations (ACOs), Managed Service Organizations (MSOs) to Bundled Payment Models. With this shift in care, CFIM has added experts in each of these fields to their team. The Chief Quality Officer for CFIM, Cardiologist Dr. Lillian Alevato’s role is to coordinate the whole circle of care as she comes from a group who were trailblazers in the Florida MSO world. Dr. Alevato is knowledgeable from the Primary Care arm and understands the importance of population health management strategies by bridging the gap between PCP and Hospitalist.

“We are the acute and post-acute providers with a transition of care component. The primary care physician (PCP) cannot be everywhere, so as Hospitalists and SNFists we can coordinate patient care in an optimal way as an extension of the PCP. We are not operating in isolation and always keep our lines of communication open with the patient’s PCP and Specialists. Our goal is to keep the patient in the same circle of providers to increase quality of care.”

Value Based Care has also increased the exchange of big data analytics to provide support for clinical decisions. CFIM has created technology allowing partners to follow their patients throughout their continuum of care while capturing the data to optimize care and increase communication. Keyur Gohel, Director of Network Development is responsible for managing and interpreting data at a rapid pace to identify any trends which can contribute to Central Florida Inpatient Medicine’s commitment of where quality meet care. “The patient is at the top of everything we do,” explains Keyur Gohel, Director of Network Development. “Our focus is that everything related to a patient’s care needs to be driven clinically by utilizing data appropriately. That’s where we work to do the right thing for the patient. It’s all about collaboration with other healthcare providers and sharing data. Our goal is to make sure all parties are on the same page coordinating patient care.”

The coordination often begins inside the hospital, then continues after discharge.

“When a PCP hands off a patient to our practitioners we coordinate that care and continue to monitor that patient. We do



PHOTO: DONALD RAUHOFFER / FLORIDA MD

Left to Right: Lilian Alevato, MD, Krishan Nagda, MD, Keyur Gohe, Dr. Nagda reviewing patient outcomes and trends with CFIM’s Value Based Care team.

a lot of coordination with the PCP office,” says Dr. Nagda. “A patient is with a PCP their whole life, they are with us sometimes just five days. We want to ensure they feel comfortable and we do that by providing a trusted voice. A voice that can help them navigate through the hospital, their PCP, their specialist and their health plan.”

That single point of contact is a new shift for health care that CFIM makes sure their patients have, every step of the way.

“The Affordable Care Act has changed the way healthcare is delivered,” explains Dr. Nagda. “For patients, having that single person who can be there for them for the next 30 days, that is a shift that hasn’t been there before. If you look back at the way things used to be done, providers operated in silos. The primary care physician rarely knew what happened in the emergency room or the nursing home. We are in a key position to be the bridge and that single point for patients to call. It’s our role that

CFIM’s I-med mobile application healthcare partners can access at their fingertips.



PHOTO: DONALD RAUHOFFER / FLORIDA MD

when patients make that call, we know what is happening with the patient's care and we can take action. Everything is being refined to have a short and long term positive impact for the patient."

CONNECTING PATIENTS - CARE CONNECT

One of the tools CFIM uses to keep that connection with patients is their Care Connect program. The telephonic, clinical outreach program is staffed by experienced registered nurse navigators. The nurse navigators offer clinical guidance and education, ensuring patients have a smooth and successful transition, often from the hospital to home. This program weaves in the Primary Care Physician to provide optimal care for those who may be at high risk of returning to the hospital.

Helping patients is three-fold explains Dr. Nagda.

"From post discharge follow up, to medications, to providing a single health care point provider, we work with patients to help them heal in the best environment possible and avoid readmissions."

CFIM's Care Connect Program provides patients with unprecedented individualized care, tailored to the patient's specific needs. For patients who either can't schedule a follow up with their PCP, or don't have a PCP, Care Connect offers an at home option. Appointments with a CFIM practitioner are scheduled in real-time for an in home physician visit within 7 days.

At the first Care Connect provider visit a full in-person medication reconciliation is completed to ensure the proper medications and dosage are being taken. Nurse navigators also work to ensure that ancillary services are met, such as home health and durable medical equipment needs that may arise.

I-MED THE GAME CHANGER

CFIM tracks and coordinates care through I-Med, their proprietary technology that helps to drive operational, clinical and financial benefits. This is a successful tool which increases physician to physician engagement to keep patient care front and center.



Left to Right: Miriam Luker, Krishan Nagda, MD, Brad Whitney Dr. Nagda reviewing the I-med portal dashboard with IT and the Director of Post-Acute Operations.

PHOTO: DONALD RAUHOFFER / FLORIDA MD

The platform is called I-Med," explains Dr. Nagda. "It's a big differentiator in communication. We customized this because each entity looks at things differently. The I-Med software allows sharing of the same data from different view points, so we can start to make decisions about where care is being provided and bridge a patient's transition from pre-hospital, to hospital and back home. We are excited about the ability these tools are giving us to standardize our communication and share information between different providers and different hospital systems."

