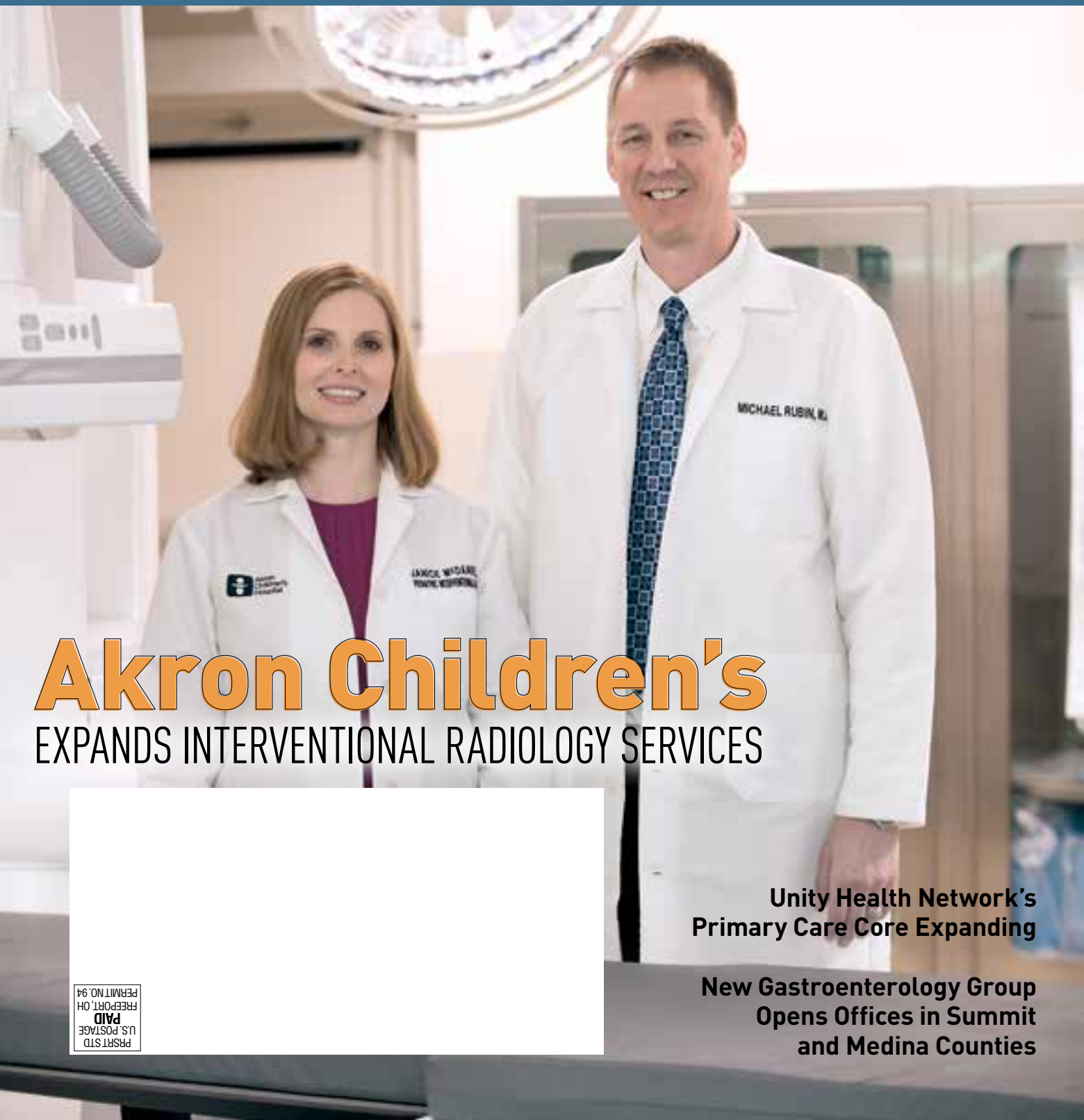
CLEVELAND/AKRON/CANTON | March/April 2017 |

MDNEWS

■ A BUSINESS & PRACTICE MANAGEMENT MAGAZINE | ABOUT PHYSICIANS | FROM PHYSICIANS | FOR PHYSICIANS ■



Akron Children's
EXPANDS INTERVENTIONAL RADIOLOGY SERVICES

Unity Health Network's Primary Care Core Expanding

New Gastroenterology Group Opens Offices in Summit and Medina Counties

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MDNEWS

ON THE COVER

(L–R) Janice McDaniel, MD, Division Director of Interventional Radiology, and Michael Rubin, MD, Chairman of Radiology at Akron Children's Hospital

PHOTO COURTESY OF AKRON CHILDREN'S HOSPITAL

Shown here in Akron Children's new IR suite are (L-R) Karah Novince, CNP; Janice McDaniel, MD; Stephanie Simmons, RT; and Diane Taray, RN.

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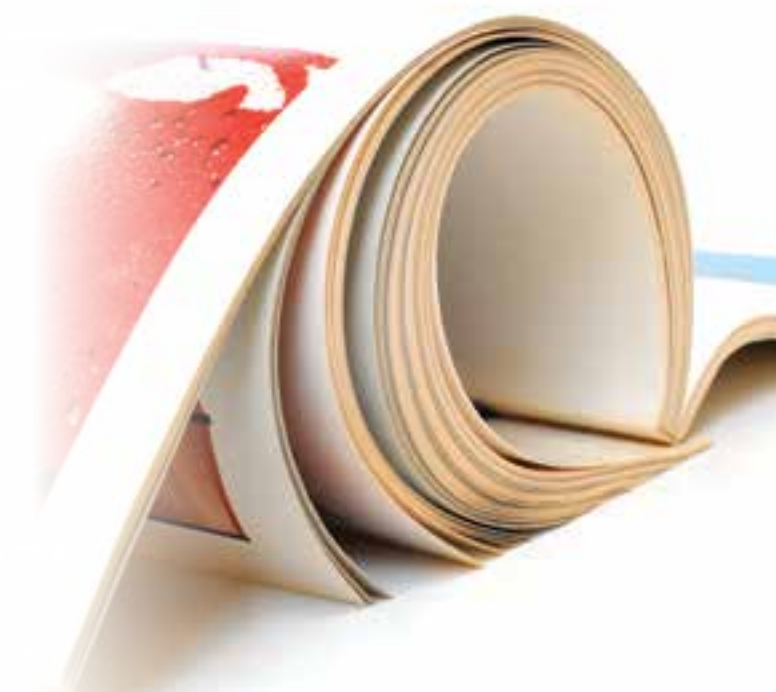

from the PUBLISHER

Ted DiFiore
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It's not news to anyone reading this magazine that healthcare is an industry filled with turbulence. The future implications of repealing and replacing Obamacare, declining reimbursements, aging populations, technology and other "noise" make change a constant.

And though much of this change involves elimination of services and shrinking medical groups, the Northeast Ohio market stays vibrant.

In this issue we proudly introduce a number of new physicians across differing specialties — primary care, gastroenterology and pediatric interventional radiology — all poised to continue to elevate the quality and access of healthcare for patients in our region.

While pediatric interventional radiology is a relatively new and evolving subspecialty, Akron Children's Hospital saw a steady and growing demand for IR services. To meet this need, they invested the human and capital resources necessary. And now ACH is the only hospital in Northeast Ohio with a dedicated pediatric interventional radiologist — Janice McDaniel, MD.

Western Reserve Hospital Physicians, Inc. (WRHPI) is also responding to consistent market demand by expanding its line of specialty healthcare services. WRHP Gastroenterology recently opened three offices in Summit and Medina Counties, led by board-certified gastroenterologists John S. Park, MD, and Corey J. Sievers, MD. The physicians connect with their oft-senior patient base with a compassionate, sensitive approach to difficult and lifestyle-impacting health issues.

Also in this issue, we introduce two primary care physicians who recently joined Unity Health Network: Troy Bishop, MD, and Ruchi Taliwal, MD. Unity is Northeast Ohio's largest independent physician group.

As always it's exciting to continue to report on new physicians, new services and continued expansion of our healthcare market. And we look forward to bringing more positive news in the next issue of *MD News*!

Ted Difiore

MDNEWS

Cleveland/Akron/Canton

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Janice McDaniel, MD, joined Akron Children's in 2014 to develop a pediatric interventional radiology program. Dr. McDaniel is a fellowship-trained pediatric interventional radiologist — reportedly the only one in NE Ohio and one of less than 200 in the world.

PHOTO COURTESY OF AKRON CHILDREN'S HOSPITAL

Akron Children's EXPANDS INTERVENTIONAL RADIOLOGY SERVICES

BY JO DONOFRIO

PEDIATRIC INTERVENTIONAL RADIOLOGY (IR) is a relatively new and evolving subspecialty. While adult interventional radiologists have been in practice for many years, the number of physicians fellowship trained in this subspecialty remains relatively low — less than 200 worldwide. For pediatric hospitals wanting to expand their IR services, this is a problem.

