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William "Bill" Clifford, MD

ON ROUNDS

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CARDIOLOGY

New UAB Clinic Addresses Women's Heart Health

BY ANN B. DeBELLIS

A new UAB Women's Heart Health Clinic has opened at The Kirklin Clinic to address the concerns of women who face cardiac issues. Directed by UAB Cardiologist Salpy Pamboukian, MD, MSPH, the clinic will evaluate and manage women with an array of cardiac issues, while attending to treatment specifics that are more germane to women.

According to the American Heart Association, only one in five women believe that heart disease is their greatest health threat. "Despite the fact there is plenty of public information about heart disease, many women are not receiving the message that heart disease is still the number one cause of death in the U.S.," Pamboukian says. "A lot of women put off getting the kind of medical care they need. I also believe that there is still a lack of understanding in the medical community of how heart disease can affect women. Whatever the reason, delays in diagnosis give the disease time to advance."

Pamboukian says that while the management of heart disease is similar for men and women, women are different with the presentation of symptoms. "Women tend to present with more atypical symptoms,

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Cardiologist Salpy Pamboukian, MD, MSPH, will direct the new women's heart clinic at UAB.

The Repeal of Obamacare

BY JANE EHRHARDT

"What the healthcare community hates about the Affordable Healthcare Act (ACA) is that our patients have very few choices and are not able to have the insurance they expect," says Chad Mathis, MD, an orthopedic surgeon in Pelham, Alabama.

Hospitals, he says, will lament the loss of the ACA. "They benefited the most from it. The formation of Accountable Care Organizations fed everything into hospital-based type systems so we've seen less control between physicians and patients under Obamacare. And we don't have as many independent practitioners anymore."

Mathis ran for Congress in 2014 in the 6th district. Though



he lost the election, he stayed connected with the "doc caucus" in DC composed of healthcare professionals serving as Republican House members, including physicians, dentists, nurses and pharmacists. "We lost a few members this last election, so we're down to nine," he says.

In December, Mathis attended the doc caucus meeting in DC where Representative Tom Price — President Trump's choice for secretary of health and human services — spoke on his plans. "He talked about what we would see moving forward," Mathis says.

Price, an orthopedic surgeon representing the northern suburbs of Atlanta, has introduced detailed bills to replace the ACA in every Congress since 2009. Many of his

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Dream Deferred Becomes Fulfilling Career for Family Physician

By CARA CLARK

For most professionals, there is a prescribed career path to follow. When that leads to success, it's time to revel — or even rest on your laurels. Not so, however, for William “Bill” Clifford, MD. When he reached the pinnacle of a legal career, he couldn't stop the niggling thought that maybe he should have been a physician.

It all went back to a dilemma he faced in college. He found science fascinating and considered medical school. Instead, the lure of the complexities of the legal field took him to Emory University School of Law, the attorney general's office, and ultimately to the Alabama Supreme Court.

With then Attorney General Bill Prior's office, Clifford litigated some of the state's most important issues at the time, including such benchmark cases as the Americans with Disabilities Act.

“We were involved in some interesting issues and were able to be part of how the state integrated itself into the national framework,” Clifford said.

It was there that Clifford also met his wife, Jennifer Nalu, who was working in the white-collar crime division.

“I worked in constitutional law for a while, then with a law firm in litigation, and I paid off my student loans,” Clifford said. “After working with the Supreme Court and the Alabama Supreme Court, I felt like I had accomplished my goals. I'd always wanted to be a doctor. So I started taking classes at night and on weekends just to see how I liked it.”

When Clifford wasn't at the law firm, he was studying medicine — balancing a successful career as a litigator with the drive that kept pushing him to do more.

“It just snowballed,” Clifford said. “I realized I really wanted to help people. That had been my motivation all along. People change careers lots of times. I never saw it as a barrier.”

Clifford earned his medical degree at UAB before completing his family medicine residencies at the Mayo Clinic School of Graduate Medical Education in Florida and at the University of Alabama program in Tuscaloosa. His goal to help people led Clifford to primary care, turning down an opportunity to go into internal medicine at Yale.

“I wanted to take care of regular people on a daily basis and get to know them,” Clifford said. “That's why I'm in family medicine.”

Medicine runs in Clifford's family. His father and grandfather were general surgeons. One of his sisters is in a radi-



Bill Clifford, MD was deployed to Afghanistan and Kosovo.

ology fellowship at Emory University, and the other is a nurse practitioner. There are six other physicians among the aunts and uncles in his family.

“I had always had this background and love of medicine, but when I talked about becoming a doctor, my wife wasn't very happy at first,” Clifford said.

After all, he was a success in the legal field and could continue to rise in the profession. She, too, was building her career and is now a judge in the Shelby County court system.

“It was a big change,” he said. “Here you are, both with established careers, and I'm going to go to medical school. Even for young doctors, being on-call is tough. My wife is the hero of it all. She's done the hardest work.”

In addition to her judgeship, the two have a four-year-old daughter. It was a natural decision to remain in Birmingham, and after a residency at the Mayo Clinic, Clifford returned to practice at Grandview in Chelsea, finding fulfillment in his relationship with his patients.

It's a success story beyond what most achieve in a lifetime, but Clifford wasn't

finished there. He made a commitment to his country by joining the National Guard. A captain now, he has served active duty, traveling to Afghanistan (2012-13) and Kosovo (2014-15) in service to the troops.

“Being a doctor in the army is the best job in the world,” Clifford said. “You get to take care of people who love this country and who are the best and brightest. Who wouldn't want to do that?”

Just before joining Grandview, Clifford was in Kosovo on a mission with a NATO peace-keeping force. As a

flight surgeon responding to emergency calls, he's a veteran of numerous missions on the army's workhorse Chinook and Blackhawk helicopters. In Afghanistan, he ran a small emergency clinic.

“I got lucky,” he said. “I basically got to fulfill all my dreams. How can you not be happy doing that? I practiced law for nine years. I love flying army aircraft. I love being a doctor.”

Clifford's philosophy sums it up: “Never stop moving. Never stop to look behind you. Always keep looking forward. If you do that everyday, things tend to work out.”

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New Breakthrough Helps High-cholesterol Patients

By DALE SHORT

30 years ago, the introduction of statins proved to be a major breakthrough in cardiovascular care. The cholesterol-lowering medicines became the best-selling drugs in pharmaceutical history. Now there is a new breakthrough - two injectable medicines, known as PCSK9 inhibitors, that fight cholesterol by attacking the enzymes that allow cholesterol to migrate into the bloodstream.

"These new drugs are totally different than statins," says Dr. Anu Rao of CardioVascular Associates. "Statins function through the liver, while the new drugs operate through the immune system by blocking the destruction of LDL cholesterol receptors."

The two drugs, known as evolocumab (Repatha®) and alirocumab (Praluent), are similar but have different chemical structures. They can be effective in as little as three to seven days.

"When LDL (low-density lipopro-

teins) particles go through the bloodstream, they're cleaned out by our cholesterol receptors," Rao says. "These new agents block the destruction of the cholesterol receptors, leaving more of them available to clean out cholesterol particles."

The mechanism by which cholesterol receptors are destroyed is a protein called PCSK9 which binds to the cholesterol receptors. The new drugs are PCSK9 inhibitors.

Thus far, the results are impressive. One 12-week study showed that Repatha® lowered LDL

an average of 71 percent when added to a statin.

"This is a huge breakthrough," says Rao. "We, of course, want to see the long-term data, but the initial figures are very impressive in reducing vascular events and mortality from heart attack, stroke, and peripheral artery disease (PAD)."

"The drugs appear to reduce deaths from those factors to a degree that is above and beyond what statins have done

in the past. The statins are really good drugs and there's still an important role for them. Unfortunately, some patients have incredibly high cholesterol despite getting the maximum dose of statins. The new medicines help patients in this category."

"The newer medications bring the focus back to numbers, but there are other bad cholesterol particles in the bloodstream and we need patients to know that their numbers don't completely indicate their risk. Some people can have low numbers and can still be high-risk, while others can have high cholesterol levels and never have a heart attack in their lifetime."

"A person's cardiovascular risk has to be considered in the context of other factors like family history, smoking, diabetes, high blood pressure, and other novel risk factors like rheumatoid arthritis and lupus. The new medications can be very helpful for patients who have familial hypercholesterolemia in whom cholesterol levels are super-elevated, contributing to cardiac risk. In patients who do not have familial hypercholesterolemia, they are currently not approved for use in the absence of a prior cardiac event like a heart attack or stroke."

"People with many risk factors still need cholesterol modification with traditional therapies including lifestyle changes and, if appropriate, statin therapy. High-risk patients or patients who already have coronary disease should ideally get high-intensity statins like Crestor (Rosuvastatin) or Lipitor (Atorvastatin)."

Can cholesterol ever be too low? "Not that we know of," Rao says. "Many decades ago it was shown observationally that people with very low cholesterol, say under 30, had a higher mortality rate. But when they examined why these people had low cholesterol, there were often other contributing factors like poor nutrition, and debilitation from cancer or other diseases that would have contributed to their mortality rates. In randomized controlled studies, there's been no significant harm seen in people with super-low cholesterol levels. If anything, lowering the LDL level well beyond the target of 70 has shown further reduction in cardiac events. Fetal cholesterol is about 30. It's actually less ideal to under-treat a person who is high risk as they may not get the full benefit of available therapies and go on to have a preventable vascular events like heart attack and stroke."



Dr. Anu Rao

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Clearing Clots With AngioVac®

BY LAURA FREEMAN

In the days of door to door vacuum cleaner salesmen, a common sales technique was to astound the prospective customer by cleaning a huge pile of debris from the living room rug. All these decades later, sometimes it's still amazing to see what a well-designed tool can do to clean up a big problem.

"The first time I used the AngioVac venous drainage system, it really was amazing," Russell Ronson, MD, of UAB Cardiovascular and Thoracic Surgery at Brookwood said. "When you see how large some of the thrombi and emboli we've removed are, it's remarkable."



Russell Ronson, MD

Venous thromboembolism is the third leading cause of cardiovascular mortality. The AngioVac system from AngioDynamics offers a new approach to treatment that could change that statistic. It is the first nonsurgical method for removing major soft, fresh thromboembolisms obstructing the large central veins and the right atrium. It is also used in serious cases of deep vein thrombosis in the legs.

"In the past, there usually wasn't a lot we could do beyond giving patients blood

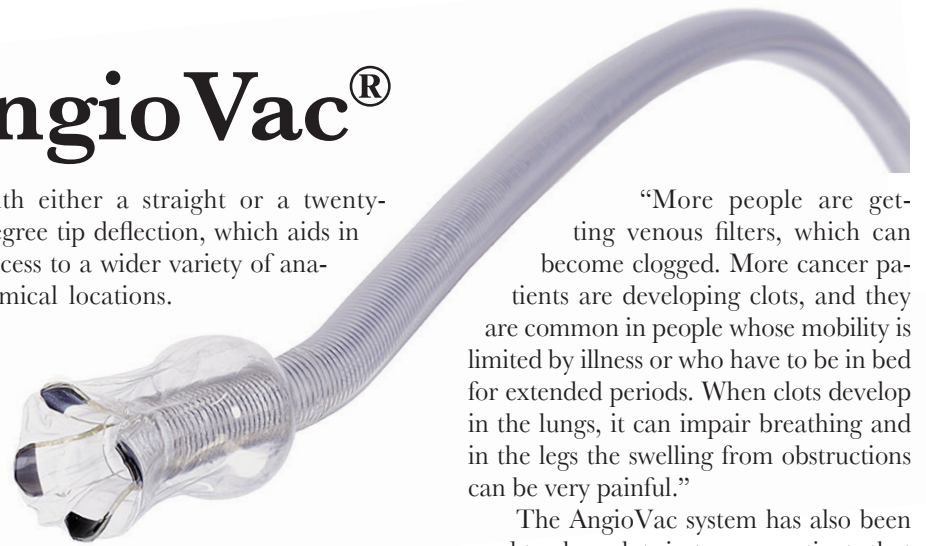
thinners and hoping the body would dissolve the clot, or give them medicines to dissolve it, but that came with a high risk of bleeding. Now, if there's a life-threatening situation or a large clot in one of the big veins of the body, we can remove it," Ronson said.