Streamlining patient care is one of CFIM's differentiators and also one of their continued challenges for the future.

"One of our goals is to obtain more information about the patient when they are hospitalized," says Dr. Alevato. "There are a lot of complications and at times a delay of care because providers do not always have full access to a patient's health record, which is important if they have not consistently seen a PCP. Our objective is to ensure we have full access to things such as X-rays and post acute records to optimize care."

The next evolution of hospitalist medicine will rely on continued engagement according to Dr. Nagda. "I think that the message is hospitalists have been very positive but the experience hasn't been standardized for everybody. Some communication issues will exist, the exciting part is that with integration of technology those issues can improve. For example, we try to call doctors but PCP's have a very busy practice. They need information at their fingertips when they have the time to access it. We need to not just push information but allow the PCP to pull information when they have time."

"The evolution of hospitalist medicine depends on how the hospitalist will continue to be part of the community and integrated care rather than a siloed piece," Dr. Nagda adds. "We want and need to be engaged with the PCP's and the care on both sides. Ultimately this sharing of the information will drive down costs and improve quality and care for patients. This is the next evolution of hospital medicine." ■




Overview

- ✓ Founded in 2001
- ✓ CFIM is the largest private Hospitalist, Shift & Transitional Care group in the State of Florida
- ✓ More than 135 licensed providers
- ✓ Hospitalist services provided at 10+ area hospitals
- ✓ Skilled Nursing Program in more than 45 facilities
- ✓ Managed more than 75,000 discharges in 2016
- ✓ CFIM has over 300,000 patient encounters per year
- ✓ Proprietary software solution to improve communications with all care lines and market partners
- ✓ Sharp focus on identifying opportunities within the market
- ✓ Poised for growth

Bilateral Elbow Replacement Saves Orlando Resident from Chronic Rheumatoid Arthritis Pain

By Corey Gehrold

Hindered by chronic excruciating pain in her elbows, Miriam couldn't accomplish even the simplest of household tasks, let alone lift her arms over her head. Tired of always being in pain or limited in what she could do in her day-to-day life, Miriam turned to Michael D. Riggenschach, M.D., a board-certified orthopaedic surgeon at Orlando Orthopaedic Center specializing in hand and upper extremity surgery, peripheral nerve surgery, and microsurgery.

After attempting to treat her discomfort conservatively and discussing all available treatment options, Dr. Riggenschach and Miriam decided elbow replacement was the best way to provide long lasting pain relief from rheumatoid arthritis.

"I had an elbow replacement first performed here on my right elbow two years ago," says Miriam. "Today, since the left elbow surgery performed eight months ago, I'm a lot stronger with both elbows. I'm extremely grateful for Dr. Riggenschach and his team."

TOTAL ELBOW REPLACEMENT FOR RHEUMATOID ARTHRITIS

Rheumatoid arthritis (RA) is an autoimmune illness where the immune system wrongly assaults the lining of the joints (synovium), causing chronic inflammation, discomfort and dysfunction. RA represents the most prevalent form of arthritis in the elbow, and its impact is most often symmetrical, affecting both elbows at the same time.

After more traditional treatment methods had failed to resolve the problem, Miriam and Dr. Riggenschach decided that elbow replacement surgery was her best option.

"Miriam had rheumatoid arthritis, and it significantly impacted her elbows," says Dr. Riggenschach. "We tried multiple attempts at injections and other conservative treatments to try and help her symptoms and improve her pain, but ultimately it required elbow replacements on both elbows."

Roughly 3,000 total elbow replacements are done annually in America. The elbow acts as a hinge joint comprising three bones: the upper arm bone (humerus), the inner forearm bone (ulna), and the outer forearm bone (radius).

Elbow replacement surgery begins with Dr. Riggenschach making an incision behind the elbow and removing inflamed tissue and bone. An artificial hinge with metallic stems is then inserted into the hollow cavities of the bones. The wound is closed and the elbow splinted.

"We did one stage at a time," says Dr. Riggenschach. "Miriam's done very well with this and she's returned to active daily living. Cleaning around the house is not a problem for her, and she's pain-free in everyday life."

Miriam says the biggest benefit to the surgery is that the pain she dealt with every day for so long is now just gone - a night and day difference. "The excruciating pain that I was suffering with is no longer in my life. I couldn't do simple things like wash dishes before. I couldn't wash my hair. I couldn't lift my arms above my head to shampoo and blow dry. I can do all those things today."

RECOVERY FROM TOTAL ELBOW REPLACEMENT SURGERY

In Miriam's case, she was able to have her second elbow replacement performed at the Orlando Orthopaedic Outpatient Surgery Center and she says it made her recovery much smoother. She was able to go home within a couple hours after her surgery.

"The second outpatient surgery was great," she says. "I went home that evening. I slept better; I wasn't tied up with any IVs; I didn't get awakened early in the morning for medication," she says. "I took strong pain medication, but only for one day."