That was the case for Akron Children's Hospital which, prior to 2014, partnered with a group of adult interventional radiologists from Akron General Medical Center (AGMC) to provide pediatric IR services on an as-needed basis. While the partnership made IR services available, it also had its limitations, according to Michael Rubin, MD, Chairman of Radiology at Akron Children's.

"The AGMC IR physicians were not always readily available because of their busy schedules, so some procedures went to the operating room instead of being done by interventional radiology because it was more expedient for the patient," he explains. "As the demand for these services increased, it became apparent that a children's hospital of our size needed a dedicated and comprehensive in-house pediatric interventional radiology program."

That need was met with the recruitment of Janice McDaniel, MD, two years ago and completion last year of a new IR procedure suite, remodeled OR space, and new equipment — a $4 million investment. Today, Dr. McDaniel directs Akron Children's IR division.

"We are the only hospital in Northeast Ohio with a dedicated pediatric interventional radiologist," says Dr. Rubin. "With Dr. McDaniel's training, and the advanced technology of our new interventional radiology suite, we can now offer our patients a wide range of new treatment options that are less invasive."

Shown here in Akron Children's new IR suite are (L-R) Karah Novince, CNP; Janice McDaniel, MD; Stephanie Simmons, RT; and Diane Taray, RN.

PHOTO COURTESY OF AKRON CHILDREN'S HOSPITAL

ABOUT DR. MCDANIEL AND IR

A native Ohioan, Dr. McDaniel received a BS degree in Biology from the University of Cincinnati and an MD degree from the University of Cincinnati College of Medicine. She completed fellowship training in Pediatric Interventional Radiology at Cincinnati Children's Hospital Medical Center before joining Akron Children's Hospital in July 2014.

"I was really drawn to pediatrics, but I also loved the aspect of radiology that was about 'reading the clues' and 'solving the case,'" she says. "Additionally, I really like working with my hands. Pediatric interventional radiology ties all these interests together — with the added rewards of helping kids feel better."

Interventional radiology involves minimally invasive, image-guided procedures to diagnose and treat disease in nearly every system of the body, including pulmonary, vascular, musculoskeletal and gastrointestinal. It's routinely used to perform needle biopsies and place feeding and drainage tubes and central venous catheters.

"Among the most common IR procedures are arthrograms of the hips, shoulders, elbows and wrists, as well as joint injections for patients with juvenile idiopathic arthritis or sports injuries," says Dr. McDaniel. Last year, joint injections accounted for about 27 percent of the procedures she performed.

Guided by imaging tools such as fluoroscopy, computed tomography and ultrasound, interventional radiologists also offer alternatives to traditional surgery. The benefits include less risk, less pain and shorter recovery times.

NEW IR SUITE, NEW TECHNOLOGY

Advanced imaging technology in Akron Children's IR suite makes it possible to more easily and less invasively insert abscess drains, access vasculature for catheter placement, place gastrojejunal (GJ) feeding tubes and perform ultrasound-guided biopsies that previously would have required open surgery.

Perhaps the most impressive piece of equipment in the new IR suite is a $1.2 million angiography unit that provides the highest resolution images in even the tiniest patients. In addition, a new cone-beam CT scanner makes it possible to overlay images from an MRI to more precisely pinpoint and treat disease. And a new 60" monitor, which can be split into several screens, enables children and teens who are awake during a procedure to watch a cartoon or favorite TV show.

It is often the most difficult cases, however, that are best served by the advanced capabilities of the IR suite. "I needed to biopsy a mass that was nestled between the aorta, inferior vena cava,

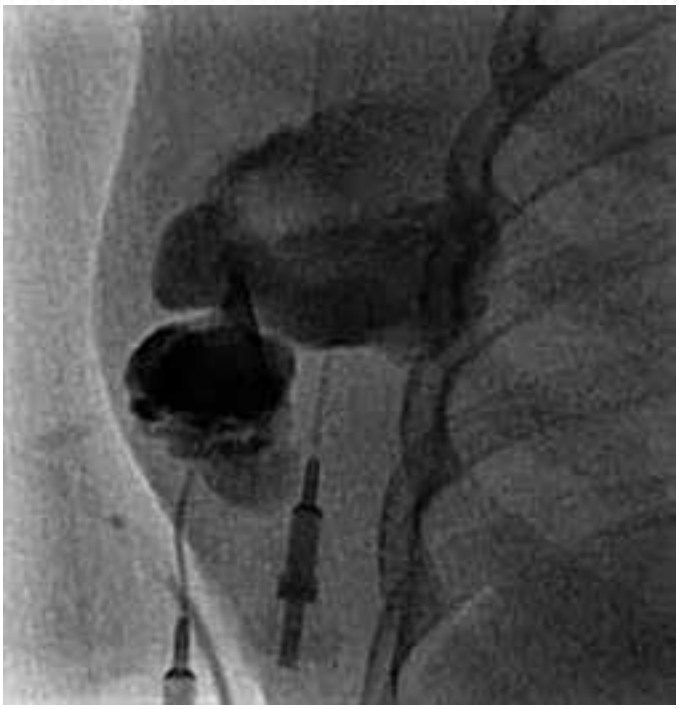

IMAGE COURTESY OF DR. JANICE MCDANIEL

This fluoroscopic image was obtained during sclerotherapy of a lymphatic malformation in the chest wall of an infant, which would have otherwise required extensive surgery to remove the entire lesion.

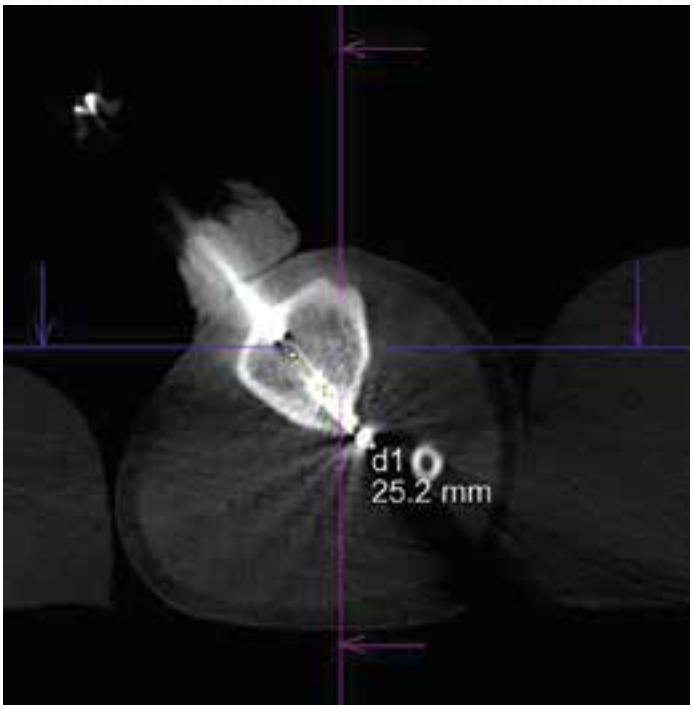

IMAGE COURTESY OF DR. JANICE MCDANIEL

This CT image taken during a treatment procedure shows a needle probe going through the tumor, which was then cryoablated, causing cell death in the tumor.

spine and the kidney," Dr. McDaniel explains. "I had a one-centimeter window in which to get a needle into the mass. The CT guidance and image overlay technology allowed me to reconstruct in 3 dimensions and plan my needle path. I then superimposed a graphic onto live X-ray and lined up my needle exactly where it needed to be."

The new equipment in the IR suite was selected, however, not only for accuracy and precision, but also for its significantly low radiation dose.

MINIMUM RADIATION, MAXIMUM SAFETY

"We all are concerned about radiation safety and the effects of radiation, even with medical imaging, and we want to minimize that as much as possible," says Dr. McDaniel. "This dedicated unit is built to minimize radiation and uses built-in pediatric protocols to ensure that the absolute lowest dose of radiation needed is used to get the job done."

Dr. McDaniel also maximizes safety by using ultrasonography whenever possible, eliminating all radiation exposure. She also often performs procedures, such as joint injections and GJ tubes, without sedation. In 2015, 50% of Dr. McDaniel's procedures were performed without sedation, 20% required sedation, and 30% required general anesthesia.

With her pediatric training, Dr. McDaniel is also focused on the child's and parents' concerns and involves the parents as much as possible. "With joint injections and GJ tube placement, the parents can usually be in the procedure room," explains Dr. McDaniel. "This results in less emotional distress for both the parent and child."

When needed, child life specialists and a pediatric sedation team are also available.

EXPANDED OPTIONS

Recently, Dr. McDaniel brought Akron Children's Venous Access Team, which places peripherally inserted central catheters (PICCs), under the IR program umbrella. She also co-directs Akron Children's Vascular Anomalies Clinic with Ananth Murthy, MD, Director of Plastic and Reconstructive Surgery at Akron Children's. Nick Nguyen, MD, Dermatology, and Heather Sprouse, CNP, are part of this multidisciplinary program that is dramatically changing how vascular malformations are treated.

"IR has always been an innovative field that embraces new technology and pushes the envelope," says Dr. McDaniel. "Our priority is always to make improvements in the way we treat our kids and get them back to being kids again as soon as possible. Having a dedicated IR suite allows us to grow our program and provide more options for minimally invasive techniques in children."