The AngioVac cannula's balloon-actuated, expandable funnel-shaped distal tip is designed to enhance venous drainage flow and prevent clogging to facilitate removal of material. The system includes the cannula and the extracorporeal circuit, which can be used in procedures requiring extracorporeal circulatory support for up to six hours.

"Ultrasound and CAT scans show us where the problem is. We perform the procedure in a surgical suite where the AngioVac system is set up at Brookwood Hospital. Patients are under general anesthesia and are given a blood thinner," Ronson said. "Two incisions are required, one for the AngioVac cannula and one for the return cannula. Depending on where the obstruction is, we can get access through any combination of the femoral or internal jugular vein as needed."

The system can be used in both percutaneous and open procedures. Radiopaque markers on the distal end of the cannula allow visualization under fluoroscopic imaging. The cannula is available

with either a straight or a twenty-degree tip deflection, which aids in access to a wider variety of anatomical locations.



AngioVac devices can be used with other manufacturer's off-the-shelf pump, filter, and reinfusion cannula.

An outflow line, centrifugal pump, filter and inflow line create an extracorporeal bypass circuit. The circuit reinfuses the filtered blood back into the body, which helps to minimize blood loss and to prevent hemodynamic instability. Once the cannulas are in place, the centrifugal pump is activated, creating a one-way flow that provides suction.

"I've been using the system for around eight months now. It's not something I use every day or in every case, but when a patient needs it, it can make quite a difference," Ronson said. "We do a lot of other cardiovascular and thoracic surgery, but it seems that venous thromboembolism cases are becoming more common."

"More people are getting venous filters, which can become clogged. More cancer patients are developing clots, and they are common in people whose mobility is limited by illness or who have to be in bed for extended periods. When clots develop in the lungs, it can impair breathing and in the legs the swelling from obstructions can be very painful."

The AngioVac system has also been used to clear clots in trauma patients that have developed vein obstructions as a secondary complication.

Generally, the device works best on fresh, soft clots rather than old, hard obstructions which have attached to the vein, so when patients present with symptoms that may need intervention, the sooner an evaluation can be scheduled, the better.

Each year in the United States, there are an estimated 900,000 to one million venous thromboembolism events. Almost 60 percent occur in hospitals or nursing homes, with a fatality rate in hospitalized patients of 12 percent which rises to 21 percent in the elderly.

"Now that an increasing number of patients are having this problem, it's great that we don't have to just give them medications and hope for the best. We can clear obstructions and clean out those veins," Ronson said.





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Brookwood Baptist Cardiovascular Research Takes a Leading Role in Two International Trials

BY LAURA FREEMAN

Can stem cells mend a broken heart? Which approach to managing carotid stenosis is the best option to help which patients avoid a stroke?

Answers might be found in two major clinical trials at Brookwood Baptist Health, which has risen in prominence in cardiovascular research after enrolling more participants in both the DREAM HF trial and the CREST 2 trial than most centers in the US.

DREAM HF Trial Rejuvenating Failing Hearts

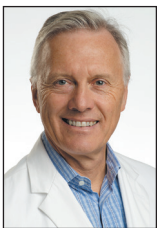
Heart disease in 2017 is a good news/bad news story. The good news is that advances in treatment are saving more lives than ever. The bad news is that a growing number of elderly people are burdened with heart failure, carrying with it a sense of inevitable decline that must feel like falling off a cliff in slow motion.

Unlike younger patients who might qualify for a life-saving heart transplant, there is little physicians can offer these patients when all medications and treatments have been optimized, but their hearts have deteriorated to the point that they experience unusual fatigue and shortness of breath and must be hospitalized frequently and treated with IV diuretics and inotropes.

"Heart transplants work, but there are too few hearts available even for younger patients. With age comes a range of other conditions that can make qualifying for a transplant list impossible. So, when another heart isn't an option, we have to look at ways to rejuvenate the patient's own heart and help it pump more effectively," said Alain Bouchard, MD, of Cardiology PC on the Princeton campus of Brookwood Baptist Health.

Bouchard and his colleague Farrell Mendelsohn, MD, are conducting ground-breaking research as part of the international phase 3 DREAM HF trial investigating the use of allogenic stem cells to stimulate the heart's own repair system.

"About 40 percent of an adult's heart cells have been replaced since birth," Bouchard said. "The heart has its own stem cells and there is a wonderful potential for the heart to repair itself. When we inject stem cells, most of those cells don't seem to be directly used to make repairs. In fact, in animal studies, few of the stem cells can be found the next day. However, the injection of the cells seems to stimulate the healing process through a paracrine effect that releases cytokines and growth factors that trigger repairs and inhibit cell death."



Alain Bouchard, MD

The double blind, 1:1 randomized, placebo-controlled study evaluates the safety and efficacy of injecting a single dose of 150 million mesenchymal precursor cells in individually targeted locations near damaged heart tissue. The propriety precursor cells from regenerative medicine company Mesoblast Limited are used in a protocol managed by their development and commercial partner, Teva Pharmaceutical Industries.

"We believe allogenic cells from healthy adult donors are more likely to stimulate a stronger response than stem cells from patients, who are likely to be older and may have other conditions that could be of concern," Bouchard said.

Bouchard follows patients clinically after they receive the stem cells in a percutaneous procedure performed by Mendelsohn.

"The stem cells are delivered to the left ventricle via transendocardial injections using a specially designed catheter with micro needles," Bouchard said. "To guide precision placement of the injections, Dr. Mendelsohn uses the NOGA[®] XP Cardiac Navigation System. We're hoping stem cells injected next to damaged tissue will reduce and possibly eliminate scarring as well as inhibit fibrosis. A heart attack kills several grams of heart muscle, and each gram contains 20 million cells. If we can enhance the heart's ability to repair itself, we can reduce the devastating effect chronic heart failure has on both the length and quality of life."

The double blind aspects of the trial are kept very separate.

"Only Dr. Mendelsohn knows which patients received the stem cells, and he doesn't follow them," Bouchard said. "I have no idea who received stem cells or placebo, but I'm seeing good progress in some patients. When the study ends, I'll be curious to look up the status of one 43-year-old lady who has done particularly well. She was on the heart transplant list. Now she has improved to the point that she has come off the list. We help patients manage other risk factors including blood pressure, diet and activity, and I will be eager to learn whether she was one of the patients who also received stem cells."

The DREAM HF trial is ongoing and continues to enroll participants. To qualify, patients must have chronic systolic heart failure with an ejection fraction of 40 percent or less.

CREST 2 Trial Determining Best Treatments for Carotid Stenosis

Although the ongoing CREST 2 trial is still enrolling new participants and the study will continue for a few more years, several interesting insights have already come to light.

"We're finding that all our patients are doing better," said principle co-in-

vestigator Gary Roubin, MD, FACC of Cardiovascular Associates of the Southeast and Brookwood Baptist Health. "Whether patients receive stents, surgery or medical management, we are seeing improvement."

"A significant protocol-driven factor is that we aggressively work to help participants get risk factors under control. We have a special team that tracks patients and helps them reach their targets for cholesterol, blood pressure, and diabetes, and supports their efforts to stop smoking, eat healthy and become more active."

"Another important aspect for patients who don't respond to the usual statin medications is that through the study they have free access to new cholesterol medications that tend to be quite expensive. This can help them bring their cholesterol down and save up to \$10,000 a year."

The CREST 2 study, Carotid Revascularization and Medical Management for Asymptomatic Carotid Stenosis Trial, is an NIH multicenter randomized 1:1



Gary Roubin, MD, FACC

investigation comparing stenting or endarterectomy followed by medications with medical therapy alone in patients who present with severe carotid blockage but no specific neurological symptoms.

The comparisons will include the incidence of stroke and death, major stroke, changes in cognitive function and differences in the effects of modification based on age, sex, severity and risk factors.

Medications have improved in recent years and once statins and antiplatelet drugs are being taken and blood pressure is under control, the risk of having a stroke is lower. Whether it will be low enough to avoid the need for an invasive procedure is the major question CREST 2 hopes to answer.

"Another improvement we see is in patient satisfaction with a more clearly determined approach to the best treatment in their case," Roubin said. "When the choice is revascularization, stents may be the best option for less complex cases. When there is a great deal of calcification or bends in the blockage, an endarterectomy can be a better choice. Patients find it more satisfying when they understand the process of making decisions and what it means for their health."

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Managing Hypertension after SPRINT

By LAURA FREEMAN

New guidelines for managing hypertension are expected this year. Meanwhile, in light of the SPRINT study and years of debate about blood pressure targets for older adults, many physicians face questions over how aggressively they should push for lower blood pressure numbers.

On one hand, the Systolic Blood Pressure Intervention Trial ended early because data showed such strong benefits in lowering systolic blood pressure to under 120 mm Hg in people age 50 and older with hypertension and at least one other risk factor for heart diseases. The risk of death from all causes was reduced by over 25 percent compared to other subjects aiming at a target of under 140 mm Hg. The lower blood pressure also reduced a combined end point of heart attack, acute coronary syndrome, heart failure and strokes by 30 percent, with the benefit particularly strong against heart failure.

On the other hand, some clinicians have raised concerns about differences in how blood pressure was measured during the trials, as well as expressing worry about possible side effects when targeting aggressive blood pressure goals in elderly patients.

“One outcome that can’t be fudged is death,” said Andrew Miller, MD, FACC, of Cardiovascular Associates of the Southeast. “The reduction in mortality (from the Systolic Blood Pressure Intervention Trial) was so significant that if

your patients match the subjects included in the trial, you have to think about how they could benefit by working toward a lower target.

“There was some worry about overtreating because the numbers doctors see in the office are likely to be higher. Other studies have shown that just checking in at the desk can raise blood pressure by 8 mm Hg and having a doctor present can raise it by 12 mm Hg.

“Perhaps, as best practice, we need a better way to take blood pressure. To more closely reflect the patient’s normal numbers, the trial allowed the patient to rest for five minutes alone in a quiet room. The pressure was measured by an automatic device with no one else present. Three pressures were taken and then averaged.”

Another concern was whether bringing blood pressure down to a lower target would require too many drugs, too much



Andrew Miller,
MD, FACC

expense that would interfere with compliance, and a potential for too many side effects.

“The group targeting under 140 usually required two drugs. To get under 120, most patients required a third drug. All the drugs were generic and have been used effectively for years. There was a formulary to choose from, and the three most common drugs were the diuretic Chlorthalidone, the calcium-channel blocker Amlodipine, and the ACE inhibitor Lisinopril,” Miller said.

Differences in side effects were low, and there was no increase in the risk of falls or fractures.

“Dosages were closely titrated and adjusted frequently to determine the minimum needed for the best result,” Miller said. “Patients were followed every month for three months, then every three months. That’s an approach that physicians might want to consider in a clinical setting.

“We physicians tend to be wary in managing blood pressure in elderly patients with stiff arteries. There can also be a greater risk of adverse effects when blood pressure gets low. But there was a special cohort of older participants in the study—25 percent of the more than 9,000 participants were 75 or older. As it turned out, the older patients saw the

greatest benefits from targeting the lower blood pressure.

“African-Americans made up 30 percent of the study, which is good to see since hypertension is such a problem in this population. The recommended mix of medications was slightly different, but showed similar results.”