Rehabilitation and physical therapy play a pivotal role in regaining strength and normal function of the elbow following surgery. Gentle exercises are usually started once the wound has healed. Most patients are able to resume normal daily activities or lift smaller objects six to eight weeks post-operatively.

"As far as my elbows are concerned," says Miriam with a smile, "I forget that there are even metal components in there."

Following her successful bilateral elbow replacement procedures, Miriam is thankful for getting her life back and for being able to enjoy the little things in life again. "Combing my hair, doing dishes, simple things like that are small feats that for everybody else might not seem like a big deal, but they're a big deal to me," she says.

Having completed more than two years under Dr. Riggenschach's care, Miriam will never forget the role he played in her healing journey. "Dr. Riggenschach has always been very sincere with me, very compassionate, and he's always told me the truth," she says. "He's just a wonderful doctor." ■



Michael D. Riggenschach, MD



Eosinophilic Esophagitis Diet and Treatment

By Srinivas Seela, MD

Primary eosinophilic esophagitis (EoE) is an emerging clinicopathologic entity that is characterized clinically by symptoms related to esophageal dysfunction and histologically by an eosinophil-rich inflammation that is limited to the esophagus. Eosinophilic esophagitis (also known as EoE) is a disease characterized by the presence of a large number of a special type of white blood cell, the eosinophil, that can cause inflammation in the esophagus. This inflammation can lead to stiffening or narrowing of the esophagus, which can lead to difficulty swallowing (dysphagia) or food getting stuck in the esophagus. When the eosinophilia is limited to the esophagus, is accompanied by characteristic symptoms, and other causes of eosinophilia have been ruled out, it is termed eosinophilic esophagitis. A panel of experts defined eosinophilic esophagitis as “a chronic, immune/antigen-mediated, esophageal disease characterized clinically by symptoms related to esophageal dysfunction and histologically by eosinophil-predominant inflammation.”

There may be regional variation, with a higher prevalence in northeastern states and lower prevalence in western states. The diagnosis also appears to be more common in urban as opposed to rural settings. Prevalence within the United States may also differ between climate zones with a higher prevalence in cold and arid zones as compared with the tropical zones.

The most common presenting symptoms in adults are difficulty swallowing solid food (dysphagia). Younger children symptoms often include feeding difficulties and abdominal pain. Most common presentation include Common clinical manifestations seen in adults include

- Dysphagia
- Food impaction
- Nausea and vomiting
- Coughing
- Failure to thrive
- Chest pain that is often centrally located and does not respond to antacids
- Gastroesophageal reflux disease-like symptoms/refractory heartburn
- Upper abdominal pain

CHILDREN MAY PRESENT WITH DIFFERENT SYMPTOMS

Children:

- Difficulty feeding, in infants
- Difficulty eating, in children
- Vomiting
- Abdominal pain
- Difficulty swallowing (dysphagia)
- Food getting stuck in the esophagus after swallowing (impaction)
- No response to GERD medication

- Failure to thrive (poor growth, malnutrition and weight loss)

Eosinophils are prominent in other diseases associated with allergies such as asthma, hay fever, allergic rhinitis, and atopic dermatitis.

There is a strong association of eosinophilic esophagitis with allergic conditions such as food allergies, environmental allergies, asthma, and atopic dermatitis. It has been estimated that 28 to 86 percent of adults and 42 to 93 percent of children with eosinophilic esophagitis have another allergic disease. People with eosinophilic esophagitis are more likely to suffer from these other allergic diseases. In eosinophilic esophagitis, you have an allergic reaction to an outside substance. The reaction may occur as the lining of your esophagus reacts to allergens, such as food or pollen. The eosinophils multiply in your esophagus and produce a protein that causes inflammation. Inflammation can lead to scarring, narrowing and formation of excessive fibrous tissue in the lining of your esophagus causing dysphagia. You may have other symptoms, such as chest pain or stomach pain.

There has been a significant increase in numbers of people diagnosed with eosinophilic esophagitis in the past decade. At first, researchers thought this was due to an increase in awareness



among doctors and greater availability of tests. However, studies now suggest the disease is becoming increasingly common, parallel to the increase in asthma and allergy.

The diagnosis of eosinophilic esophagitis should be based upon symptoms, endoscopic appearance, and histological findings. The diagnosis of eosinophilic esophagitis is suspected whenever dysphagia for solid food occurs, even though it is not one of the most common causes of dysphagia. Dysphagia almost always is evaluated by endoscopy (esophagogastroduodenoscopy or EGD) in order to determine its cause. EGD shows narrowing of the esophagus in many cases, series of rings in the esophagus also called feeline esophagus, attenuation of the subepithelial vascular pattern, linear furrows, whitish papules representing microabscesses.

Diagnosis often requires biopsies of the mid esophagus. Other causes of dysphagia should be ruled out.

Some of the risk factors associated with EoE are climate, season, sex, family history, allergies and asthma and age.