Dr. Rubin agrees. "We have seen tremendous growth under Dr. McDaniel's leadership and, with the opening of our dedicated interventional radiology suite, we are excited about future opportunities to grow our program and expand our reach."

For more information about Akron Children's Interventional Radiology Program, visit www.akronchildrens.org/cms/pediatric_radiology/index.html. To refer a patient, call 330-543-0834. ■

I AM

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"Being part of Unity Health Network gives me the independence to preserve the direct and lasting relationships I have with my patients. Together, we make important clinical decisions, and there is no bureaucracy in the way of providing care. I maintain my focus on being a doctor, provide high quality care while striving for optimal satisfaction and am accessible. My patients enjoy and benefit from my independence, and I thrive on practicing medicine in this way."

Kevin Mineo, MD
Primary Care Physician
Unity Health Network

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OHIO'S MEDICAL MARIJUANA LAW PROGRESSES,

but Are Physicians Willing to Recommend?

BY JOSEPH J. FELTES, JD

IN THE FACE of Ohio's opioid epidemic that leads the nation in fatal heroin overdoses — an ironic byproduct of addiction to prescription painkillers — does medical marijuana provide a viable alternative for physicians to manage intractable pain and other Qualifying Medical Conditions? The issue remains up in the air.

Ohio's Medical Marijuana Act (House Bill 523) became effective September 8, 2016. It still has a way to go before becoming fully implemented by the September 8, 2018 deadline. To get there, cultivator/processor rules, testing laboratory rules, dispensary rules, patient/caregiver rules, and physician certificate rules must go through the rule making process by September 8, 2017.

On December 15, 2016, the State Medical Board of Ohio published its proposed draft of physician certificate rules for public comment.[1] At the same time, it published the results of a survey to Ohio physicians, asking whether they would recommend medical marijuana to their patients.

PROPOSED PHYSICIAN CERTIFICATE RULES

The proposed rules require physicians (MDs/DOs) to obtain from the State Medical Board a Certificate to Recommend medical marijuana, defined as cultivated, processed, dispensed, tested, possessed, and used for a medical purpose[2], to treat or alleviate 21 enumerated Qualifying Medical Conditions. Qualifying Medical Conditions include (but are not limited to) Alzheimer's, cancer, glaucoma, MS, chronic and severe or intractable pain, Parkinson's, epilepsy, and post-traumatic stress syndrome. Doctors also must annually complete two hours of Board-approved CME on medical marijuana.

As proposed, doctors who hold a certification to recommend[3] medical marijuana, must: (1) establish a bona fide physician-patient relationship; (2) conduct an in-person physical exam; (3) diagnose the patient with a Qualifying Medical Condition; (4) review the patient's medical/drug records; (5) obtain an OARRS report over the past 12 months; (6) inform the patient of the risks and benefits of medical marijuana; (7) determine that the benefits of medical marijuana outweigh the risks and may be more effective and beneficial than mainstream conventional drugs and therapies; (8) establish a care plan with ongoing monitoring; and (9) obtain an informed consent from the patient or caregiver. All this must be documented in the patient's medical record.

Physicians are prohibited from personally furnishing or dispensing medical marijuana or from issuing a recommendation for a family member or the physician's own use. Physicians also must not have an ownership, investment interest, or compensation arrangement with a medical marijuana cultivator/processor, dispenser, or other related entity. Those who violate these prohibitions not only face cancellation of their Certificate to Recommend, but are also subject to disciplinary action.

Physicians must submit an annual report to the State Medical Board, describing their observations regarding the effectiveness of medical marijuana in treating patients (described in the aggregate) during the year covered by that report.

PHYSICIAN SURVEY RESULTS

In September, 2016, the State Medical Board distributed a survey to the 46,000 physicians licensed in Ohio in order to gauge their attitude toward recommending medical marijuana for their patients. Three thousand physicians of those surveyed replied. Only three out of 20 indicated that they would be "highly likely" to recommend medical marijuana. Forty-five percent indicated that they would unlikely recommend medical marijuana to their patients, stating that they need to see more results from peer-reviewed research on efficacy, side-effects, disorder and diversion, OVI data, and mental health events before they would consider recommending medical marijuana.

The smoke needs to clear before Ohio's medical marijuana law takes effect and physicians are inclined to recommend medical marijuana to their patients.

Joe Feltes is an attorney with Buckingham, Doolittle & Burroughs in Canton OH and a member of its Health & Medicine Practice Group. He is also the managing partner of Buckingham Canton. For more information about the law firm, go to www.bdblaw.com or email Mr. Feltes at JFeltes@BDBLAW.com. ■

References

1. *The Medical Board received numerous comments and articles supporting and opposing the proposed rules.*
2. *Medical marijuana is classified as a schedule II controlled substance.*
3. *In Ohio, doctors technically will only be able to recommend, not prescribe, medical marijuana to patients, because of the Federal Controlled Substances Act.*

Strong Market for Medical Office Investment

AN EVOLVING HEALTHCARE landscape is fueling an expanded patient base and strengthening the outlook for investment in medical office buildings, according to real estate crowdfunding firm CrowdStreet.

Aging baby boomers and the ACA have contributed to larger numbers of patients, who are likely to need more extensive healthcare services. Americans ages 51–69 number approximately 75 million, the Pew Research Center notes, and the U.S. Health and Human Services Department says 20 million people have insurance because of the ACA.

Portland, Oregon-based CrowdStreet points to estimates that U.S. spending on health care could nearly double between 2014 and 2024, from $3 trillion to $5.5 trillion.

"From an investor's perspective, medical office buildings ... are an attractive niche that is outperforming the broader office market," the firm says on its website.

During one recent quarter, medical office vacancy rates were 9.5 percent, compared with 12.7 percent for other office space. ■

— By Steve Barrett

Growth in Medical Real Estate Construction

CONSTRUCTION OR EXPANSION of medical office buildings and hospitals across the United States grew substantially from 2015 to 2016, according to Revista, an Annapolis, Maryland-based firm that gathers healthcare real estate data.

Medical real estate construction in the pipeline as of late 2016 was valued at slightly greater than $102 billion. That is a 5.1 percent increase from the approximately $97 billion figure from late 2015, Revista notes.

Included in the 2016 figure are medical office building and hospital projects that:

+ Are in late planning stages or already in progress
+ Represent an expansion of a minimum 7,500 square feet
+ Are valued at more than $5 million

Revista reported that hospital construction in the pipeline was valued at $81.8 billion, compared with roughly $20.3 billion in medical office building projects. Median square footage per project for hospitals was 60,000. The figure was 45,000 square feet for medical office buildings. ■

— By Steve Barrett

The Right Medicine for Ailing Malls?

MANY CITIES SEEK to repurpose space in partially vacant shopping malls. Increasingly, medical offices are filling those gaps.

Denver-based kidney care company DaVita Healthcare Partners is opening as many as 150 locations annually, largely in retail sites or quasi-retail sites in community centers, Garrick Brown, Vice President of Retail Research for the Americas for real estate services firm Cushman & Wakefield, told *The Philadelphia Inquirer*. While medical offices transitioning into malls is a newer phenomenon, he expects it to grow.

"The big question is if we may start to see entire healthcare campuses moving into struggling malls," he told the newspaper. "This has not happened in large numbers yet, but we do see this as a likely trend ahead."

Joe Coradino, CEO for Pennsylvania Real Estate Investment Trust (PREIT), echoes that sentiment. PREIT negotiated leases for medical facilities at some Philadelphia-area malls that it owns. That's a response to consumers' desire for convenience and ready access, Coradino says. ■

— By Steve Barrett

NEW GASTROENTEROLOGY GROUP
Opens Offices in Summit and Medina Counties

BY NEIL ALLEN

John S. Park, MD

AS THE NUMBER of aging Americans continues to grow, physicians who care for this population are faced with increasing challenges. Older adults often present with higher acuity diseases and multiple chronic conditions, requiring more follow-up tests and treatments. Add to this the ongoing push for preventive medicine and early diagnosis through screening, and it is easy to understand why the demand for specialized healthcare services is on the rise. One specialty in particular that is being affected by the growing senior population is gastroenterology.

Western Reserve Hospital Physicians Gastroenterology recently opened three offices in Summit and Medina Counties. Led by board-certified gastroenterologists John S. Park, MD, and Corey J. Sievers, MD, the new practice offers comprehensive GI care.

Dr. Park earned his undergraduate degree in Integrated Life Sciences at Kent State University and his medical degree at Northeast Ohio Medical University (NEOMED) in Rootstown, Ohio. He completed his Internal Medicine residency at Summa St. Thomas Hospital in Akron, and his Gastroenterology fellowship at Strong Memorial Hospital/University of Rochester School of Medicine in Rochester, New York, where he was chief resident.

Dr. Sievers graduated with a BS in Biology from Saint Mary's University of Minnesota in Winona, and an MD degree from Ross University School of Medicine in Dominica. He completed residencies in Internal Medicine and Gastroenterology at MetroHealth Medical Center/Case Western Reserve University in Cleveland and is a member of the American College of Gastroenterology, American Association for the Study of Liver Diseases, and American Gastroenterological Association.