One criticism of the study has been that patients with diabetes, a previous stroke and certain types of kidney disorders were excluded. This was done by design, as these populations were included in previous studies and the trial was focused on getting a clear view of hypertension as seen in average patients.

“Hypertension is the most common cardiovascular disorder in America,” Miller said. “It is also under-diagnosed and under-treated, and all too often patients fail to achieve control. Hypertension does so much damage to the body, and can lead to cardiovascular damage, heart failure, stroke and kidney disease.”

It’s also vital that patients understand how important controlling their blood pressure is and what their efforts in compliance and lifestyle changes can mean for their future and quality of life.

“Getting rid of ten pounds is equal to four points off your blood pressure. Even small changes can make a difference,” Miller said.



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New Phone App Keeps Doctor and Patients in Touch

BY DALE SHORT

A recently developed cell phone application gives new meaning to the term 'house call.' The program, known as ChronicCareIQ, is an app that helps doctors remotely monitor the care of chronic patients.

"We were one of the first groups to start using it regularly," says Brian Flowers, MD of Birmingham Heart Clinic. "It's very user-friendly and our patients tend to like it."

Essentially a patient chooses a time of day to be contacted, and the app sends an alarm and opens a screen with questions to be answered about their condition. "There are different protocols depending on the indications we're monitoring," Flowers says. "In our case it's heart failure, atrial fibrillation, and hypertension." The program is for patients who have two or more chronic conditions.

Sample questions might be, "Have you had shortness of breath?" Other questions target more details: "did this occur



Brian Flowers, MD

while you were climbing stairs, walking on level ground, or stationary?" The app also asks for blood pressure and weight.

"We rotate the questions," Flowers says. "So one week we might ask if the patient is sleeping on one, two, or three pillows. And maybe follow up by asking if that is more or fewer pillows than before. Another day we could ask if their swelling has increased, or if they're more or less fatigued."

"Occasionally we find a patient whose blood pressure is higher than we thought it was, or whose weight is more than we expected, and they haven't notified us. So sometimes patients come in sooner, make appointments to discuss some of these issues and make further changes. At times it's possible to make those changes over the phone, but if we're making changes in a lot of their medicines, they need to come in so we can make sure that there aren't other factors contributing to it."

"We don't know that this has significantly reduced office visits, but my hope is that it reduces hospitalizations. That's the big picture, and I think there are a few patients this has actually been effective for."

While common wisdom might suggest that patients' willingness to try the new technology is in proportion to their

age, Flowers says he's been pleasantly surprised by older patients. "Some say it gives them another reason to get a smart phone. The interface is very intuitive and user-friendly. Once we set it up in the office, and get them logged in and enrolled, they don't have to do anything but listen for the alarm and read the screen on their smart phone or other device."

Flowers makes it clear to his patients that the new product is not a one-stop solution for reporting health problems. "It's more of a way to give us trends," he says. "So if there's some major change in a day, we tell everyone it's not an emergency device or program. This is made to help with chronic conditions. So if something changes drastically, whether it be their symptoms such as blood pressure, we want them to call the office or go to the emergency room as they would normally do."

Some 150 of Flowers' patients are using ChronicCareIQ, and he plans to add more during the year. Even though the patients' compliance rate fluctuates, Flowers been very satisfied overall. "We have a handful of patients enrolled who don't input the data on a daily basis, in which case we contact them to give us the information. What's more telling, to me, is that

only a very few people have wanted out of the program. Maybe five people haven't continued it for various reasons. But the vast majority who have started the program like it and want to stay with it, and that has probably been my biggest surprise."

The application lends itself to many other specialties in addition to cardiology. "The man who founded the company is diabetic, and he envisioned it as a great tool to use in those situations," Flowers says. "It's a perfect example for managing chronic conditions like that."

"We wanted to be on the forefront of the move toward technology and electronic medical records, and one of the biggest struggles of the new technology has been that it's sort of fractionalized things more than it's brought people together. My hope is that this helps create a tool to allow all the providers to collaborate better."

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Taking Pulmonary Embolism Care to the Next Level

BY ANN B. DeBELLIS

A cutting-edge treatment for pulmonary embolism (PE) is giving medical personnel a new weapon in the treatment of these deadly lung clots. Physicians at Princeton Baptist Medical Center are leading the way with the state's first comprehensive PE response team which uses cutting-edge, minimally invasive techniques to treat even the largest clots. The new treatment techniques often avoid the need for high doses of clot-bursting medicines or open heart surgery.

A major cause of morbidity and mortality, PE is both common and dangerous and affects almost one million people each year in the United States. "PE may often present as sudden death. For those who survive, there is the possibility of decreased life expectancy and impaired quality of life. It is critical to make sure cases are diagnosed correctly and managed properly as that can make all the difference," says Mustafa Ahmed, MD, director of the PE response team, and one of the team's inter-



Mustafa Ahmed, MD

ventional cardiologists.

PE typically begins with deep venous thrombosis of the leg that moves through the right side of the heart to the lung and blocks blood flow. "When I am informed about a PE, the first call I make is to Mike Crain, MD, the team's pulmonologist," Ahmed says. "We assess every patient together and decide on the treatment required. It's not uncommon for us to have a cardiologist, pulmonologist, radiologist, cardiac surgeon, and anesthesiologist and emergency medicine physician all making decisions and treating the patient together, even in the early hours of the morning. It's an incredible and very unique team effort."

Determining the immediate seriousness of a large PE comes down to two main factors: the stability of the patient and the strain placed on the right side of the heart. "Based on these factors, we characterize the PE as submassive or massive," Crain says. "Massive PE's are extremely high-risk events and a serious situation that often results in sudden cardiac arrest. Submassive embolisms are not as dangerous but can still be considered high risk for a poor outcome. It is important to note that not everyone with a submassive pulmonary embolism requires aggressive procedures, although it

is important to identify those that are at the highest risk and treat them appropriately."

While there are several treatment options for PE, the therapy chosen depends on what is available at the facility. "The key is to have a team of specialists and every treatment option immediately available, whether it is just blood thinner or emergency surgery," Ahmed says. "A treatment we commonly use for large PEs involves specially designed, tiny tubes known as EKOS catheters. We insert the catheter through the leg and into the arteries of the lung where we use ultrasound waves to pulse tiny doses of clot bursting medicine directly in to the clot, often dissolving it in a matter of hours. It is incredible technology. In the case of massive PEs, my preferred technique is to use different instruments to break up the clot before potentially using the clot bursting medicines."

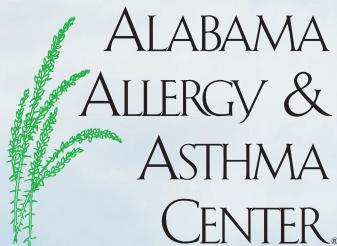
Treatment of PE is a rapidly evolving field, particularly when it comes to catheter-based therapies. "We noted that concomitant use of intrapulmonary thrombolysis with other catheter-directed treatments had a significant interaction and led to decreased in-hospital mortality. This may be because index catheter-directed treatment exposes a larger surface area of

thrombus than what would ordinarily be exposed to intrapulmonary thrombolytics," Ahmed says. "The favorable efficacy outcomes can likely be explained by the fact that the catheter-directed treatment allows for a targeted method of relieving obstruction, which leads to restoration of blood flow through pulmonary arteries and reduction of right heart strain."

Ahmed is the senior author of two recently published studies that have examined the role of catheter-based techniques and surgical treatments for large pulmonary embolisms. The research group includes first authors Navkaranbir Bajaj, MD of Harvard Medical School and Rajat Kalra, MD, of the University of Minnesota.

PE team members include:

Interventional Cardiology - Mustafa Ahmed, MD (Princeton) and Hudson Segrest, MD (Shelby); *Pulmonary medicine* - Mike Crain, MD; *Team coordinator* - Brad Richardson; *Cath Lab team* - Katie Evatt; Brooke Harris; Bobby Wells; *Intensive Care* - Josh Smith, MD and Ronnie Roan, MD; *Cardiovascular Surgery* - Clifton Lewis, MD; *Anesthesia* - Arpan Patel and associates of Southern Anesthesia Management; *Emergency Department* - Bruce Burns



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Ask the Allergist

IgE Blood Testing for Food Allergies

We get many questions from practitioners about the value of IgE blood testing in diagnosing food allergy. Unfortunately, properly diagnosing food allergy is more complex than using a blood test alone. IgE blood tests measure a patient's amount of IgE antibody to specific foods and indicate the "likelihood" of a reaction to that food.

IgE blood testing is well associated with high negative predictive values, but also has the pitfall of low positive predictive values and falsely elevated results. While 30 percent of the general population produces IgE towards foods (sensitization), only about five percent actually have a true food allergy.

A recent study published in *Pediatrics* concludes that IgE blood testing alone should not be used in diagnosing food allergy, and "can lead to misinter-

pretation, over diagnosis, and unnecessary dietary elimination. The use of IgE food allergen panels has been associated with increased cost and burden."

The *2010 Guidelines for the Diagnosis and Management of Food Allergy in the United States* says that IgE blood testing (RAST or ImmunoCAP testing) should be considered along with a combination of the following:

- Medical history and physical exam (symptoms of an IgE based food allergy)
- Skin prick testing
- Physician-supervised oral food challenge (the "gold standard" in food allergy testing)

When a patient's history suggests food allergy, a board certified allergist can offer proper testing and interpretation for an accurate diagnosis.

References: Guidelines for the Diagnosis and Management of Food Allergy, published in 2010 (Journal of Allergy and Clinical Immunology, 126(6); supplement S1-S6). Stukus DR, Kempe E, Leber A, et al. Use of Food Allergy Panels by Pediatric Care Providers Compared With Allergists. *Pediatrics*. 2016;138(6):e20161602

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Ten Measures for the Prevention of Sudden Cardiac Death

By CINDY SANDERS

A joint report from the American College of Cardiology and the American Heart Association released at the end of 2016 outlines 10 quality and performance measures intended to prevent sudden cardiac deaths.

Published Dec. 19, 2016 in both the *Journal of the American College of Cardiology* and *Circulation: Cardiovascular Quality and Outcomes*, the evidence-based, guideline-endorsed recommendations address key risk factors for sudden cardiac arrest (SCA) and interventions to prevent sudden cardiac death (SCD).

"The scope of the issue is that SCD is the most common mode of death in the U.S., and despite many advances in resuscitation and other areas of SCA/SCD care, the survival rate of SCA victims is still low and the risk of SCD is still high," Sana Al-Khatib, MD, FACC, co-chair of the writing committee and a professor of Medicine at Duke University, explained of the need for this first comprehensive measure set for SCD prevention.



Sana Al-Khatib,
MD, FACC

Each year there are more than 350,000 out-of-hospital cardiac arrests in the United States. "While some people – such as patients with heart failure – are known to be at risk for sudden cardiac death, others are not," Al-Khatib noted. "We need initiatives to improve the quality of care for those with a known risk but also for the victims of sudden cardiac arrest."

To move the needle on improving survival rates, Al-Khatib said the committee proposed performance measures and quality metrics that span different aspects of care ranging from prevention to resuscitation, as well as management of known conditions.

The 10 performance measures (PM) and quality measures (QM) are:

Preventive Cardiology Measures

PM-1: Smoking cessation intervention in patients who suffered SCA, have ventricular arrhythmias, or are at risk for SCD.

QM-1: Screening for a family history of SCD.

QM-2: Screening for asymptomatic left ventricular dysfunction among individuals who have a strong family history of cardiomyopathy and SCD.

Resuscitation/Emergency Cardiovascular Care Measures

QM-3: Referring for CPR and AED education the family members of patients who are hospitalized with known cardiovascular conditions that raise the risk of SCA.