TREATMENT:

Currently, there is not one accepted therapy for all patients with EoE. Although dietary therapy is the most common treatment of pediatric EoE, this has not been widely accepted among gastroenterologists who treat adult patients. Many adult patients are initially treated with acid-blocking medications to rule out GERD. If this does not improve symptoms or tissue changes of the eosinophils, then steroids taken using an asthma inhaler, but swallowed rather than inhaled by the patient, have been tried with good, although limited results. This treatment tends to be well tolerated; side-effects of a fungal infection called thrush or candida of the esophagus are relatively rare.

Four-food elimination diet for eosinophilic esophagitis (July 2017)

The traditional six-food (cow's milk, hen's egg, soy, wheat, peanut/tree nuts, and fish/shellfish) elimination diet for eosinophilic esophagitis (EoE) results in resolution of EoE in approximately three-quarters of children but is challenging and can have negative nutritional consequences. In a prospective study of four-food elimination (milk, soy, egg, wheat) in 78 children with EoE, histologic remission was achieved in 64 percent, with decreased symptoms in 91 percent. Thus, we now suggest either the four-food or six-food empiric elimination diet for most patients who opt for dietary management of EoE. Patients should be counseled that the disease is chronic. Untreated, patients may remain symptomatic or have episodic symptoms and that there is a high likelihood of symptom recurrence after discontinuing treatment. The long-term

prognosis of eosinophilic esophagitis is unclear, but EoE does not appear to significantly shorten lifespan.

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 Residence (MD and DO) programs. He is a regular contributing writer for Florida Md magazine. For an appointment with Dr. Seela, please call 407-384-7388. ■

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When the Cuff is Not Enough

Pulmonary Hypertension requires a specialty diagnosis

By James Tarver, III, MD



WHAT IS PULMONARY HYPERTENSION?

Pulmonary Hypertension (PH) is a condition that occurs when the pressure in the blood vessels coursing through the lungs is elevated. Previously described as extremely rare, recent studies suggest that the prevalence of the disease is higher than is usually reported, likely due to better recognition and diagnosis. It can affect people of all age groups, from infancy to old age, and is diagnosed in people of all races and ethnic backgrounds. Certain forms of the disease affect women more frequently than men. PH can exist alone, or in association with other diseases.

SYMPTOMS

Diagnosis of PH can be challenging as the symptoms often present gradually and are often similar to symptoms of other more common diseases. The most common symptom of PH is shortness of breath, particularly with exertion. Inability to perform physical exertion, palpitations, dizziness, chest pain or pressure and fatigue are also symptoms. In advanced cases, passing out or fainting with exertion can occur, and should be considered a medical emergency if it occurs. As the disease progresses, the symptoms become persistently worse and can become incapacitating.

DIAGNOSIS

Making the diagnosis of pulmonary hypertension can be challenging because the symptoms often mimic those of more common diseases. Symptoms that do not respond to standard treatments for common diseases should raise suspicion for the diagnosis of Pulmonary Hypertension. PH specialists often rely on subtle clues in physical examination and common diagnostic tests to raise suspicion for the diagnosis. Specific testing to make the diagnosis may be ordered. One such test, an echocardiogram, is very helpful for screening for the presence of PH but is not accurate enough to be relied upon alone to make the diagnosis. In patients in whom suspicion is high based on symptoms or echocardiogram, a Right Heart Catheterization is mandatory to confirm and categorize the diagnosis. In this test, small hollow catheters are inserted via a needle into a blood vessel in the neck or groin and advanced to the heart where they are utilized to directly measure pressures within the heart and lungs, as well as to obtain other relevant information. This is typically an outpatient procedure and is performed with minimal sedation.

CATEGORIZING THE DISEASE

Once the presence of elevated blood pressure in the lungs is confirmed, properly categorizing the type of pulmonary hypertension is essential, as treatments for the disease vary widely between the different types of PH.

There are five categories (WHO Groups) of Pulmonary Hypertension. Type I is Pulmonary Arterial Hypertension (PAH). This

is caused by processes that damage the small blood vessels in the lung, causing them to become narrowed and thickened.

This type of pulmonary hypertension can be associated with genetic factors, connective tissue diseases such as scleroderma, use of certain weight loss drugs, HIV infection, advanced liver disease, and congenital heart disease.

Type II Pulmonary Hypertension is associated with left sided heart disease, and can be caused by heart valve disease, cardiomyopathy (weakening of the heart muscle on the left side) and diastolic dysfunction (stiffening of the left sided heart muscle). This is the most common type of PH and is often referred to as Pulmonary Venous Hypertension (PVH)

Type III Pulmonary Hypertension is associated with lung disease and may be seen with sleep apnea or with severe cases of pulmonary fibrosis, COPD or emphysema.

Type IV PH is also called Chronic Thromboembolic Pulmonary Hypertension (CTEPH). It is caused by chronic blockage of the blood vessels in the lung by blood clots, and can occur in 3-4% percent of people who have previously had an acute blood clot in the lungs (pulmonary embolism), even if they were appropriately treated at the time of the clot. Unfortunately, a significant percentage of people with CTEPH have no prior history of blood clots.