Together these two specialists provide high quality, compassionate care for all diseases of the gastrointestinal system, including:

+ bloating, constipation and diarrhea
+ celiac disease
+ colon polyps
+ Crohn's disease and colitis
+ dysphagia (difficulty swallowing)
+ gallstones
+ gastroesophageal reflux disease (GERD)
+ gastrointestinal bleeding
+ heartburn
+ irritable bowel syndrome (IBS)
+ liver disease
+ pancreas disease

They also offer screening and prevention of colorectal and gastric cancer through a full complement of basic and advanced endoscopic procedures and patient education.

"Many of the healthcare issues we diagnose and treat are difficult for the patient to talk about, or something that has been troubling them for a long time and they have finally decided to seek help," says Dr. Park. "It's important for us to be empathetic to their condition, and work closely with the referring physician to fully understand the patient's history and what has led them to our care."

Dr. Sievers agrees. "Our patients must feel comfortable with us for us to succeed. By listening carefully, being sensitive to their problems and working in concert with their primary care physician and other specialists that could be part of the treatment protocol, we are able to help deliver the needed care in a manner that is always focused on the patient."

Colorectal cancer is the third most commonly diagnosed cancer in both men and women in the US, according to the American Cancer Society (ACS). This year alone, the ACS estimates that 135,430 people in the US will be diagnosed with colorectal cancer, and 50,260 people will die from the disease. One in 22 men and one in 24 women will be diagnosed with colorectal cancer in their lifetime.

"As physicians, we must always advocate for life-saving screenings, and the colonoscopy is one of the most important, especially for those patients over the age of 50," says Dr. Park.

In recent years, questions regarding the effectiveness of colon cancer screening with colonoscopy have been laid to rest. A study published in *Annals of Internal Medicine* found that colonoscopies cut the risk of colon cancer by 77 percent over 10 years. Even more impressive, researchers found that the risk of right-sided colon cancer (the most difficult to identify with a colonoscopy) was reduced by 56 percent as a result of screening and early diagnosis.

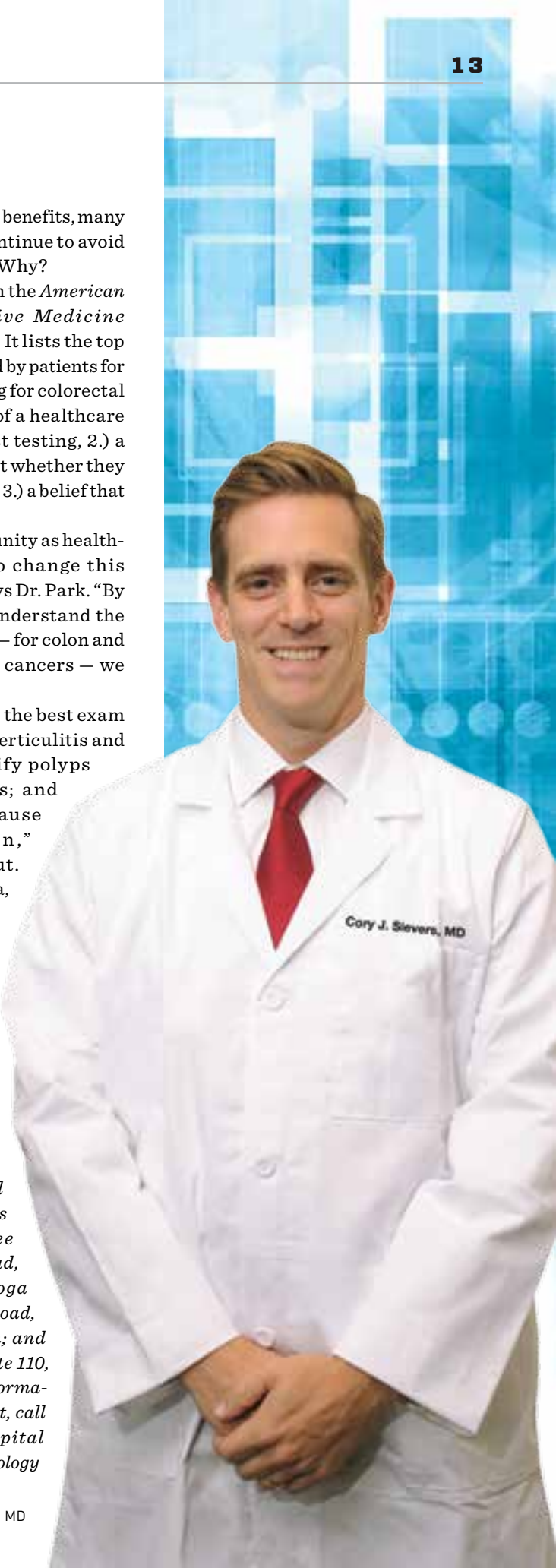
Despite the lifesaving benefits, many patients over age 50 continue to avoid having a colonoscopy. Why?

A survey published in the *American Journal of Preventive Medicine* answers that question. It lists the top three reasons expressed by patients for not obtaining screening for colorectal cancer: 1.) the failure of a healthcare professional to suggest testing, 2.) a lack of awareness about whether they should be screened, and 3.) a belief that testing is too costly.

"We have the opportunity as healthcare professionals to change this trend of avoidance," says Dr. Park. "By helping our patients understand the benefits of screenings — for colon and other life-threatening cancers — we can truly save lives."

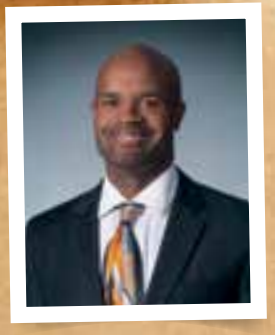
"Colonoscopy is also the best exam to diagnose colitis, diverticulitis and diverticulosis; identify polyps and bleeding lesions; and help diagnose the cause of abdominal pain," Dr. Sievers points out. "Symptoms like anemia, weight loss, abdominal pain or cramping could arise from many different causes. A colonoscopy can determine whether the symptoms a patient is experiencing are related to colon disease or something more benign."

Dr. John Park and Dr. Corey Sievers see patients at three offices: 3033 State Road, Suite 203, in Cuyahoga Falls; 4016 Massillon Road, Suite C, in Uniontown; and 3780 Medina Road, Suite 110, in Medina. For more information or to refer a patient, call Western Reserve Hospital Physicians Gastroenterology at 330-926-3313. ■



Corey J. Sievers, MD

Benefits of Autologous Breast Reconstruction



BY DEREK CODY, MD, FACS

EVERY YEAR, 200,000 WOMEN are diagnosed with breast cancer. This diagnosis and its treatment exact a heavy toll on patients and families. Recognition of the beneficial role of breast reconstruction in addressing the physical and psychological effects of breast cancer can be seen in the passage of multiple legislative acts aimed at increasing breast reconstruction awareness. Despite these efforts, only about 40% of eligible patients undergo breast reconstruction. The vast majority, 80%, will undergo an implant-based procedure. While great results are achievable with implants, other options exist, including autologous procedures which have been shown to have higher satisfaction ratings in patient-reported outcomes data.

Autologous breast reconstruction has the benefit of recreating "like with like," allowing for reconstructions that closely parallel the presurgical form. Additionally, using one's own tissue avoids the maintenance inherent in implant-based reconstruction. There are multiple areas of a woman's body that are suitable for breast reconstruction, including the inner and posterior thigh and abdomen. While they all closely resemble breast texture and can be easily shaped into a natural breast form, the abdomen excels at this.

Composite tissue from the lower abdomen is one of the most commonly used donor sites for autologous breast reconstruction. Multiple procedures exist for using this tissue for breast reconstruction with varying degrees of functional impact. Techniques like the Transverse Rectus Abdominis Myocutaneous flap (TRAM) harvest skin, subcutaneous tissue and muscle from the lower abdomen for breast reconstruction, and in doing so, sacrifice the function of the rectus abdominis muscle. The Deep Inferior Epigastric Perforator (DIEP) flap uses the same lower abdominal tissue as the TRAM procedures, but does so without sacrificing the function of the stomach muscles. To achieve this, perforator vessels to the skin and subcutaneous tissue are isolated from surrounding muscle and nerves and transplanted to the chest with microsurgical anastomosis. By preserving the abdominal wall musculature, core strength is maintained, promoting faster recoveries and allowing patients to maintain active healthy lifestyles.

Dr. Derek Cody is a board certified plastic surgeon and a member of Crystal Clinic Plastic Surgeons in Montrose (Akron), OH. A native of Cleveland OH, he obtained his medical training at The Ohio State University College of Medicine and Cleveland Clinic, and he completed his plastic surgery training at Summa Health. Dr. Cody specializes in aesthetic surgery of the face and body and complex reconstructive procedures, including microsurgical breast reconstruction and facial reanimation. He is a member of the American Society of Plastic Surgery, the American College of Surgeons and the California Society of Plastic Surgery. ■

Hallux Rigidus: Fusion or Implant?