Heart Failure/General Cardiology Measures

PM-2: Use of ICD for prevention of SCD in patients with heart failure and reduced ejection fraction who have an anticipated survival of > 1 year.

PM-3: Use of guideline-directed medical therapy (ACE-I or ARB or ARNI, beta-blocker, aldosterone receptor antagonist) for prevention of SCD in patients with heart failure and reduced ejection fraction.

PM-4: Use of guideline-directed medical therapy (see above) for the prevention of SCD in patients with myocardial infarction and reduced ejection fraction.

Electrophysiology Measures

PM-5: Documenting the absence of reversible causes for ventricular tachycardia/ventricular fibrillation cardiac arrest and/or sustained VT before a secondary-prevention ICD is placed.

PM-6: Counseling eligible patients about and ICD.

QM-4: Counseling first-degree relatives of survivors of SCA associated with an inheritable condition.

Although guidelines exist for the prevention of sudden cardiac death, there has been an underutilization of public health initiatives, treatments and device therapies for at-risk patients. Al-Khatib said many of the measures the committee proposed are novel or not well established in the format proposed. "We have data on low use of these proven interventions in relation to most measures," she said, adding the novel construct of the 10 measures should impact care if it put in place.

"The hope is that most would use all of these measures, but even if a few of these measures are implemented, we still expect to make a difference," she said. Al-Khatib continued, "These measures were picked based on what is most important and what would be most impactful emphasizing the importance of the problem and gaps in care."

In addition, she said the committee, which was divided into smaller groups based on expertise, took into account validity and reliability of data sources and collection, usability and feasibility in terms of workflow to come to a consensus on the measures.

"Despite the existence of many proven interventions, the use of these interventions is lacking in many areas and so the survival rates for SCA victims have not appreciably improved," she said, again emphasizing that SCD is the most common mode of death in the nation. "A multifaceted approach to this problem is needed. Such an approach is achievable through the implementation of this set of performance measures and quality metrics," Al-Khatib concluded.



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New UAB Clinic Addresses Women’s Heart Health, *continued from page 1*

rather the usual symptoms of heart disease,” she says. “Most physicians read about these differences, but I think we can still tend to forget this at times when we evaluate a female patient.

“We want our clinic to be the entry point for women who need our services. Based on what we find in the initial consultation, we will direct the patient to the appropriate testing. If the patient is diagnosed with a heart issue, we will take the next step for treatment.”

The concept of a women’s heart clinic was something Pamboukian had been contemplating when a patient, who was the illustration for the women’s heart clinic, was referred to her. The 40-year-old woman, active in her community, had been having symptoms for more than a year and had been seen by numerous physicians without even a basic cardiac evaluation. “After about six months, a physician diagnosed her with congestive heart failure and she came to me for a second opinion,” Pamboukian says.

“We worked on her medications and

within a couple of months, she saw tremendous improvement and was able to resume her activities. That drove home the point that someone like her might not receive the health care she needs when all it took was standard medicines to improve her condition,” she says. “The key was making the diagnosis so that you know what you are treating. This clinic is needed so we can reach out to help people like her.”

Pamboukian points out that the clinic is a collaborative effort among female physicians who specialize in cardiac treatment. “Because women have unique risk factors and symptoms, they may need heart care designed to address their specific needs. We want women to come here so they can get specialized help. Our team includes hypertension specialist Suzanne Oparil, MD; advanced heart failure specialist Indranee Rajapreyar, MD; interventional cardiologist Brigitta Brott, MD; and nurse practitioner Sondra Curry, CRNP,” she says. “We will work as a team, and patients will see these providers in our clinic.”

The clinic will take referrals from outside Birmingham to ensure women can get the care they need if services are not available in their area. “This clinic is something UAB has never had, and it joins the other specialty services that UAB provides,” Pamboukian says. “I think the time is right for a clinic like this in our area.”

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National Trends in Heart Disease Treatments

A report released last month showed over 93 percent of heart attack patients are receiving stents within the guideline-recommended threshold of 90 minutes after arriving at the hospital, with the median time to stenting only 59 minutes. “Trends in Cardiovascular Care in the United States: a Report from Four American College of Cardiology National Cardiovascular Data Registry Programs” provides insights into the patient populations, participating centers and patterns of care based on 2014 data from 4 of the 10 NCDR programs – CathPCI Registry, ICD Registry, ACTION Registry-GWTG and IMPACT Registry.

“We were able to report on the care and outcomes of patients undergoing common cardiovascular procedures, including percutaneous coronary interventions, implantable defibrillators, and interventions for congenital heart disease, as well as for patients with acute heart attacks,” NCDR Management Board Chair and lead author of the study Frederick A. Masoudi, MD, MSPH, FACC, said. “In some cases, hospitals are consistently providing excellent care; the registries, however, allow us to identify those aspects of care where the cardiovascular clinical community can improve.”

Key findings from each registry include:

CathPCI Registry

- Of the 667,424 patients undergoing PCI in 2014, 35.3 percent of PCIs were performed for elective indications, compared to 64.7 percent performed for non-elective indications.
- Between 2011 and 2014, the use of femoral access declined from 88.4 percent to 74.5 percent, while the use of radial access increased from 10.9 percent to 25.2 percent.
- Use of evidence-based therapies, including aspirin, P2Y12 inhibitors and statins for eligible patients, remained high at 93.3 percent.
- Median door-to-balloon time for primary PCI for STEMI also remained strong at 59 minutes for patients receiving PCI at the presenting hospital and 105 minutes for transfer patients.

ICD Registry

- Of the 158,649 patients receiving ICD therapy in 2014, 120,228 received a device for primary prevention reasons, compared to 38,421 who received a device for secondary prevention indications.
- Of all ICD implants in 2014, 25 percent involved single chamber devices, 32 percent involved dual chamber devices and 43 percent involved CRT-D devices, compared to 19 percent, 37 percent and 44 percent, respectively, in 2011.
- While use of evidence-based therapies are generally high – performance on a composite medication metric, including use of ACE or ARB for patients with LVSD and beta blockers for patients with LVSD – could be a target for quality improvement efforts. Between 2011 and 2014 the composite rate of use grew from 76.7 percent to 80.3 percent, with room for continued improvement.

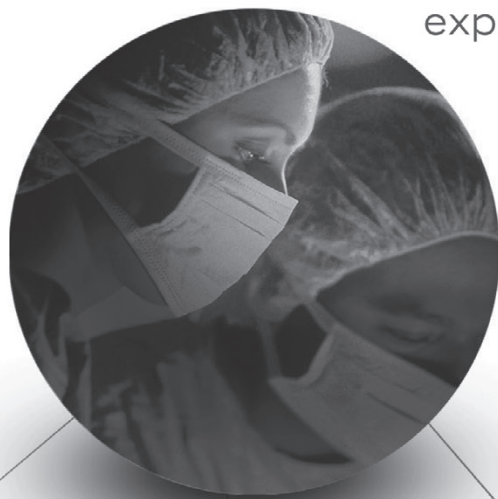
ACTION Registry-GWTG

- Of the 182,903 patients with acute myocardial infarction (AMI) in 2014, 71,368 had ST-segment elevation MI (STEMI), while 111,535 had non-ST-segment elevation acute coronary syndromes (NSTEMI).
- There is room for improvement in the areas of overall defect-free care (78.4 percent); P2Y12 inhibitor use in eligible patients (56.7 percent); and use of aldosterone antagonists in patients with LV systolic dysfunction and either diabetes or heart failure (12.8 percent).
- Compared to NSTEMI patients, STEMI patients were more likely to experience certain adverse events during hospitalization, including death (6.4 percent vs. 3.4 percent), cardiogenic shock (4.4 percent vs. 1.6 percent), or bleeding (8.5 percent vs. 5.5 percent).

IMPACT Registry

- Of the 20,169 patients with congenital heart disease undergoing cardiac catheterization or a catheter-based intervention, 86 percent were under the age of 18, and 24.6 percent were under one year old.
- Procedures such as atrial septal defect (ASD) closure, patent ductus arteriosus (PDA) closure, aortic coarctation stenting and pulmonary valvuloplasty had success rates exceeding 84 percent. Aortic coarctation balloon angioplasty was less successful at 55.1 percent.
- Device embolization was reported in 1.2 percent of ASD closure procedures and 1.1 percent of PDA closure procedures. A clinically significant increase in aortic regurgitation follow valvuloplasty was noted in 10.6 percent of cases.

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Alabama Gains from National Hospital Quality Program

By JANE EHRHARDT

"The great thing about being part of Partnership for Patients is you have access to a lot of resources," says Vicki Britt, director of quality management at Pickens County Medical Center.

The 56-bed rural hospital in Carrollton, Alabama, dropped readmissions from 11 percent in 2012 to 3.6 percent last year. The previous year alone showed a 71 percent reduction. "Every year, we have been able to make improvements on our all-calls readmission rate," Britt says. The statistic covers readmission for any reason within 30 days of discharge, and is just one

of the 11 data points of the Partnership for Patients (PIP) initiative.

PIP began four years ago when the Centers for Medicare & Medicaid Services (CMS) awarded grants to various hospital networks to reduce patient harm and preventable complications by a specific amount. "It focuses on key areas, such as preventing falls, readmissions, infections, blood clots, and sepsis," says Rosemary Blackmon with Alabama Hospital Association (AlaHA), a participant in PIP as part



Rosemary Blackmon

of the grant awarded to the American Hospital Association (AHA).

"The goal was very ambitious that first year — 40 percent reduction in harm incidents and 20 percent in readmissions," Blackmon says. This past year, those targets dropped to 20 percent and 12 percent.

Even before the CMS program, AlaHA had been holding monthly quality task force meetings. "We called it our Revival, because they were really faithful," Blackmon says. The group had met monthly for 12 years. "We would get 20 or more in person and 20 or more on the phone every time." Their larger biannual

meetings would draw in around 300 hospital personnel.

With PIP funds, AlaHA expanded their staff and their support to include national experts to meetings, twice-weekly webinars by AHA, and an array of "change packets." The packets contain best practices tools, a sample protocol, and a Top 10 checklist for reducing incidents of that particular target area.

Each month, AlaHA calls the 35 hospitals who directly participate with them in PIP and does an annual site visit. "We talk through their monthly data, find out what's going on, and ask if we can provide resources," Blackmon says. About 90 percent of the acute care hospitals in Alabama participate in some form of a hospital engagement network (HEN) that connects to PIP.

Those who don't, still benefit. "My people pore through meeting notes and share that information with all the hospitals. So we get a lot of bang for the buck from any regional meeting," Blackmon says.

It was with the BOOST and LACE tools garnered through PIP that Pickens County Medical Center reduced their readmissions declines. "These are nationally known tools. We're so small with so few resources that to have a nationwide group to pull from is a huge advantage for us," Britt says. The hospital uses the tools to score a patient's risk for readmission and to indicate how to work with the patient after discharge for the best possible outcome.

For patients with a diagnosis that proves to be high readmission for their facility, like pneumonia and congestive heart failure, the hospital calls within 72 hours of discharge.

They also schedule an appointment for the patient with her primary care physician in the week before the patient leaves. "It's been found that if they're seen within a week, they will ask questions rather than sit on it and let it become something bigger," Britt says.

As part of PIP, Grandview Medical Center improved their numbers in four areas from 20.7 percent to 72 percent in the last year. All stimulated by weekly meet-

(CONTINUED ON PAGE 22)

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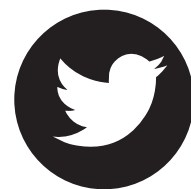
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Delivering Quality Health Care with Compassion and Innovation

By ANN B. DeBELLIS

"We look for better ways to deliver health care to our patients," Uptagrafft says. "We want to provide outstanding medical care in the most exceptional way. We do this by centering our health care services around compassion, quality, and technology."