Type V PH is associated with other factors that are not easily categorized into the other four types of PH, and can be associated with blood disorders, particularly sickle cell disease, advanced kidney disease, and other rare conditions.

DIAGNOSTIC TESTING

Diagnostic testing is used by your health care team to diagnose and properly categorize the disease, evaluate the presence of any diseases that may be causing or exacerbating the pulmonary hypertension, and to follow the effects of treatment. The most important diagnostic test for pulmonary hypertension is the Right Heart Catheterization, in which pressures in the pulmonary blood vessels are directly measured. PH cannot and should not be diagnosed or treated without data from a properly performed Right Heart Catheterization. Other tests may also be performed such as echocardiography, pulmonary function testing, 6 minute walk testing, VQ scanning, CT scanning and blood tests, among others.

TREATMENTS

Treatments for PH are based on the type and severity of the disease. There are specific medications used for Type I (PAH) disease, and the use of these medications is tailored to the individual patient's situation. These medications, such as Revatio (also known as sildenafil or Viagra), Tracleer, Flolan, etc., should

only be used after a complete evaluation and only for patients with PAH. These medications can be hazardous if used in other types of pulmonary hypertension.

In addition to medical therapy, some patients may benefit from surgical therapy. Patient with Type IV Pulmonary Hypertension (CTEPH) may benefit from surgical removal of these clots in a procedure called PTE (pulmonary thrombo-endarterectomy). This surgery can be curative in many patients.

In patients with PAH, lung transplantation may be an option for the small number of patients who do not respond to maximal medical therapy.

ABOUT THE CENTER FOR PULMONARY HYPERTENSION & CARDIOVASCULAR DISEASE

The Center for Pulmonary Hypertension & Cardiovascular Disease is a leader in pulmonary hypertension and cardiovascular care diagnosis, treatment, and management. Our patient-focused approach to diagnosis and intervention entails both inpatient and outpatient procedures, coupled with informative, personalized care. Our center is well versed in every type of care available for patients with pulmonary hypertension, and also offers our patients the opportunity to participate in research trials investigating cutting edge therapies for pulmonary hypertension.

James Tarver, III, MD is a board-certified cardiologist with more than 20 years of hands-on clinical experience in treating and managing pulmonary hypertension. He is a veteran of the United States Navy where he served as a medical officer, achieving the rank of Commander. Dr. Tarver received his medical degree from the Boston University School of Medicine, completing the 6 year Combined BA/MD program, and completed his internship, residency and fellowship in cardiology at the National Naval Medical Center/Walter Reed Army Medical Center in Bethesda, MD. He also served as a Pulmonary Hypertension Clinical Fellow at Johns Hopkins Hospital. While serving in the Navy, Dr. Tarver received the Navy Achievement and Navy Commendations medals, along with the Navy ACP Governor's Award for Outstanding Clinical Research. ■



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2017 Recap of Court Rulings Affecting Health Care Providers

By Julie A. Tyk, Esq.

FLORIDA SUPREME COURT DECLARES MEDICAL MALPRACTICE CAP IN PERSONAL INJURY CASES UNCONSTITUTIONAL

On June 8, 2017, the Florida Supreme Court declared Florida's medical malpractice cap on noneconomic damages in personal injury medical malpractice cases unconstitutional in *North Broward Hospital District v. Kalitan*, on the ground that it violates the Equal Protection Clause of the Florida Constitution.

The 4-3 decision found that the law capping damages is unconstitutional. The 2003 law limits noneconomic damages to \$500,000, or \$1 million in catastrophic cases. The Court found that the law violates the equal protection clause of the state constitution because some plaintiffs are fully compensated for their injuries, but those with the most serious injuries face an arbitrary limit.

ELEVENTH CIRCUIT STRIKES DOWN FLORIDA LAW RESTRICTING WHAT PHYSICIANS CAN SAY TO PATIENTS ABOUT FIREARM OWNERSHIP

The U.S. Court of Appeals for the Eleventh Circuit held that doctors in Florida must be allowed to discuss guns with their patients, striking down portions of a Florida law that restricts what

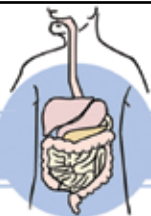
physicians can say to patients about firearm ownership.

In a 10-1 decision, the full panel of the Court found that the law, known as the Privacy of Firearm Owners Act, violates the First Amendment rights of doctors. A federal judge blocked the 2011 law from taking effect shortly after it was passed, and legal challenges by medical and gun control groups have been moving through the courts ever since. In 2014, a three-judge panel of the Eleventh Circuit upheld the constitutionality of the Florida law. The ruling overturned the panel's decision, noting there is no evidence that by asking about guns doctors were in any way infringing on the Second Amendment rights of their patients.

The Florida law passed in 2011 targeted pediatricians who asked parents about firearms in the home. Under its provisions, doctors can be punished with a fine of up to \$10,000 and loss of their medical licenses for discussing guns with patients.