BY DUANE J. EHREDT, JR., DPM, AACFAS

HALLUX RIGIDUS is the term used to describe a severely painful 1st metacarpophalangeal joint (MPJ) secondary to range of motion limitation and osteoarthritis of the great toe joint. Historically the 1st MPJ arthrodesis procedure has been performed to fuse the great toe joint together, thereby eliminating pain and improving function. There are many long-term clinical studies that have demonstrated the safety and efficacy of this procedure. Despite these excellent results, some clinicians argue the need for joint replacements, citing the fact that the 1st MPJ is an "essential" joint for normal foot function and ambulation. Many patients also find the option of joint replacement initially more attractive and frequently present with the request for a joint replacement.

Unfortunately, the quest for a suitable prosthesis for the great toe joint has been difficult. Clinical studies show varying results, and revision rates tend to be quite high. In addition, most of the clinical studies are less than 5 years in length, making a prediction on long-term survivability nearly impossible. Interestingly, multiple studies comparing 1st MPJ arthrodesis vs. implant arthroplasty demonstrate similar results in patient reported outcomes in regards to pain and function within the first 5 years of the procedure. However, post-operative complications are much more frequent with MPJ replacement arthroplasty. In 2012, Kim et al. reported on the results of a large multicenter comparative study.[1] Their results clearly demonstrated an increased complication rate following joint replacement, with revisional surgery frequent. This demonstrates a clear superiority of the 1st MPJ fusion procedure for longterm stability and predictability.

Although these findings are quite striking, I do occasionally perform 1st MPJ replacement in a select group of patients. Interestingly, the candidates for joint replacement are similar to those with end-stage ankle arthritis who qualify for an ankle replacement. These individuals are typically older (>60 years) with low ambulatory demands, and the inability to remain non-weightbearing for a fusion. Also considered are individuals who may require a certain amount of motion or function about the 1st MPJ for work related purposes. However, they are highly educated on the rate of failure and possible need for future revision (which tends to center around a more complicated bone-block arthrodesis procedure).

In summary, 1st MPJ fusion remains the gold standard for surgical treatment of hallux rigidus. However, a select group of patients may benefit from joint replacement. Any surgeon contemplating 1st MPJ fusion should be well versed in patient selection criteria, as well as revisional techniques if necessary.

Dr. Duane Ehredt is board qualified in Foot and Reconstructive Rearfoot/Ankle Surgery by the American Board of Foot and Ankle Surgery, and an Associate of the American College of Foot and Ankle Surgeons. He is an Assistant Professor in Foot and Ankle Surgery at Kent State University College of Podiatric Medicine in Independence OH. ■

Reference: *1. Kim, PJ, Hatch, D, DiDomenico, LA, Lee, MS, Kaczander, B, Count, G, Kravette, MA, multicenter retrospective review of outcomes for arthrodesis, hemi-metallic joint implant, and resectional arthroplasty in the surgical treatment of end-stage hallux rigidus.* J Foot Ankle Surg. *2012; 51:50-56.*

THE IMPORTANCE of Expressive Therapies in Healing

BY SARAH FRIEBERT, MD, AND ERICA WADE, BS

Sarah Friebert, MD

Erica Wade, BS

THE POTENTIAL OF Expressive Therapy (ET) to provide relief and healing for children with a variety of medical conditions, including those with mental and behavioral health concerns, has wide-reaching implications for health-care providers.

Simply defined, ET is facilitated therapeutic healing in which a safe space allows relationship exploration through a variety of creative outlets. Focused on process, not product, ET enables the development of personal awareness together with a sense of community. Regardless of the modality employed by the therapist or chosen by the participant, ET is a powerful healing tool for achieving therapeutic and medical goals. These include easing distressing symptoms (pain, nausea and anxiety); coaxing out hidden feelings and dynamics (anger, sadness and disappointment); enhancing patient choices and control (especially when their external situations are out of their control); facilitating growth and life opportunities; enabling inward focus and relaxation; and nurturing helpless, exhausted and distraught caregivers. Other family members, such as siblings who are often "forgotten" during a child's medical crisis, also benefit from ET, which is truly family-centered in its approach.

ET is effective for patients because it helps them gain many skills and empowers them to focus on healing. Patients may have many skill levels, ages or experiences, and no prior experience with the arts is required for participation. The purpose is to use the preferred art modality to interact with patients and families who need more options or outlets than other therapies offer, such as talk therapy. For physicians, it can be helpful to think about this approach in terms of a child's point of view: Young children do not yet understand or have the words to express their emotions verbally. How, then, can talk therapy be effective? If you are that same child, for whom creativity is a familiar concept, what better way to express your emotions and pain than by using those things you understand, such as art, music or dance? We have found that for many patients, ET facilitates coping with feelings of fear, depression, isolation, withdrawal, anxiety and even physical pain, creating physiologic benefits through reductions in stress and harmful pain pathways. Further, we have observed that some of these patients require less pain medication for their medical treatment because of the healing power of art.

Expressive therapies can be of key importance not only for the child receiving care, but also for the family members and caregivers of the child. Incorporating ET into treatment can provide a sense of normalcy in the patient's and family's hospital experience, giving families a chance to be together away from the hospital room (if they are able) and a chance to decrease feelings of isolation while increasing communication.

Overall, ET can help children and families focus on healing by reducing the child's perception of pain and anxiety, teaching them relaxation and stress management skills and thereby providing support for them during difficult times.

Dr. Sarah Friebert is board certified in Pediatric Hematology/Oncology, and Hospice and Palliative Medicine. She is Director of the Akron Children's Hospital Pediatric Palliative Care division. Erica Wade is Coordinator for the Emily Cooper Welty Expressive Therapy Center at Akron Children's Hospital. ■

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UNITY HEALTH NETWORK'S Primary Care Core Expanding

BY ALEX LANDERS

UNITY HEALTH NETWORK, Northeast Ohio's largest independent physician group, continues to grow with the recent addition of two long-standing, highly respected physicians: Troy Bishop, MD, and Ruchi Taliwal, MD. Dr. Bishop is board-certified in internal medicine; Dr. Taliwal, in family medicine.

"Primary care physicians are a community's most valuable and cost-effective resource for managing everyday health conditions and chronic diseases. They are the physicians best poised to lead the ongoing transformation of care delivery in our country," says Robert Kent, DO, President of Unity Health Network. "Dr. Bishop and Dr. Taliwal are now providing this much-needed care as members of our team. We are honored to contribute to the healthcare community in our hometown of Cuyahoga Falls and in more than 30 surrounding cities."

COMPLETE FAMILY CARE SERVICES

Dr. Taliwal will add to Unity's home base, seeing patients at the group's flagship office — 3033 State Road in Cuyahoga Falls. She offers rapid scheduling to provide all ages with complete family care, including sick visits; wellness check-ups; seasonal cold, flu and allergy treatment; and more.

"I'm passionate about helping people overcome their health hurdles and live happy, healthy lives, and I'm very excited to join Unity Health Network and serve the families of Cuyahoga Falls and the surrounding communities," says Dr. Taliwal. She earned her medical degree from Dayanand Medical College & Hospital in Ludhiana, Punjab, India, and completed her residency at Summa Barberton Hospital in Barberton, Ohio.

ADDITIONAL OFFICES IN CUYAHOGA FALLS

Dr. Bishop joins Unity Health Network with more than 20 years of experience. He earned his undergraduate degree at Youngstown State University in Youngstown, Ohio, before going on to earn his doctorate at Northeast Ohio Medical University (NEOMED) in Rootstown.

Dr. Bishop sees patients at two locations in Cuyahoga Falls: 3033 State Road, and 1900 23rd Street at Western Reserve Hospital's Professional Building. He will be instrumental in helping to build on the strong infrastructure and processes supporting the population health approach already developed by Unity Health Network. This includes the creation of programs that focus on caring for patients with multiple and serious health issues, along with utilizing preventive care and chronic disease management strategies to improve overall quality of life. Dr. Bishop will also lead a care management team that coordinates care through the home, hospital and post-acute care settings. This team includes a

Troy Bishop, MD

complementary and comprehensive staff of nurse practitioners, RNs and social workers.

"I feel privileged to have been given the opportunity to help patients for the last 20 years of practice. However, the challenges and complexities that face both patients and providers have grown significantly in recent years," Dr. Bishop explains. "I am excited to be a part of Unity Health Network's work of improving the quality and coordination of care for those who need it most."

120+ PROVIDERS

Unity Health Network was built around a primary care core, but it has continued to attract new specialties over the years, including dermatology, gastroenterology, gynecology, infectious disease, orthopedic surgery, otolaryngology, physical and rehabilitation medicine, physical therapy, neurology and neuroscience, nephrology, podiatric medicine and surgery, psychiatry, pulmonary and critical care medicine, rheumatology and sleep medicine. Currently, Unity is comprised of more than 120 healthcare providers with offices in over 30 locations.

"The addition of these two highly respected physicians with great professional reputations is a clear example of how we are expanding our primary care network and our capabilities to deliver high quality comprehensive care," says Dr. Kent.