Brooke MD Primary Care, honored as Huntsville's Medical Practice of the Year, utilizes an innovative patient care model. In response to the shortage of primary care physicians, Dr. Brooke Uptagrafft manages three nurse practitioners who are the principal patient care providers. This enables the staff to be more responsive and to see more patients every day.

The nurse practitioners perform annual exams and manage chronic illnesses the same way a doctor does. Under Alabama law, nurse practitioners are required to have a collaborating physician and must meet with that doctor at least once a quarter. Brooke MD is different because Uptagrafft collaborates with her nurse practitioners daily.

"I'm in the office when the nurse prac-



Brooke Uptagrafft, MD, left, and nurse practitioner Amy Pittman review a patient's information together.

tioners are seeing patients," Uptagrafft says. "I review their notes, labs and imaging services. I'm available to answer questions or to see one of their patients if needed. We work together, and it allows us to provide more same-day appointments for our patients when needed."

"Many primary care and urgent care settings use nurse practitioners in separate satellite locations," Uptagrafft says. "We are different because our nurse practitioners are

very close with me. We not only see patients together, but we also review labs and imaging results together. We work as a team to make sure our entire patient population is taken care of."

"It has made a world of difference in the efficiency of our practice as well as with patient satisfaction. Responsiveness to our patient's needs has improved tremendously. Many clinics struggle to get patients in for office visits in a timely manner and to respond to messages from patients within the same day. We are doing this in a matter of hours."

Amy Pittman is one of the nurse practitioners at Brooke MD and enjoys being a part of the staff.

"Our clinic is unique in that our nurse practitioner role is vital to our primary care model. We triage patients and offer more accessibility for them which allows us to see more people each day," she says. "We have a great collaborative physician in Dr. Brooke, and it is reassuring that she is close by in case we have questions."

Pittman particularly likes being able to get to know patients along with their families. "I can provide better care when I understand their background and what is going on in

their lives," she says. "I think that's something that is missing in most outpatient settings."

Uptagrafft points out that with the increased complexity of our health care system, patients must rely on providers to help them navigate the system. All new Brooke MD patients receive an orientation, and the staff public relations coordinator explains each patient's insurance coverage to them. "Figuring out insurance agreements, deductibles and copays is complicated enough, not to mention obtaining your own personal medical information, needed referrals, prescription management through specific pharmacies and scheduling the appointments you need in a timely manner," she says. "My vision is to focus on improved education and to simplify things where we can."

The use of technology makes it easier to offer quality health care, and each new patient is set up to use the Brooke MD patient portal where they can see their personal medical records, lab results, medical history, and referrals. Patients also can use the portal to communicate with the medical staff.

"We use the portal heavily, and we've become more accessible than ever to our patients through the web message feature

(CONTINUED ON PAGE 16)

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The Repeal of Obamacare, *continued from page 1*

ideas were part of the “Better Way” agenda issued several months ago by House Republicans.

The plan is to replace the ACA via the reconciliation process. “This is how Obamacare was passed in the first place, which is through the budget, because it requires only a simple majority,” Mathis says.

“It’s legislative jujitsu.” This allows the legislature to alter any financial aspects of the ACA, such as the tax allowances for those



Chad Mathis, MD

buying marketplace policies and cutting the Medicaid expansion.

The main thrust of the replacement plan rests on Health Savings Accounts (HSAs). These allow individuals to set aside pre-tax earnings in a designated bank account to be spent only on medical costs. Unlike a deductible, money saved to an HSA does not roll back to zero at the start of the year, so money for deductibles, prescriptions, and co-pays would be on-hand, assuming patients have the capacity to continue refilling their HSA.

HSAs have been in play for years. The plan would expand their use to most any-

thing medically related, including over-the-counter drugs.

“It’s the best way to control healthcare costs because the individual is in charge of his own healthcare dollars,” Mathis says. That way, patients pay for most of their annual standard medical costs from that account, instead of insurance companies and the government. That frees them to need only lower-cost catastrophic policies.

Add in the probable relinquishments of government and insurance-based requirements under the new administration, and treatment and diagnosis options will open up. “If the end user and the physician

are making the choices, you’ll see healthcare spending come down,” Mathis says.

Policy choices for both individuals and employers could also broaden with the proposed ability to purchase coverage from out-of-state. “You won’t see changes in the rates of your current plans,” Mathis says. “Instead, you’ll see new plans available so people can switch to lower-cost ones.”

A nationwide marketplace would give physicians greater input with their reimbursements. “But we will have to be willing to push back and say that we can’t accept a particular fee schedule if it’s not cost-effective,” Mathis says.

However, it remains unclear, especially in Alabama, as to whether or not many insurance providers will find it economical to recruit physicians and market for new policy holders. In addition, healthcare providers will have to find it worthwhile to get credentialed at countless insurance companies nationwide.

Mathis stresses that the overhaul of the ACA will only be felt in the billing department. “This won’t affect physician interaction with the patient. You’ll still see patients and provide care,” he says. “But now it will be about how this care is going to be reimbursed and having the patient determine if they want to pay for it. You’re going back to multiple insurance models.”

This lack of change will disappointment the healthcare community in repealing Obamacare. “Physicians want something to affect their day-to-day, and this is not going to do that,” Mathis says. “That’s MACRA reform [Medicare Access and CHIP Reauthorization Act]. We’re getting bombarded with regulations and spending so much time on being compliant, but that has nothing to do with Obamacare.”

The replacement plan faces numerous conundrums, including what to do with those on the extended Medicaid coverage created under the ACA. Or how to keep affordable coverage for those with high-risk and pre-existing conditions without boosting premiums for others.

“There are lots of moving parts,” Mathis says. “This is a time to sit back and pop your popcorn, and see what happens.”

Delivering Quality,

continued from page 15

on our patient portal,” Uptagrafft says. “Send me, my staff or nurse practitioners a message any time and we strive to respond within two business hours. We communicate with our patients much more frequently on the portal than by phone.”

Both patients and staff are benefitting from these innovative processes. The practice is preparing to move to a larger location that offers more space to incorporate additional services, including counseling and nutrition education. “The change in location will also include a name change to Innova Primary Care. Innova is the Latin word for ‘renew’ and the root word for innovate,” Uptagrafft says. “The new name represents what we are trying to do with our practice as we strive to provide the best, compassionate medical care possible and to leverage incredible technological advances to do so.”



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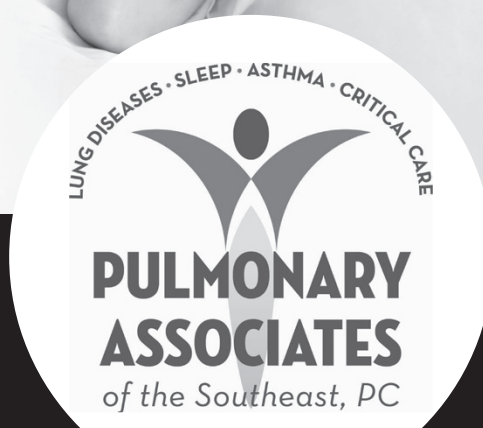
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PHYSICIAN COMPENSATION: Getting Your Legal Structure Right With Tax Reform

BY JAMES M. McCARTEN

By the time this article is published, President Trump will have been sworn in and he and House Speaker Paul Ryan will be hard at work in finalizing their tax reform proposal. It is now mid-January and the most up-to-date information on the basics of the Republican overhaul of the tax code are found in the Blueprint published by the GOP's House Ways and Means Tax Reform Task Force. Before exploring what tax reform will mean, let's look at where tax planning starts under current law.

The Current Rates

Income from professional services is taxed as regular income and according to IRS statistics, most medical professionals pay tax at one of the top four brackets: 28% (\$151,900 to \$231,450), 33% (\$231,450 to \$413,350), 35% (\$413,350 to \$466,950) or 39.6% (over \$466,950).

However, that is not the end of the tax calculation. Alabama takes its "fair share" at 5% and additional Medicare taxes of 0.9% and 1.45% are imposed on wages received over the Social Security limit (for self-employed individuals, this total is 3.8%). So, for physicians and many

other professionals, this combination often results in an effective tax rate of just under 50%.

The distinction between portfolio and investment income versus earned income was more important for planning until the enactment of the net investment income tax ("NIIT") in 2012. In truth, very little of a taxpayer's income now escapes the extra 3.8% Medicare tax; it applies as either the Medicare surtax or as the NIIT.

The only types of income which receive a true preferred rate under current law are capital gains and qualified dividends, both of which are taxed for most high income professionals at 15% (20% when the taxpayer is in the 39.6% bracket). And except for the exemption allowing up to \$25,000 of losses from rental real estate, only passive loss can offset passive income or active loss offset active income. So, as a general proposition, much of the tax planning available for high income professionals focuses on matching the taxpayer's deductions and losses with the type of income he or she regularly generates.

Current Planning Issues

The legal form of a medical practice (P.C., LLC, sole proprietor), partially de-

termines how the income from the practice is taxed. If the practice is a regular corporation (not an S corporation for tax purposes), the practice income is paid out as wages and bonuses which are effectively taxed at a total maximum rate in Alabama of 47% (rounded); however, any income retained by the practice is taxed at a flat 35% (often resulting in a total 55% tax rate).

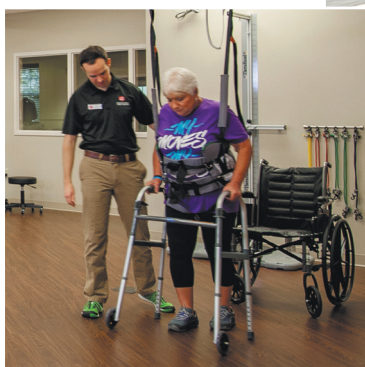
S corporations and LLC's are "flow through" entities; the income earned by the practice flows through to the owners' returns. In an LLC, practice income is treated as self-employment income and taxed at an effective rate of 48.4% for those in the highest bracket. If the practice is an S corporation, only the portion of the practice income paid out as salary is taxed at the highest rate of 47%, with any excess treated as non-employment income and taxed to the owner at a maximum combined federal and state rate of 44.6% (amounts in excess of wages and bonuses avoid the 3.8% NIIT tax).

When the practice is a traditional corporation for tax purposes, e.g., not an S corporation, the owners must be aware of the "unreasonable compensation" doctrine. If the IRS applies that doctrine during an audit, some portion of an owner's

salary may be reclassified as a dividend. If that happens, no deduction is allowed and such income becomes subject to double taxation. Further, both the taxpayers (the practice and the owners) are subject to tax penalties. In professional practices, "unreasonable compensation" arises most often when more than an insignificant portion of the practice's income is attributable to services performed by non-owners and/or intellectual property or other capital assets.

In addition to unreasonable compensation, another tax planning challenge for physicians and other high income taxpayers is how to properly group business activities under the passive activity loss rules. Late in 2016, the IRS issued technical advice memorandum ("TAM") 201634022, in which it provided a roadmap for taxpayers who wish to avoid automatically treating certain income related to their profession as earned income. In the TAM, the IRS held that the IRS could not require a physician to treat income from his investment in a surgery center the same as income from his practice because, under the surgery center's legal documents, the physician had no say in the day-to-day operations of the center. This ruling is

(CONTINUED ON PAGE 22)



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Precision Medicine: UAB Study Creates 'Mini-lung' to Study Effect of Pulmonary Fibrosis Drugs

Pulmospheres, three dimensional multicellular spheroids composed of lung cells from individual patients, were shown to be effective in predicting the efficacy of medications for idiopathic pulmonary fibrosis, according to findings from UAB scientists presented in JCI Insight, a journal of the American Society for Clinical Investigation.