The decision upheld a portion of the law that explicitly prevents doctors from discriminating against patients who own guns.

FLORIDA SUPREME COURT REJECTS ARGUMENTS TO SHIELD RECORDS FROM THE REQUIREMENTS



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IRRITABLE BOWEL SYNDROME

Irritable bowel syndrome (IBS) is a chronic condition of the digestive system that produces abnormal intestinal contractions.

Despite extensive research, and although there are multiple theories about how and why IBS develops, there is no definite cause. Various factors of the patient can play an important role including episodes of recent or remote gastroenteritis, the malabsorption of bile acid and alterations in the intestinal bacteria. IBS can occur at any age, but it often begins in adolescence or early adulthood and is twice as common in women as in men.

The symptoms are variable and patients with IBS may experience abdominal pain and swelling, changes in the pattern of evacuation (diarrhea and / or constipation) and excessive flatulence.

The diagnosis of IBS requires a complete medical history, physical examination, and in several patients the exclusion of other conditions such as infectious gastroenteritis, disease, inflammatory bowel or celiac disease. In many cases blood tests are done including tests of thyroid and excrement to rule out other causes of symptoms of the patient.

The chronic nature of IBS and the challenge of controlling symptoms can be frustrating for both patients and health providers. Fortunately, there are a variety of treatments and therapies available. These measures help to alleviate and control symptoms but they do not cure the condition. Part of the treatment consists of exercise, eliminating certain products in the diet (lactose, caffeine) and ingesting probiotics and fiber. We sometimes add antidiarrheal medications, stool softeners, and anticholinergics (dicyclomine and hyoscyamine) taken approximately ½ hour before eating to control the spasms of the muscles of the intestine. If you think you may have irritable bowel syndrome, do not wait, call us at 407-384-7388 and make an appointment today.

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OF AMENDMENT 7

The Florida Supreme Court this year issued opinions in two cases related to a patient's constitutional right under Article X, Section 25 of the Florida Constitution (Amendment 7).

The Florida Supreme Court held in *Charles v. Southern Baptist Hospital of Florida, Inc.*, that adverse incident reports produced in conformity with state law could not be classified as confidential and privileged "patient safety work product" under the federal Patient Safety and Quality Improvement Act (PSQIA). The Supreme Court reasoned that adverse incident reports do not constitute "patient safety work product" because Florida Statutes and Florida Administrative Rules require that providers create and maintain adverse incident reports. Additionally, the Court noted that patients have a constitutional right to access records relating to adverse medical incident reports. The Court also held that the PSQIA did not expressly or impliedly preempt a patient's constitutional right under Amendment 7.

As background, in *Charles*, the plaintiffs sent an Amendment 7 request to Baptist Hospital. The plaintiffs' discovery request specifically asked for reports prepared pursuant to several sections of the Florida Statutes. The request specifically stated:

This request is limited to adverse incident documents (as described above) that are created by you, or maintained by you, or provided by you to any state or federal agency, pursuant to any obligation or requirement in any state or federal law, rule, or regulation. As limited, this request includes, but is not limited to, documents created by you, or maintained by you pursuant to Fla. Stat. § 395.0197, 766.010, and 395.0193. This request, as limited, specifically includes, but is not limited to, your annual adverse incident summary report and any and all Code 15 Reports.

In response, Baptist Hospital produced Annual Reports, Code 15 Reports and two incident reports relating to the decedent. However, the hospital objected to the production of any other document claiming privilege under the PSQIA. Plaintiffs filed a motion to compel production of all Amendment 7 documents. The trial court held that the information required to be gathered under Florida law, whether reported or not, is precluded from being protected patient safety work product under the PSQIA. The hospital appealed to the First District Court of Appeals, which held that the documents were entitled to federal protection and that Amendment 7 was preempted by the PSQIA.

Following the Supreme Court's holding in *Charles*, adverse incident reports placed in a patient safety organization (PSO) under the PSQIA are also most likely discoverable following a recent Florida Supreme Court decision. Therefore, a patient can obtain copies of adverse incident reports stored in PSOs.

In October 2017, the Supreme Court overturned a decision by the 2nd District Court of Appeal in *Edwards v. Thompson*, that would have allowed Bartow Regional Medical Center to avoid turning over records that were prepared – at the request of the hospital's counsel – outside of the ordinary peer-review process and in anticipation of litigation.

The Supreme Court majority stated "the result asserted by Bartow would provide a trap door through which hospitals could totally avoid their discovery obligations by outsourcing their adverse medical incident reporting to external, voluntary risk management committees separate from those required by the Florida statutory scheme."

FLORIDA SUPREME COURT STRIKES DOWN EX PARTE INTERVIEW REQUIREMENT

On November 9, 2017, in *Weaver v. Myers*, the Florida Supreme Court struck down parts of the state's medical malpractice law in a 4-3 decision finding provisions violated patients' constitutional rights to privacy and access to courts.