To contact the office of Dr. Ruchi Taliwal, call 330-928-6780. Dr. Troy Bishop is available at 330-928-6780. For more information on Unity Health Network's growing group of providers, visit www.unityhealthnetwork.org. ■

Ruchi Taliwal, MD

Unity Health Network NE Ohio Providers

Victoria Alexander, DO, Hudson
Michelle Bandurka, MSN, CNP, Tallmadge
Sherri Barr, MD, Streetsboro
Vera Bicak-Odak, DO, Cuyahoga Falls
Troy W. Bishop, MD, Cuyahoga Falls
Patrick Blakeslee, DO, Cuyahoga Falls
Kelley Cerroni, MD, Kent /Tallmadge
Matthew Chase, MD, Hudson /Stow
Ashwin Pai Dhungat, MD, Twinsburg
David Fantelli, MD, Kent/Hudson/Tallmadge
Janine Galeski, FNP-C (Ambulatory)
Lori Gemma, DO, Macedonia
Paul Gibbons, MD, Stow
Erin Jeffers, DO, Macedonia
James Johnston, DO, Cuyahoga Falls
Douglas Kast, DO, Stow
Robert Kent, DO, FACOI, Cuyahoga Falls
Walter Klatt, MD, Akron
Carrie Leister, PA-C, Stow
Nathan Lucardie, MD, Kent/Streetsboro
Cheryl Lango Mader, DO, Macedonia
Julia LaRocca, CNP (Ambulatory)
Thomas Maguire, Jr., DO, Macedonia
Alicia Medina, MSN, CNP (Ambulatory)
Laura Meyer, DO, Stow
Kimberly Miller, DO, Cuyahoga Falls
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Brian Pollock, DO, Cuyahoga Falls
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Ronald Russ, DO, Hudson
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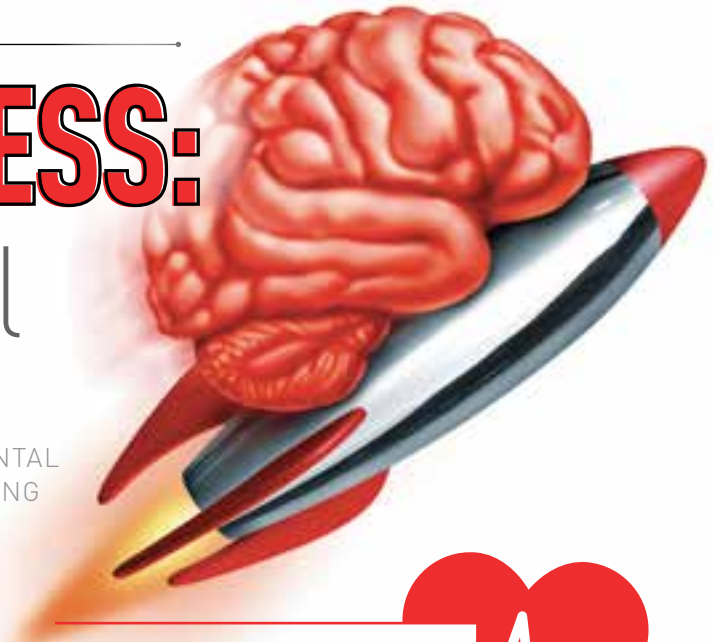
Michael Shanafelt, DO, Kent/Tallmadge
Ruchi Taliwal, MD, Cuyahoga Falls
Jon Tosino, MD, Hudson
David Uhall, MD, Kent/Tallmadge
John Wagner, DO, Stow

MENTAL ILLNESS: A Rising Toll

BY STEVE BARRETT



MILLIONS OF AMERICANS ARE AFFECTED BY MENTAL ILLNESS. HOWEVER, A WORSENING SHORTAGE OF MENTAL HEALTH SERVICES COULD BLOCK ACCESS TO PROMISING NEW THERAPIES FOR MANY.

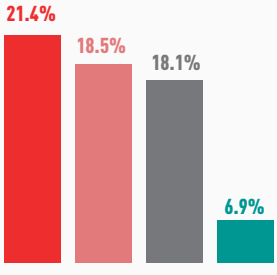
LEFT UNTREATED ...

Mental illness is financially devastating for individuals, families and society. Americans lose more than **$193 billion** in income annually due to serious mental illness. Among adults ages 18–44 and youths, mood disorders are the third most common reason for hospitalizations.

Premature Death

Typically, Americans die **25 years** sooner if they have a serious mental illness.

RATES OF MENTAL ILLNESS IN THE U.S.



21.4% of youths 13–18 experience a severe mental disorder.

18.5% of adults experience mental illness in a given year.

18.1% of adults experience an anxiety disorder.

6.9% of adults had one or more major depressive episodes in the past 12 months.

PROVIDER SHORTAGE

The dearth of mental healthcare services is visible on multiple fronts.

+ As a proportion of their populations, **45 states** had fewer psychiatrists in 2014 than in 2009.
+ The United States needs **123,300 psychiatric hospital beds** in addition to the existing **37,700**.
+ A 2014 survey of **38 state mental health directors** found half of those states were held in contempt or were threatened with contempt citations for slow placement of mentally incompetent inmates in mental health facilities.
+ **Seven in 10 emergency rooms** have boarded psychiatric patients for at least 24 hours. Those stays have stretched to at least a week for **10%** of emergency rooms.

TELEMEDICINE TO THE RESCUE?

Behavioral health-related telemedicine services are reimbursed by **48 state Medicaid programs**, and some organizations are leveraging telemedicine to treat patients who might otherwise go without care.

The **10,000 subscribers** to Teladoc Behavioral Health's direct-to-consumer behavioral healthcare program engage in "more than **1 million asynchronous texting sessions** per quarter," according to Forbes. ■

GLOBALLY DEBILITATING

Issues such as drug use, depression and anxiety are the main cause of disability worldwide. Among people 20 to 29 years of age, they account for the equivalent of more than **40 million years** of disability.

Sources: National Alliance on Mental Illness, The Lancet, *Mental Health Foundation, Stateline, Association of American Medical Colleges, Forbes*

COMPLYING

with the New Conditions of Participation for Home Health Agencies

BY LAURA FRYAN

THE CENTERS FOR Medicare & Medicaid Services (CMS) revised and re-organized the existing conditions of participation (CoPs) for home health agencies (HHAs). The CoPs have not been updated for almost two decades, so on January 9th CMS finalized an overhaul. The changes are effective July 13, 2017 — here is an overview:

CARE PLANNING, COORDINATION OF SERVICES, AND QUALITY OF CARE (§ 484.60)

The HHA must provide the patient with a plan of care that sets out the patient's care and services and anticipated outcomes. Key requirements in this section include:

+ The plan must be reviewed and revised by the physician who was responsible for the HHA's plan of care and the HHA as frequently as the patient's conditions or needs require, but no less frequently than every 60 days.

+ The HHA must ensure that each patient and caregiver, if applicable, receives ongoing training and education regarding the care and services identified in the plan of care that the patient and caregiver are expected to implement.

+ The HHA must ensure that each patient and caregiver receives any training necessary for a timely discharge.

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT (QAPI) (§ 484.65)

This section replaces two current CoPs with a new QAPI program. The QAPI program will show measurable improvement in indicators for which there was evidence that the improvement led to improved health outcomes, safety, and quality of care for patients.

INFECTION PREVENTION AND CONTROL (§ 484.70)

This new CoP requires HHAs to follow infection prevention and control best practices, maintain a coordinated agency-wide program to identify and control infectious and communicable diseases, and provide education on current best practices to staff, patients, and caregivers.

SKILLED PROFESSIONAL SERVICES (§ 484.75)

This new CoP sets forth requirements for skilled professional services. One of the key requirements is the supervision of skilled professional assistants. An RN must supervise the care provided by nurses such as licensed vocational nurses and licensed practical nurses. All rehabilitative therapy assistant services must be provided under the supervision of a physical therapist or occupational therapist. Also, all medical social services must be provided under the overall supervision of a Master of Social Work.

PERSONNEL QUALIFICATIONS (§ 484.115)

An HHA administrator must be a licensed physician, a registered nurse, or hold an undergraduate degree, with at least one year of supervisory or administrative experience in home health care or a related health care program. Current HHA administrators are grandfathered in under this new CoP. A speech-language pathologist must have a master's or doctoral degree in speech-language pathology and be licensed as a speech-language pathologist by the state in which he or she furnishes these services.

In addition to the changes above, CMS eliminated the concept of sub-units. Existing sub-units, which already operate under their own provider number, will now be considered distinct HHAs and will be required to independently meet all CoPs without sharing a governing body or administrator.

HHAs should begin to implement any changes needed to comply with the new and revised CoPs. While CMS intended to streamline some of the requirements for HHAs and provide flexibility, HHAs have even more requirements now for patient care and administration.

Laura Fryan is an attorney in the Health Care Practice Group of Brouse McDowell in Akron OH. ■

WILL PRESIDENT TRUMP BRING COMPREHENSIVE TAX REFORM?