Pulmospheres are tiny spheres —

about one millimeter in diameter — which contain all the various cell types found in a human lung and are grown from tissue obtained from a surgical lung biopsy. Pulmospheres give researchers a 3D model to study various aspects of cell biology and disease mechanisms.

“Our results suggest that pulmospheres simulate the microenvironment in the lung and serve as a personalized

and predictive model for assessing responsiveness to antifibrotic drugs in patients with IPF,” said Veena Antony, MD, professor in the Division of Pulmonary, Allergy and Critical Care Medicine.

The UAB research team grew pulmo-



Veena Antony, MD

spheres from 20 patients with idiopathic pulmonary fibrosis and nine control patients. They then examined whether the pulmospheres reacted to one of two commonly used medications for IPF.

“There is no cure for IPF, but there are two drugs that can help slow the rate of decline,” Antony said. “Not all patients respond to both drugs. We need a reliable test that can predict which drug works best for which patient.”

The pulmospheres were grown to useable size in about 24 hours following the biopsy, then exposed to the two medications, pirfenidone and nintedanib. Within about 16 hours, researchers were able to observe if the spheres responded favorably to one, both or neither of the medications.

“This is a wonderful example of precision medicine,” said Victor Thannickal, MD, director of the UAB Division of Pulmonary, Allergy and Critical Care Medicine. “Using pulmospheres derived from a patient’s own cells may allow clinicians to tailor specific drugs to an individual patient without exposing that patient to potential side-effects or harm from treatments that are unlikely to be effective.”

Of the 20 subjects enrolled in this study, three patient’s pulmospheres responded only to nintedanib and the pulmospheres of four patient’s responded only to pirfenidone. Eleven patient’s pulmospheres responded to both drugs and two patient’s pulmospheres did not respond to either drug.

Researchers confirmed the findings by following the patients over time, establishing that the response predicted by the pulmospheres was clinically observed in the patients.

Pulmospheres were developed in cancer research as a means of targeting potential drugs. A hallmark of IPF is an aggressive invasion by myofibroblasts, which mirrors the invasive phenotype of malignant cells, giving researchers reason to think that pulmospheres might work in IPF. The UAB trial was the first to study pulmospheres in IPF.

Antony also hopes that modern drug discovery techniques, using high-throughput screening technology will be enhanced by the use of pulmospheres.

“There are many potential therapeutic agents for IPF in the discovery pipeline now, and this technique might prove to be an effective way to determining which are the most promising,” she said.

The UAB team consisted of Antony, Thannickal, Joao de Andrade, MD, Ranu Surolia, PhD, Fu Jun Li, MD, PhD, Zheng Wang, MC, Huashi Li, Gang Liu, MD, Yong Zhou, MD, PhD, Tracy Luckhardt, MD, Sejong Bae, PhD, Rui-ming Liu, MD, PhD, and Sunad Rangarajan, MD.



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First Do No Harm: National Safety Efforts Paying Off

By CINDY SANDERS

A report released at the end of 2016 by the Agency for Healthcare Research and Quality (AHRQ) highlighted the positive changes being made to improve patient safety through a coordinated national effort.

The *National Scorecard on Rates of Hospital-Acquired Conditions* showed a significant decline in adverse events from 2010 through 2015. The 21 percent decrease from the 2010 baseline data through the preliminary 2015 figures equaled three million fewer hospital-acquired conditions (HACs), which extrapolates to 125,000 lives potentially saved and nearly \$28 billion in healthcare cost avoidance.

Rear Admiral Jeffrey Brady, MD, MPH, director of AHRQ's Center for Quality Improvement & Patient Safety, said the report "is a helpful reinforcement of a lot of effort that has happened in regards to reducing patient harm."

The national focus on reducing HACs stemmed, in part, from provisions in the Affordable Care Act. The Center for Medicare & Medicaid Services, through a program created by the ACA, worked with hospital networks and aligned payment incentives to bring about a shared and sustained effort to make care safer. Similarly the Partnership for Patients, a public/private partnership launched by Health and Human Services in 2011 and primarily coordinated by the CMS Innovation Center, has targeted a set of specific HACs through quality improvement efforts.

Brady said a primary purpose of the

AHRQ scorecard is to track the progress of those initiatives. Although national in scope, he noted the real work happens on the frontlines in hospitals across America. "Providers throughout the country all had a role in this effort," Brady said.

"We wanted to capture, as best as possible, this notion of 'all cause harm,'" he continued of tracking the overall HAC rate that includes a range of specific issues from falls and pressure ulcers to central line-associated blood stream infections (CLABSI) and medication errors.

"For patient safety experts and for clinicians, the rates themselves are pretty compelling," Brady continued of the drop from 145 HACs per 1,000 patients discharged in 2010 to 115 per 1,000 in 2015. "3.1 million ... that's the number of adverse events that *didn't* happen over that time period. We're excited about things that didn't happen."

That excitement is with good cause. "For each of the adverse events we are tracking, we also look to the literature to get an idea of related mortality," he explained. By applying those mortality rates across the averted HACs, AHRQ estimates 125,000 lives have been saved since 2010.

Perhaps more importantly is that expectations have changed over the years. Brady said there was a time when CLABSI was viewed as an unfortunate but inevitable consequence of care for some. "Over time, forward thinking researchers and clinicians found there are best practices," he said, noting CLABSI is now one of the more rare HACs because of the processes that have been put in place to avoid such infections.

Track & Act

"Measurement overall is a critically important aspect of safety," Brady said of tracking HACs in the hospital setting.

"You have to be able to trust the numbers, but the other important aspect is that the measurement is as efficient as possible ... not so complex. We need to leave some capacity, time and energy for (healthcare providers) to make changes responsive to the things they are measuring," he explained.

"The challenge is the gap between knowing what needs to be done and actually doing it," Brady continued of changing the culture to look at safety from a systems perspective. He pointed out the best patient safety research findings won't matter if those discoveries don't fit into the bigger picture of how workflow happens.

To turn data into action items, hospitals and health systems have adopted a number of strategies and management styles such as Comprehensive Unit-based Safety Programs (CUSP), TeamStepps and Six Sigma. In support those efforts, AHRQ has created toolkits and resources (ahrq.gov) to disseminate information and help providers apply best practices in their everyday practice.

More to Do

As pleased as Brady is to see the HAC rate drop from 145 to 115, he said there is much more work to be done. "The rate is not zero. It's still 115 HACs per 1,000 discharges ... that's a lot of patients that are harmed still."

Colleague Noel Eldridge, a senior advisor and public health specialist, said when AHRQ began this work, 80 of the HACs out of the original 145 per 1,000 "were probably not preventable based on the information we had at that time." He contin-

ued, "The goal is to get to zero, but conceptually if we did everything we knew, we'd only get down to 80."

Clostridium difficile and patient falls are examples of two stubborn issues that continue to frustrate hospitals. "There's a threshold we get to when we've applied everything we know but still have falls," said Brady. At that point, he continued, the underlying issue is most likely that the problem is still not fully understood. The good news, Eldridge added, is that research continues to chip away at those unknowns.

The work continues to track data, assess risk and transform information into actionable items. "It's a proven formula, but the job is not done," Brady concluded.



Dr. Jeff Brady



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Alabama Gains from National Program, *continued from page 14*

ings of clinical teams. “They’re involving themselves in the case while the patient is still here or while surgery has just been performed, so any harm can be managed on a real-time basis rather than after the patient has been discharged,” says Keith Granger, president and CEO.



Keith Granger

Out of the meetings came a simple solution. Hospital staff had noticed a greater prevalence of deep vein thrombosis in obese patients. “The pharmacy’s staff suggested we increase the anticoagulant dosage on these patients, and since that change, we have had no incidence of that condition arise,” Granger says. “It’s one situation where you observe data and get results. If we had not been doing that on a highly focused basis, I’m not sure it would

have been identified.”

Communication proved to be the lever of change at Monroe County Hospital as well. In 2013, 20 percent of babies were early-elected deliveries before week 39 for no medical indications. “It was for patient preference,” says Anne Shirah, director of quality services at the 94-bed rural hospital. By the fall of 2014, they had dropped that number to zero. A well-accepted practice among obstetricians, “if a physician schedules for induction at 38 weeks, it takes a strong, hospital to say no,” Shirah says.



Anne Shirah

PIP provided an avenue to reach patients by placing posters in physicians’ waiting rooms showing the difference in a baby’s size in one week, along with

monthly child-birth education classes. Shirah also presented at medical staff meetings, met one-on-one with the manager of obstetrics, and had the hospital sign a pledge that they would not electively deliver before 38 weeks.

“It was not until guidelines came out from obstetric resources that physician practices changed, though. You have to give them the data,” Shirah says, which she gathered from PIP and hospital engagement network sources.

Blackmon says the networking and pool of knowledge through PIP participation is invaluable. “The beauty of this project is that there are so many great resources out there,” she says, emphasizing the impact of the national participation, including the American Heart Association and the Health Research & Educational Trust. “After being here forever, it’s nice to see a project that’s really making a difference.”

PHYSICIAN COMPENSATION, *continued from page 17*

important to physicians because of the distinction between the TAM and Treas. Reg. Section 1.469-4(f)(2), in which physicians unsuccessfully attempted to separate radiological service income from their regular medical practices.

The GOP’s “Better Way” Blueprint for Tax Reform

The first part of tax reform that will impact tax planning are the proposed cuts to tax rates for corporations, flow-through entities and individuals. While the Blueprint calls for the corporate tax rate to be cut to 20%, even more important is that business income flowing through to a personal tax return (e.g., from an S Corporation, LLC and/or partnership) is to be capped at 25%. Proposed individual tax rates go down to 12%, 25% and 33%.

So what will these rate changes actually mean for professional practices? The most important change is the one which caps the tax rate on income from flow-through entities at 25%. Professional practice income flowing through to the owners of LLC’s and S corporations is to be taxed at a rate less than wages from a regular corporation. Accordingly, professional corporations which have not yet elected S status because of the built-in gain tax cost (usually the tax on accounts receivable) should begin to consider whether to make an S election for 2017, especially since the corporate rate for built-in gains will also have been significantly reduced.

Another important portion of the Blueprint for tax planning is the provision allowing investors to deduct one-half of their capital gains, dividends and interest (a completely new wrinkle), before subjecting the remainder to tax. Under this format, the tax rate on such income will effectively be reduced to 6%, 12.5% or 16.5% (depending on the taxpayer’s regular tax bracket). Unfortunately, as of the week before his inauguration, Mr. Trump’s plan has not endorsed this proposal.

It seems clear that tax reform is going to significantly broaden and flatten corporate and individual tax rates. Exactly what happens with respect to investment types of income and gain is still up in the air, but I tend to believe that there will be reductions in those rates too. Therefore, I believe that many, if not all professional service providers are going to be looking to take advantage of both sets of lower rates by converting PC’s treated as corporations to S corporations and/or LLCs, even if that means taking a one-time hit on certain built-in gain. I also expect that these lower rates will generate more investments in other types of business and income producing activities which should likewise be organized as pass-through entities.



Jim McCarten is a partner with Burr & Forman LLP who focuses on general tax planning.





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The Literary Examiner

BY TERRI SCHLICHENMEYER

What Doesn't Kill Us

by Scott Carney

c.2017, Rodale; \$26.99 / \$31.50 Canada; 240 pages

You might need an extra blanket to-night.

Or three, because the temperature doesn't seem to match your comfort level. Brrrrrrrr. Yes, it's winter and yes, the mercury plunges, but that doesn't mean you like being cold – although, as you'll see in *What Doesn't Kill Us* by Scott Carney, cold might be keeping you alive.

With very little between him and a snowy wind, had Scott Carney questioned his own sanity on his way to the top of Africa's highest mountain some months ago, few would have blamed him. Temps dived but there he was, on a purposeful quest.