Under Chapter 766, Florida Statutes,



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prior to filing a medical malpractice lawsuit, a claimant must satisfy certain statutory pre-suit requirements. In 2013, the Florida Legislature added a requirement to the pre-suit discovery devices available to potential defendants that a claimant allow the potential defendant to informally interview the claimant's treating physician without the claimant or his or her attorney present.

The Florida Supreme Court struck down the 2013 statutory amendments as violating the constitutional rights of privacy and access to courts. Writing for the majority, Justice Fred Lewis made clear that Weaver's late husband's privacy right survived his death and could be raised by his wife in these proceedings. As to the constitutional privacy claim, the Court held that the statutory amendments unconstitutionally require claimants to waive the right to privacy as to both relevant and irrelevant medical information.

The majority rejected the reasons given to justify the legislation as not "sufficiently compelling" to outweigh patient privacy rights under the Florida Constitution. The Court also held that the amendments violated the constitutional right of access to courts because they coerced claimants into foregoing their fundamental right to privacy in order to exercise their fundamental right to access to courts.

If you have specific questions about medical malpractice claims that may impact your practice, please contact Wilson Elsner's Medical Malpractice & Health Care attorneys in Orlando, Florida.

Julie Tyk concentrates her practice in medical malpractice and health care. She has experience representing physicians, hospitals, ambulatory surgical centers, nurses and other health care providers across the state of Florida in matters involving professional liability, risk management, peer review, general liability and premises liability. Ms. Tyk assists organizations and individual medical providers in navigating the federal and state health care regulatory environment in such areas as the Anti-Kickback Statute, the Stark Law, HIPAA, HITECH, state patient self-referral laws and state patient brokering laws. ■

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#WearableDevices

By Khalilah Filmore



Greetings, subscribers and readers of Florida MD. In an effort to keep my personal health on track I purchased a fitness tracker to monitor my steps and even my daily calorie intake. I lost over twenty pounds exercising, eating healthy and devoutly using my tracker. The tracker kept me engaged and even competitive with myself, always striving to outdo my goals. Recently I lost my tracker and found it extremely challenging staying on track without it. I still exercise and eat healthy, but I don't have the constant reminder on my arm to walk more, run faster or climb that extra set of stairs. The reminder now comes from new habits born from over a year of positive reinforcement.

When I lost my tracker, it made me ponder how many consumers purchase these helpful devices, and if they ever discussed their goals and/or results with their physicians. Admittedly, I did not. I wondered if consumers even discuss with their primary care physicians their interest in purchasing a wearable, and solicited advice on which unit to purchase. I consulted with friends.

Considering where healthcare is headed and the growing trend for personal accountability, coupled with physicians having the added burden of managing a patient's personal actions, the need for such convenient devices may add a small but helpful contribution to a much larger issue. I now discuss my individual fitness goals with my personal physicians and when I invest in a new tracker, I will share this data also.

#WEARABLEDEVICES

The fields of medicine, fitness, health and wellness, aging, and disabilities, to name a few, have seen an increase in technology geared towards the consumer "wearing" devices that can positively influence their daily habits. Examples are daily step counters, medication and appointment reminders, and sleep monitoring.

The terms "wearable technology", "wearable devices", and "wearables" all refer to electronic technologies or computers incorporated into items of clothing and accessories which can comfortably be worn on the body; Fitbit, Apple Watch, K-Track Glucose and Fever Scout, are a few examples. [1] These wearable devices, in most cases, out-perform mobile phones and laptops because the data collected is often accessible real-time using biofeedback and physiologic functions.

#ADIGITALPRACTICE

Usage of medical devices is already common in medical practice; think of home sleep apnea tests and portable ECG machines. The transition to wearables can be seamless. The key is communication and documentation.

So where does the conversation of "wearables" fit into a medical practice? For new patients, completing registration forms including the question of device usage (brand, goal, etc.) is a great way to establish rapport, and easily incorporate goals and shared data

in the patient's regime. For current patients, staff can be trained to be in the habit of spotting wearables, and asking patients during vital signs procedures if they use wearables.

By initiating the conversation with patients and identifying health and fitness goals, this reiterates patient accountability and encourages them to take the lead in making positive decisions regarding their own health.

#PATIENTACCOUNTABILITY

Monitoring a patient's habits once they leave your office is incredibly challenging; this presents a unique niche for medical practices struggling with patients who are not compliant or struggle with their symptoms due to lack of resources or knowledge.

Patients who are suffering from a chronic disease or multiple co-morbidities may benefit from devices that trigger alerts to caregivers, case managers and even physician offices in the hopes of preventing unnecessary hospitalizations while helping the patient remain at home.