BY FRED LUECKE, CPA, CMPE

THE PATHWAY TO tax reform may be clearer than ever. During his presidential campaign, President Donald Trump advocated for tax reform and released a detailed plan of changes he would make. Republicans in the House of Representatives also developed a 'blueprint' for tax reform that shares common goals with President Trump's plan.

Changes to the individual and corporate tax code could have a significant impact on the medical community, particularly if these changes include a repeal of the Patient Protection and Affordable Care Act (ACA), which imposes a 3.8 percent net investment income tax (NIIT) on capital gains for individuals with net investment income above certain thresholds and an additional .9 percent Medicare tax on individual wages above certain thresholds.

Reform is a priority both for President Trump and Congress, and they are well-positioned to put their plans into action through either bipartisan bills or a budget reconciliation process. Whatever the pathway used, the outcome will likely be a mixture of President Trump's tax plan and the House Republicans' Tax Reform Blueprint. Evaluating how the provisions align may indicate the shape tax reform takes.

TAX IMPLICATIONS OF AN ACA REPEAL

An early executive order and budget activities in Congress have signaled that health care reform may be coming soon. Some provisions of the ACA have already been singled out for change. The Consolidated Appropriations Act of 2016 put the ACA's 2.3 percent excise tax on the sales of certain medical devices on hold until December 31, 2017. Repealing the ACA would likely mean the medical device tax would go away, as would the additional Medicare tax and the NIIT.

INDIVIDUAL TAX CONSIDERATIONS

President Trump's plan and the Tax Reform Blueprint would create three tax brackets: 12 percent, 25 percent and 33 percent. Thresholds in both plans differ slightly, but the effect would be a significant reduction in tax rates for the highest earners, particularly when combined with a repeal of the ACA. Eliminating the NIIT and lowering the top tax rate could lower the current maximum individual tax rate by 10 percent.

Standard deductions would be revisited in both plans as well. The Tax Reform Blueprint combines the standard deduction with the personal exemption to create a $12,000 deduction ($24,000 if filing jointly). President Trump's standard deduction is slightly higher at $15,000 ($30,000 if filing jointly). Under the House Republican plan, all itemized deductions would be disallowed except for mortgage interest and charitable contributions. President Trump's plan puts a cap on itemized deductions. Both plans call for the repeal of the alternative minimum tax.

CAPITAL GAINS

The NIIT isn't the only provision being considered that could affect tax treatment of capital gains. House Republicans advocate taxing capital gains, dividends and interest as ordinary income with a 50 percent exclusion. If the Tax Reform Blueprint plans are enacted along with the consolidated tax brackets, capital gains would be taxed in three brackets: 6 percent, 12.5 percent and 16.5 percent. President Trump's plan would lower the capital gains tax so that the maximum rate would be 20 percent.

ESTATE TAX

Proposed changes to the estate tax may be more easily discussed than enacted, as the estate tax has long been a hotly contested issue. The Tax Reform Blueprint and President Trump's plan call for the repeal of the estate tax. President Trump's plan supports taxing capital gains held at death if the gains exceed $10 million.

MONITORING LEGISLATIVE ACTIVITY

No matter which tax changes are approved, it is highly unlikely that reform will be retroactive. Individuals that plan ahead with gifting, charitable contributions or other planning vehicles may be able to take full advantage of revised tax provisions. An experienced tax advisor can offer assistance in maximizing available benefits.

Fred Luecke is the Health Care & Accounting Services Practice leader for the Northeast Ohio region of CBIZ, MHM, LLC, an independent CPA firm. He provides consulting services to physician practices to facilitate financial accounting and tax functions, strategic decision-making, and business management. ■

2017 MDNEWS Editorial Calendar

MAY-JUNE
Neurology and Neurosurgery – Stroke, Parkinson's and essential tremor, epilepsy, Alzheimer's, ADHD, spine disorders, etc.

JULY-AUGUST
Chronic Diseases – Diabetes, heart & vascular disease, cancer, obesity, infertility, arthritis, ENT disorders, vision problems, etc.

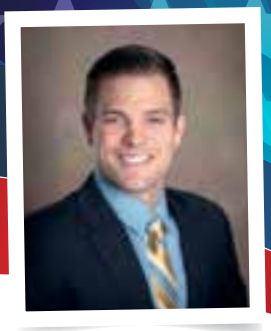
SEPTEMBER-OCTOBER
Cancer, Hospice & Palliative Care
Diagnosing, treating, palliating and offering end-of-life care for adults and children with cancer.

NOVEMBER-DECEMBER
Surgery – Laparoscopic, endoscopic, robotic-assisted, single-port, NOTES, TAVR, and more.

PRESIDENT TRUMP

Pumps the Brakes on the Fiduciary Duty Rule

BY LUCAS W. MURRAY, ESQ.



ON APRIL 6, 2016, the Department of Labor (DOL) released the Final "Fiduciary Duty" Rule (29 CFR Parts 2509, 2510, and 2550); generally set to go into effect on April 10, 2017. The rule expands the definition of "investment advice fiduciary" under the Employee Retirement Income Security Act (ERISA), and requires the disclosure of fiduciary conflicts of interest in retirement advice, which, prior to the rule, were not always required to be disclosed to clients. The DOL's intent was to save middle-class families on investment costs.

On February 3, 2017, President Trump issued a Presidential Memorandum on Fiduciary Duty Rule directing the Secretary of Labor to evaluate the rule in order to determine the potential adverse impact on investors, retirees, and the retirement industry. President Trump's stated priorities are to empower Americans to make their own financial decisions, facilitate Americans' ability to save for retirement and build the wealth required to afford life expenses and weather unexpected financial emergencies. Should it be determined that the current rule fails to comport with these goals, the Secretary is directed to propose rescission or revision of the rule. The DOL responded to President Trump's memorandum with one simple sentence: "The Department of Labor will now consider its legal options to delay the applicability date as we comply with the President's memorandum."

There are many that support the rule, including the Certified Financial Planner Board and the Consumer Federation of America Director of Investor Protection, who argue that financial service firms have already begun to make adjustments to implement the rule, with little impact on their investment offerings or price. Moreover, three Courts have recently upheld the rule, finding that the DOL acted within its statutory authority under ERISA.

Until further notice, the April 10, 2017, implementation date remains in effect.

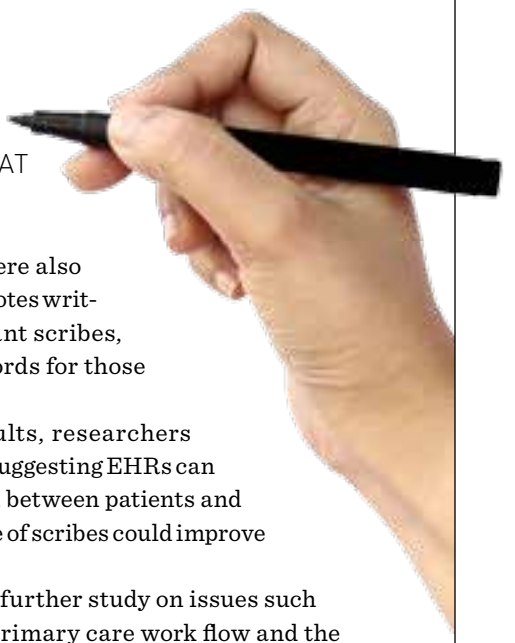
NOTE: This general summary of the law should not be used to solve individual problems since slight changes in the fact situation may require a material variance in the applicable legal advice.

Lucas W. Murray is an attorney with the law firm of Krugliak, Wilkins, Griffiths & Dougherty Co., LPA, in Canton OH. ■

Scribes May Enhance Quality of Outpatient Notes

BY STEVE BARRETT

THE GROWTH OF EHRs HAS BOOSTED USE OF MEDICAL ASSISTANT SCRIBES. A STUDY IN *THE JOURNAL OF FAMILY PRACTICE* SUGGESTS THAT MAY BE A WORTHWHILE INVESTMENT.



RESEARCHERS COMPARED THE quality of 217 outpatient progress notes written at eight practice sites within a single health system before and after the practices shifted from physicians writing the notes to medical assistant scribes handling that task. The notes were related to diabetes care and same-day appointments.

With regard to diabetes, notes written by medical assistant scribes were of higher quality overall than those written by the primary care physicians. The scribes' notes were deemed more thorough, understandable, useful and up to date, according to the study.

Quality was similar, however, for physicians' and scribes' notes that related to same-day appointments. The average lengths of the notes were also similar: 618 words for notes written by medical assistant scribes, compared with 558 words for those written by physicians.

Discussing the results, researchers cited previous studies suggesting EHRs can hinder communication between patients and physicians, and that use of scribes could improve those interactions.

They recommended further study on issues such as how scribes affect primary care work flow and the cost of care. ■

Local Docs in National News

TRAPP AND MACIEJEWSKI RECEIVE NIH OUTSTANDING INVESTIGATOR AWARD

Bruce Trapp, PhD, a specialist in multiple sclerosis (MS) and myelin biology, and Jaroslaw Maciejewski, MD, PhD, an expert in blood and bone diseases, have each received an Outstanding Investigator Award from the National Institutes of Health (NIH).