A journalist by trade, Carney was looking for modern-day snake-oil salesmen for a book he was writing when he came across Dutchman Wim Hof, who claimed he could teach people to do simple, but extraordinary, things to increase endurance and productivity. His methods,

as a skeptical Carney learned first-hand by signing up for Hof's course, tapped into that which our ancestors naturally did.

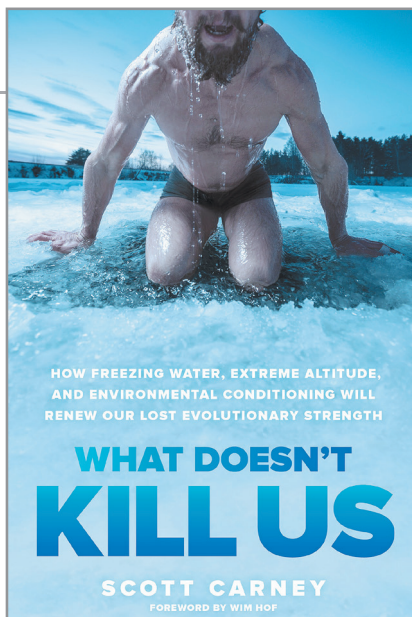
Today's humans live in what Carney says is an "ocean of perpetual comfort." We don't have to catch our food or spend much time in extreme climates; conversely, early humans didn't have the comforts of deli lunches or down coats. That difference – the hardships they endured, as opposed to the physical comforts we almost demand – has negatively shaped humanity through obesity, diabetes, autoimmune disorders,

lost ability to intuit direction, lessened navigational aptitude, and other once-innate skills that might be lying dormant but that we don't use very much anymore.

Skills lost - but Carney was determined to find them again. He followed, then tweaked, Hof's methods before and after endurance testing in a Colorado laboratory. He tackled an obstacle course



Scott Carney



Doesn't Kill Us.

There's a reason for that, actually: what Carney discovered can be very dangerous if tried improperly or inappropriately. Readers may note, for instance, that nearly all practitioners of the Hof method are men. Carney hints at a reason which, when added to the intriguing first-person accounts and tantalizing possibilities, made me want more gender-balanced investigation. Even so, and that aside, there's no limit to the sense of swashbuckling adventure, limit-pushing, and derring-do you'll find here.

Certainly, this book is for super-athletes, but it's also a great read for sofa slugs who want better health, thrills, and a few pounds gone. If you're looking for something that will make you look forward this year by looking backward, *What Doesn't Kill Us* won't leave you cold.

Terri Schlichenmeyer is a professional book reviewer who has been reading since she was 3 years old and she never goes anywhere without a book.



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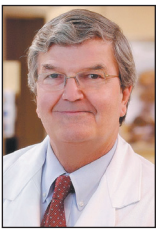
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UAB's Lay Navigation Program Demonstrates Significant Cuts in Costs

A new UAB study shows that, when older cancer patients were paired with trained nonmedical professionals in the form of lay navigators, there was significant decline in health care resource utilization and Medicare costs, providing an innovative model in transitioning to value-based health care on a national scale.

The study, published recently in *JAMA Oncology*, zeroes in on the influence of lay navigation on Medicare spending and resource use, such as emergency room visits, hospitalizations, intensive care admissions and chemotherapy in the last two weeks of life, to determine the financial implications on the health care system.

"This study provides evidence that we can reduce inefficiency and duplication of services, and at the same time make it easier for people to get the cancer care they need," said Edward Partridge, MD, director of the UAB Comprehensive Cancer Center. "Unlike the traditional fee-for-service approach, where providers are paid based on the number of health care services they deliver, the lay navigation program is a value-based



Edward Partridge, MD

approach that puts patients at the center, employing evidence-based medicine that takes into account each patient's preferences."

Over a three-year period, from 2012-2015, the study examined 12,428 geriatric patients, age 65 and older, enrolled in the Patient Care Connect Program (PCCP) through the UAB Health System Cancer Community Network, which includes 12 community cancer centers across Alabama, Georgia, Florida, Mississippi and Tennessee.

Comparisons were analyzed between 6,214 navigated and 6,214 non-navigated patients. The primary exposure was contact with a patient navigator who was guided by distress screenings that assessed practical, informational, financial, familial, emotional, spiritual and physical concerns. Navigated patients were matched to non-navigated patients on age, race, sex, cancer acuity, comorbidity and pre-enrollment characteristics.

The study found total costs declined by \$781 more per quarter per navigated patient for an estimated \$19 million decline per year across the network. Inpatient and outpatient costs had the largest decline with \$294 and \$275, respectively, per patient per quarter. Emergency room

visits, hospitalizations and intensive care unit admissions decreased per quarter by 6 percent, 7.9 percent and 10.6 percent, respectively.

"We know that our lay navigators have a positive effect on our patients," said Gabrielle Rocque, MD, medical director of the PCCP.

UAB has a history of utilizing a variety of navigation programs. While most navigation programs focus on early detection and the initial disease management, the PCCP focuses on the whole continuum of care from diagnosis through survivorship to end of life, and in an age group with high symptom burdens, who experience more hospitalizations and incur higher medical costs.

"Using lay navigation is a low-cost strategy to meet the demand for navigation services," Rocque said. "When done right, lay navigators can take the time-consuming pressure off the medical team through phone communication and proactive approaches that lead to earlier identification and management of symptoms."

Despite benefits to patients from navigation, programs have struggled be-



Gabrielle Rocque, MD

cause of a lack of financial support. The PCCP helps make a financial case to organizational leadership that a navigator can manage a caseload of about 150 patients per quarter and can target high-risk, high-cost patients. Navigators are uniquely positioned to meet the needs of high-risk patients because they can engage patients in the hospital, in multiple clinics and by phone. Navigators connect patients and their caregivers to appropriate resources across multiple disciplines, in different health care settings and within the community at large.

"Programs such as the Affordable Care Act are driving improvements in mandating better care with lower costs, and that is a good thing," Partridge said. "And this study is a step in the right direction in that we have a definitive assessment of impact that can provide opportunities for improvement nationally and system-wide."

REPRINTS: If you would like to order a reprint of a *Medical News* article in a PDF format or request an additional copy of an issue, please email: steve@birminghammedicalnews.com.

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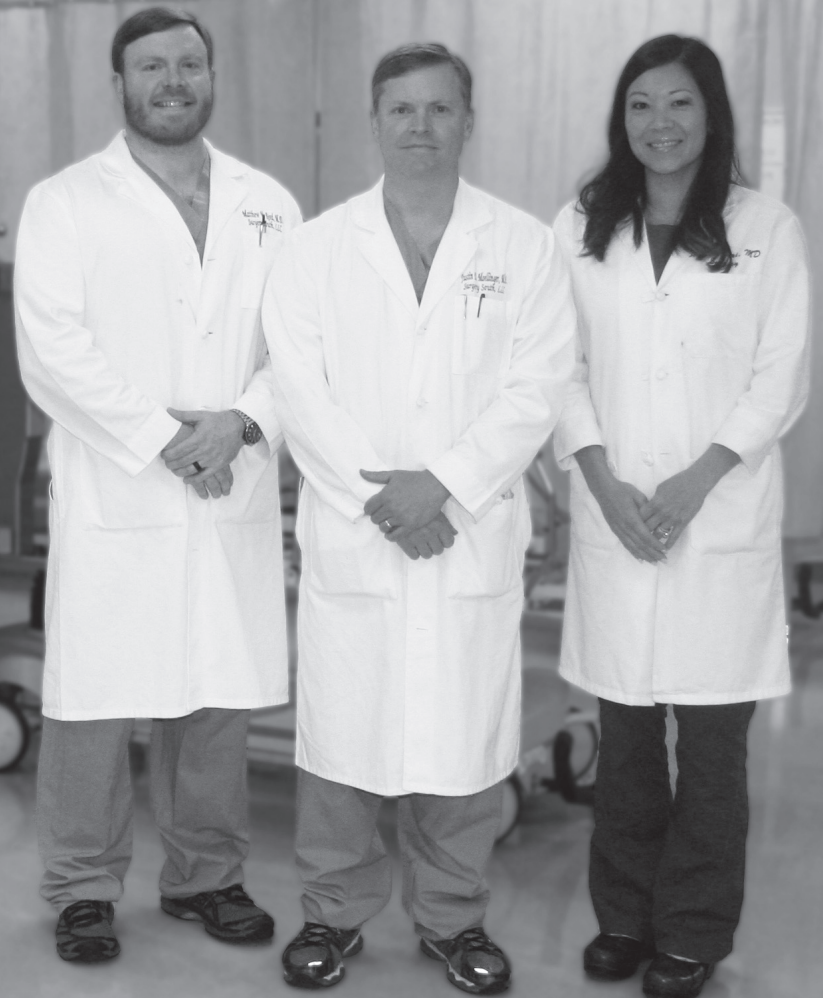
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Pictured left to right: Dr. Matthew Reed, Dr. Justin Moellinger, Dr. Beatrice Chaicharncheep



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RESEARCH NOTES

New England Journal of Medicine Lauds UAB Study

A study on the efficacy of surgery to remove the thymus in myasthenia gravis (MG) patients, led by researchers at UAB, has been named one of the top neurology stories of 2016 by the New England Journal of Medicine Journal Watch.

The study was the first randomized trial to assess whether surgery to remove the thymus, long a mainstay of treatment for MG, actually provided improved clinical outcomes.

Gary Cutter, PhD, professor in the Department of Biostatistics in the UAB School of Public Health, led the multisite, multinational and multidisciplinary study. Inmaculada Aban, PhD, professor in the Department of Biostatistics, served as the study's deputy director and ran the data-coordinating center.



Gary Cutter, PhD

The study enrolled 126 patients with MG without a thymoma, or tumor. Some underwent a surgical procedure to remove the thymus, known as a thymectomy, and received a commonly used MG medication called prednisone. A second group received prednisone alone.

The surgery group had a better Quantitative Myasthenia Gravis score (6.15 vs 8.99) and a lower average requirement for alternate-day prednisone, requiring 44 mg against 60 mg for the medication-only group over the three years of follow-up.

Cutter and colleagues concluded patients treated with thymectomy were less affected by symptoms than those treated with prednisone alone, required less prednisone and other immune-suppressing medications, and had fewer hospitalizations due to flare-ups. The authors wrote that thymectomy improved clinical outcomes over a three-year period in these patients.

UAB Involved in Study Identifying Genomic Features of Cervical Cancer

Investigators with The Cancer Genome Atlas Research Network, including a researcher from the UAB, have identified novel genomic characteristics of cervical cancer that will aid in the subclassification of the disease and may help target therapies that are most appropriate for each individual patient.

The new study conducted an analysis of the genomes of 178 primary cervical cancers, and found that more than 70 percent of the tumors had genomic alterations in either one or both of two important cell signaling pathways. The researchers also found that a subset of tumors did not show evidence of human papillomavirus infection.

The study was jointly managed by the National Cancer Institute and the National Human Genomic Research Institute, and was performed by a con-

sortium of more than 150 researchers at dozens of institutions across the world.

Akinyemi Ojesina, MD, PhD, assistant professor in the UAB Department of Epidemiology, has been involved with the study for the past three years. "We performed genomic analyses of cervical cancers, and identified genetic mutations that are novel drivers of the disease," he said. "This is exciting because we can now develop targeted therapies."



Akinyemi Ojesina, MD, PhD

The study researchers found that a unique set of eight cervical cancers showed molecular similarities to endometrial cancers. Most of these endometrial-like cancers were HPV-negative, and they had strikingly high frequencies of mutations in the PTEN, ARID1A and KRAS genes.