Listed below are a few concerns and/or obstacles regarding "wearables" that may preclude or limit patient participation:

- Cost – the average cost for a "wearable" is \$290. [2] This can prove to be a challenge for patients who are on limited incomes or with competing financial priorities.
- Access – some hospitals and insurance companies have launched programs providing qualified patients a wearable at little to no cost and most have support teams (RNs, Case Managers, etc.) who contact enrolled patients via phone and/or in person to ensure effectiveness, commitment and promote engagement.
- Patient Engagement – Additional education may be needed for patients who are not tech savvy or intimidated by the use of wearables. Offering an educational session during lunchtime or an after hours/weekend class for patients may prove beneficial.
- Patient Support – Once patients are successfully using "wearables", how will you support them if questions arise from the data collected? Piloting a program with 5- 10 patients and using a nurse or medical assistant to call these patients weekly for support can be a great place to start.

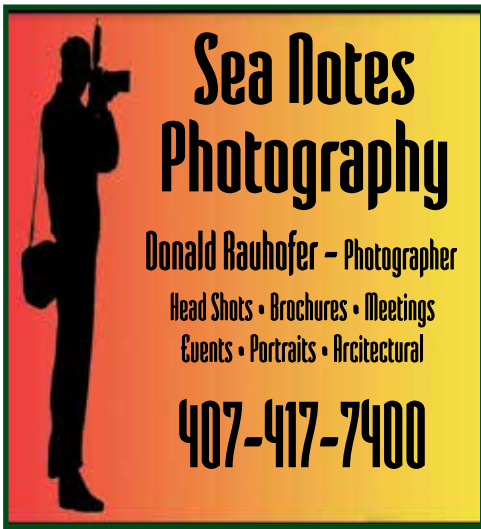
Promotion of wearables in your medical practice can be an effective tool to add to your prescribing arsenal; it is non-invasive and a cost effective approach to managing your patient population focusing on patient commitment and personal accountability.

Please tell me if and how you are using "wearables" in your

medical practice! I welcome you to submit your thoughts or questions by email with the subject line #PracticeTactics to Khalilah@wehelpdrs.com or on Twitter using handle @Medkeen—and don't forget to use the hashtag #PracticeTactics. See you next month!

References:

1. *Introduction to Wearable Technology*. (2014, March 26). Retrieved from <http://www.wearabledevices.com/what-is-a-wearable-device/>.
2. *The Advisory Board Company*. (2016) *The Advisory Board Company Market Innovation Center Telehealth Primer: Wearables*.

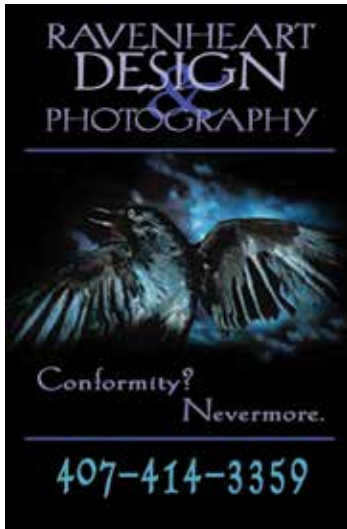


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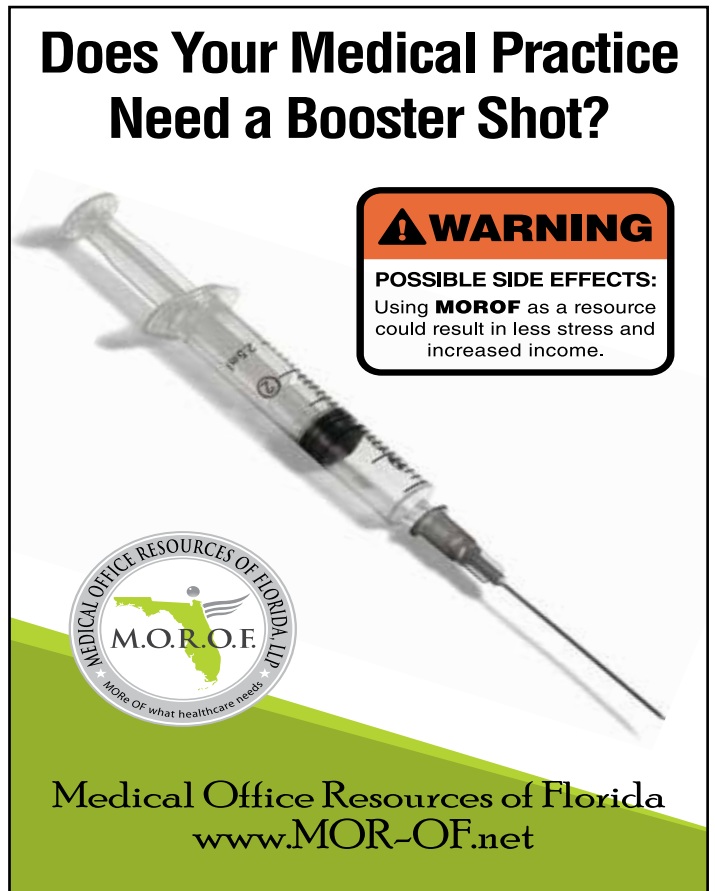
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