The awards are designed to provide long-term support and flexibility to scientists whose work holds out promise for achieving medical breakthroughs, allowing them to focus on research instead of funding.

Dr. Trapp, chair of the Department of Neurosciences at the Lerner Research Institute, becomes the first Cleveland Clinic researcher to be named an Outstanding Investigator by the National Institute of Neurological Disorders and Stroke of the NIH. He will receive nearly $7 million over the next eight years to examine the biology of MS and to seek treatments that could slow or reverse the disease. With this grant support, Dr. Maciejewski, chair of the Department of Translational Hematology and Oncology Research at Cleveland Clinic, will receive more than $5.5 million over the next seven years from the National Heart, Lung and Blood Institute of the NIH. The award will support his work translating scientific advances in bone marrow failure syndromes into improved patient care.

LASS RECEIVES CORNEA SOCIETY'S HIGHEST HONOR

The Cornea Society has awarded Jonathan Lass, MD, the Castroviejo Medal, its highest honor. Dr. Lass, an ophthalmologist at University Hospitals Eye Institute at UH Cleveland Medical Center and Charles I. Thomas Professor of Ophthalmology at Case Western Reserve University School of Medicine, receives the award in recognition of his lifetime contributions to research and pioneering advancements in corneal transplant and surgery.

Dr. Lass is a nationally recognized specialist in corneal diseases and corneal transplantation. He directs the UH Cornea Image Analysis Reading Center, one of the top cornea image analysis centers in the country. He has authored or co-authored more than 200 publications, and coordinated many multi-institutional trials to add to the body of knowledge about eye donation and cornea viability.

He is the former Chair of Ophthalmology at UH Cleveland Medical Center and Case Western Reserve University School of Medicine. He served as one of the study leads on the National Eye Institute (NEI) sponsored Cornea Donor Study, the first masked, randomized, controlled study to demonstrate that donor age has no impact on the success of the transplant for 80 percent of recipients, eliminating a common bias against corneas from older donors. Currently, he serves as the principal investigator on an NEI-sponsored national multi-center, masked, randomized trial to determine the optimal time frame for usage of donated corneas, the Cornea Preservation Time Study. ■

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PRODUCT SPOTLIGHT

BY STEVE BARRETT

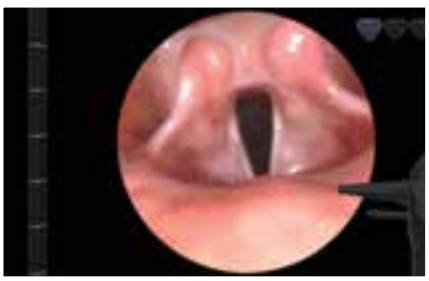

Image courtesy of Level EX

AIRWAY EX MOBILE APP

A NEW 3-D virtual surgery app by technology company Level EX draws on the knowledge of leading surgeons and video game developers to help physicians sharpen their minimally invasive surgical skills for procedures involving the airway.

Critical care specialists, otolaryngologists, emergency medicine physicians, anesthesiologists and pulmonologists will find the free Airway EX app useful, according to the company.

The technology simulates endoscopic device optics, the dynamics of human tissue and the movement of fluids accurately to generate lifelike surgeries. Actual surgeries submitted by physicians serve as models for virtual patient cases. Level EX helps physicians prepare for seldom-seen or unexpected occurrences during surgery, according to Sam Glassenberg, CEO and Founder of the Chicago-based company.

"[T]he video game industry is at least a decade ahead of medical simulation when it comes to technology, distribution and business models," Glassenberg says.

Almost one in five U.S. physicians has used virtual reality professionally, according to a 2016 study by information technology company Decision Resources Group. ■

Image courtesy of BioTrace Medical

TEMPO LEAD

SAN CARLOS, CALIFORNIA-BASED BioTrace Medical has gained FDA clearance for a temporary pacing lead for use in transcatheter aortic valve replacement (TAVR) or other procedures that make temporary pacing necessary.

Tempo Lead produces stable, secure cardiac pacing through use of an innovative active fixation mechanism, a soft tip and bipolar electrodes, according to the company, and it promotes earlier ambulation by patients and reduced complications.

Conventional leads can easily become dislodged from the heart, possibly causing a loss of pacing. That frequently restricts patients to bed rest for the length of time during which they have temporary pacing lead placement, which can lengthen ICU stays. Conventional technologies also can perforate the heart wall, leading to cardiac compression. Tempo Lead's fixation mechanism and soft tip reduce those possibilities.

Nearly 400,000 procedures annually require the use of temporary leads, the company states in a news release. ■

Image courtesy of BIOTRONIK

INVENTRA HF-T

AN ESPECIALLY POTENT implantable cardioverter defibrillator has arrived in the United States.

On the first shock, Berlin-based BIOTRONIK's Inventra HF-T, a cardiac resynchronization therapy defibrillator (CRT-D), delivers 42 joules (J), according to the company.

The device is designed for patients who experience heart failure.

"For an increasing number of patients — specifically those with larger cardiac anatomy and lower ejection fraction — a shock that is higher than the standard 36–37 J may be needed to convert irregular arrhythmia," Mark Mascarenhas, MD, electrophysiologist at Jersey Shore University Medical Center in Neptune, New Jersey, says in a news release about Inventra HF-T. "The sooner an effective shock can be delivered, the likelihood of survival increases for these patients."

He notes that a CRT-D that delivers a higher initial level of energy is more likely to convert irregular arrhythmias. ■

MDNEWS link

For a Vital Curriculum Vitae

BY STEVE BARRETT

UNLESS YOU NEVER PLAN TO SEEK EMPLOYMENT OUTSIDE YOUR CURRENT ORGANIZATION, A CV THAT SUMMONS TO MIND PRE-INTERNET EDITIONS OF ENCYCLOPAEDIA BRITANNICA MAY BE, SHALL WE SAY, SUBOPTIMAL.

ST. LOUIS-BASED physician recruitment and staffing firm Kendall & Davis offers hints for constructing a CV that reduces eye glaze among hiring managers:

+ **And you are ...?** It may seem obvious, but your name and all contact information should be front and center.

+ **Cut, cut again.** Brevity multitasks as the soul of both wit and an effective CV. Max out at five pages, but note that you can provide information about research grants, CME, etc., on request.

+ **Categorically speaking ...** A section about your medical education should include detailed information about internships, residencies and fellowships, as well as actual or anticipated completion dates. An employment section should start with your most recent position and note all titles, admitting facilities and contact information.

+ **Get it right.** Inaccurate dates of service or a failure to list all the jobs you've held can doom your chance of employment if (read: when) a hiring officer double checks.

+ **Rules for references.** If you list professional references, provide no more than six and limit them to name, title and contact information. Or just state that they are available on request. ■

MDNEWS link

PHYSICIANS GIVE THE SKINNY ON RECRUITMENT

BY STEVE BARRETT

GENERATING THE RIGHT POOL OF PHYSICIAN CANDIDATES FOR A POSITION IS TRICKY UNDER THE BEST OF CIRCUMSTANCES. IT'S TOUGHER STILL WITHOUT A CLEAR UNDERSTANDING OF WHAT PHYSICIANS VALUE.

FORT WASHINGTON, PENNSYLVANIA-BASED M3 Global Research spent 18 months surveying physicians to glean their views about recruiting, onboarding and retention. Here are some of the key takeaways:

+ **Getting mobile.** More than four out of five physicians told M3 they were willing to relocate for their next position, and a majority of those said they were willing to move out of state.

+ **Getting to the point.** Job title and location should be prominent in job postings. Physicians rarely read beyond the headlines in emailed postings unless the headline does something to spark their interest or they are already actively seeking a new job.

+ **Getting to know you.** More than 40 percent of physicians who responded said an orientation program was available at their organization, compared with only 10 percent whose organization provided a formal onboarding program. (Almost half said their organization had neither.)

+ **Getting retention right.** It's not all about the money, but money matters. More than three out of five respondents ranked bonuses as the most important retention program feature. However, work-life balance was a close second. ■

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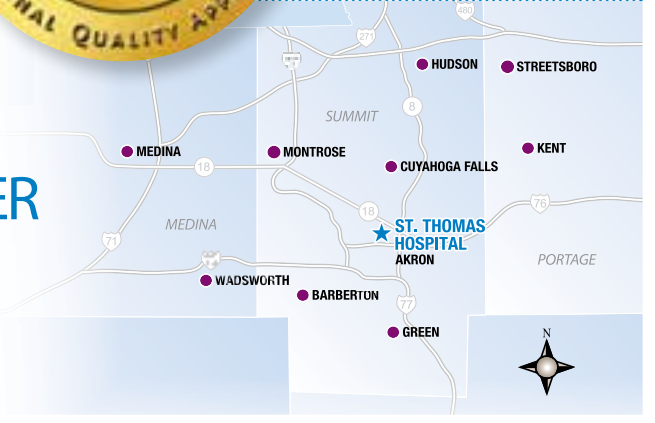

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