It has been thought that all cases of cervical cancer are caused by HPV, and just two HPV types are responsible for about 70 percent of all cases. "Basically, this study confirms some of our previous work that HPV infection may not be involved in all cases of cervical cancer," Ojesina said.

One of the most important parts of this study has to do with identifying targets for immunotherapy. Investigators examined genes that code for known immune targets to see whether any were amplified, which may predict responsiveness to immunotherapy. They found amplification of several such genes, specifically CD274 (which encodes the PD-L1 immune checkpoint protein) and PDCD1LG2 (which encodes the PD-L2 immune checkpoint protein). Several checkpoint inhibitors have been shown to be effective immunotherapeutic agents.

"Immunotherapy has emerged as one of the most promising areas of cancer therapy," Ojesina said. "Some treatments boost the body's immune system in a general way, and others help train the immune system to attack cancer cells specifically. We have now found evidence of mutations in genes that normally put 'brakes' on the immune system, suggesting treatment with drugs that take those brakes off may be effective against cervical cancer cells."

In addition, the analysis identified several novel mutated genes in cervical cancer, including MED1, ERBB3, CASP8, HLA-A and TGFBR2. The researchers also identified several cases with gene fusions involving the gene BCAR4, which produces a long noncoding RNA that has been shown to induce responsiveness to an oral drug that inhibits a key pathway in breast cancer known as lapatinib. Therefore, BCAR4 may be a potential therapeutic target for cervical cancers with this alteration.

Also, when analyzing the biology behind the molecular alterations in the cervical cancer tumors, researchers found that nearly three-quarters of

cervical cancers had genomic alterations in either one or both of the PI3K/MAPK and TGF-beta signaling pathways, which may also provide targets for therapy.

Next, Ojesina and the other authors hope to determine whether HPV-positive and HPV-negative tumors will respond differently to targeted therapies.

HudsonAlpha Researchers Identify Genetic Variants That Cause Intellectual Delay

Researchers at the HudsonAlpha Institute for Biotechnology, along with an international team of collaborators from six countries, have identified a new genetic disorder that causes intellectual and developmental delay in children. GeneMatcher, an online "matchmaking" system for scientists researching rare genetic variants, connected the team members. The research is published online in the American Journal of Human Genetics.

"Essentially, we did experiments to understand how variants in the EBF3 gene might change its function during development," said Drew Hardigan, a graduate student in the Myers Lab at HudsonAlpha and a co-lead author. "The role of EBF3 had been studied in terms of neural development, but had not been previously described as a gene in which mutations cause intellectual delay. We were able to demonstrate that changes to the gene are the cause of a clinical disorder."

EBF3 was identified at HudsonAlpha as an interesting gene for research through a pediatric genomics program led by Greg Cooper, PhD. Through genomic sequencing, Cooper's lab had identified two patients with changes to EBF3. However, his team could not find any similar cases or publications on the gene to confirm the variants were causing the patients' symptoms. The genetic changes were labeled variants of uncertain significance, or a VUSs.

The group turned to the website GeneMatcher, which operates like a matchmaker site for scientists interested in genetic variants. Using the online system, Cooper's team was able to contact researchers around the world who were also interested in VUSs in EBF3. Once connected, the international group performed a statistical analysis confirming the gene was likely the cause of the symptoms for 10 patients located on three continents. The group then used a variety of genomic assays to investigate the function of the variants.

The experiments demonstrated that the genetic changes to EBF3 – the same changes found in those 10 patients – disrupt important functions required for normal development. They also found that changes in this gene were likely the cause of about one in every 1,000 patients with unexplained neurodevelopmental disorders.

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GRAND ROUNDS

Grandview Names Chief Nursing Officer

Sherry Cole, RN, MSN, has been named Chief Nursing Officer for Grandview Medical Center.

Cole began her clinical career at Carraway Methodist Medical Center following graduation from UAB. In 1987 she earned her Master's Degree in Nursing from UAB and moved to University of Alabama Hospital before joining Trinity Medical Center in 1994. During her career, she has served in a variety of clinical positions including staff nurse for OHICU and CVICU, cardiac transplant coordinator, clinical nurse specialist for CVICU and CV surgery, cardiovascular clinical excellence coordinator, chest pain center coordinator, director of CICU, clinical director of the CV service line and interim CNO.

In 2012 Cole was named an Alabama Hospital Hero by the Alabama



Sherry Cole,
RN, MSN

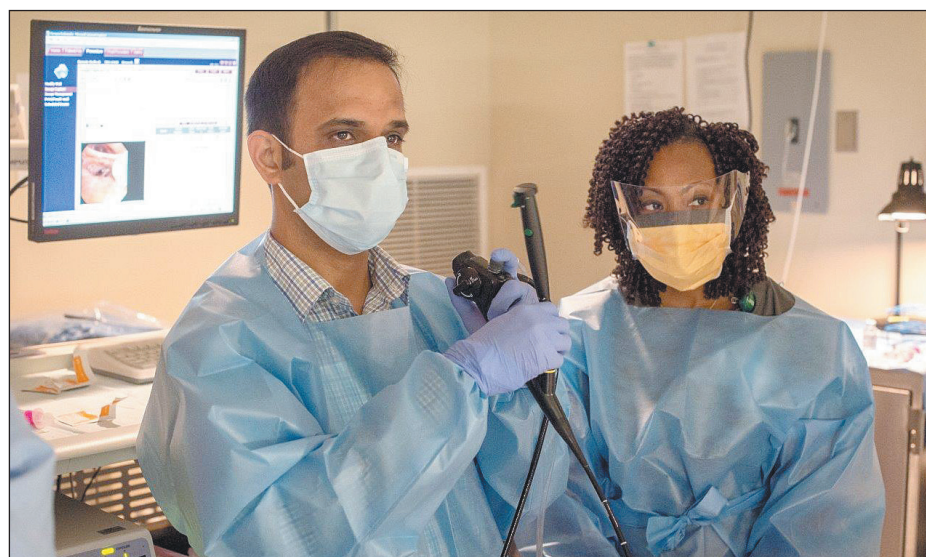
Hospital Association. In 2014 she was recognized as the Outstanding Critical Care Manager by the Greater Birmingham Chapter of the American Association of Critical Care Nurses and in 2015 was named Nursing Director of the Year for Trinity Medical Center.

Lemak Health Relocates

Lemak Health has relocated its Birmingham clinic from Montclair Road to a new 20,000 square foot facility on Cahaba River Road next to the intersection of I-459 and Highway 280.

The facility houses two digital x-ray units, an MRI, and C-Arm. Drayer Physical Therapy will provide on-site physical therapy.

Lemak Health CEO, Matthew Lemak, said "We wanted a location near the new Grandview Medical Center, but were very focused on patient convenience. With four separate access points, both from 280 and I-459, we think we achieved this."



Surya Bhatt, MD with Melessia Wells, lead respiratory therapist.

UAB Launches Comprehensive Interventional Pulmonary Program, First in Alabama

UAB has created a multidisciplinary program in interventional pulmonology. It is the only comprehensive program covering all facets of interventional pulmonology in Alabama, and one of only about 25 in the nation.

Interventional pulmonology is a relatively new concept in pulmonary medicine, using endoscopy and other methods to diagnose and treat lung and chest diseases.

"The program provides a complete approach to treating a variety of lung diseases, including cancer and central airway obstruction," said Hitesh Batra, MD, assistant professor in the Division of Pulmonary, Allergy and Critical Care Medicine with the UAB School of Medicine and director of the program.

The program offers the full range of interventional pulmonology procedures including flexible and rigid bronchoscopy, electromagnetic navigation guided bronchoscopy, airway stents, photodynamic therapy, bronchial thermoplasty, and pleural biopsy.

The program is designed to rapidly see patients who are referred to UAB, make or confirm a diagnosis, and commence treatment in a short time frame.

"We see all patients within a week of receiving a referral, and if needed, therapy is usually delivered within a two-week span," Batra said.

The program offers access to UAB's other medical disciplines, such as thoracic surgery, radiation oncology, radiology and pathology.

"Patients with confirmed lung malignancies are immediately assessed by our UAB Tumor Board, which meets regularly to follow the progress of cancer patients," Batra said.

The program will also be engaged in clinical research efforts to find new diagnostic and therapeutic approaches to lung disease, as well as serving to train the next generation of pulmonary physicians.

Joseph Thachuthara-George, MD is co-director of the program. Other pulmonary physicians involved are Mark Dransfield, MD, Veena Antony, MD, Gerald Belopolsky, MD, Jennifer Trevor, MD and Surya Bhatt, MD.

Dixon Retires as Executive Director of the Alabama Board of Medical Examiners

Larry Dixon has retired from his post as executive director of the Alabama Board of Medical Examiners after serving over 35 years.

"It has been my privilege to serve Alabama's physicians and our staff because we are so much like family. I'm going to miss that," Dixon said.

Dixon established the Medical Association of the State of Alabama's education department, which has continued to flourish by producing original continuing medical education programs for Alabama's physicians, as well as nurse practitioners and CRNPs.

Dixon served four terms on the U.S. Federation of State Medical Boards and was the first president of the Administrators in Medicine. He has also served on committees of both AIM and FSMB. In 2009 he received the Meritorious Service Award from FSMB, and in 2014 FSMB awarded him the Lifetime Achievement Award. He was inducted into the Alabama Healthcare Hall of Fame in 2016, and the Medical Association honored him by renaming



Larry Dixon

the building that houses the Alabama Board of Medical Examiners to the Dixon-Parker Building.

Dixon served seven terms in the Alabama Legislature and has been a member of the board of directors of the Montgomery Airport Authority; board member of the finance committee and past member of the administrative board of First United Methodist Church; charter member of the Certified Medical Board Executives; member of the advisory committee of the Prescription Drug Monitoring Program; and member of the board of directors of the FSMB Research and Education Foundation.

Quentin Riggins Joins Grandview Board of Trustees

Quentin Riggins, Senior Vice President of Governmental and Corporate Affairs for Alabama Power, has been appointed to the Grandview Medical Center Board of Trustees.

Riggins has 23 years of experience in Alabama government having worked under three governors. He holds a bachelor's degree from Auburn where he was a second team All-American and All-Southeastern Conference linebacker. He serves



Quentin Riggins

on the Auburn Athletics Strategic Advisory Committee and chairs the Auburn University Capital Campaign. He also serves on the board of directors for VOICES for Alabama's Children, Energy Institute of Alabama and the Business Council of Alabama Progress PAC. He is a former member of both the Leadership Alabama and the Baptist Foundation boards.

HudsonAlpha forms Economic Development Advisory Committee

HudsonAlpha Institute for Biotechnology has established the HudsonAlpha Economic Development Advisory Committee. The committee is comprised of leaders in site selection and economic development who will collaborate on strategy focused on the retention, expansion, and attraction of life science companies on the HudsonAlpha biotech campus and throughout North Alabama.

"The life sciences community at HudsonAlpha has drawn extraordinary bioscience talent and has a reputation of fostering startups and spinouts, as well as established life sciences companies seeking to expand," said Erin Koshut, director of Cummings Research Park.

Warren Averett Hosts MACRA Luncheons

Warren Averett is hosting MACRA luncheons in Birmingham on February 23; Huntsville on February 21; and Montgomery on February 22.

Luncheons topics include an overview of MACRA and MIPS; choosing quality measures for effective participation; choosing the correct reporting mechanism; and understanding the scoring methodology.

To register, contact Becky Cruise at 205-769-3234.

DCH Purchases Lifesaving Neonatal Equipment

Brave Beginnings, a program of the Will Rogers Motion Picture Pioneers Foundation, has awarded DCH Health System a grant to purchase two stand-alone ventilators that attach to portable Giraffe OmniBeds.

The portable ventilators allow physicians to intubate a baby in respiratory distress at the time of delivery rather than having to wait until the baby is transported from the delivery room to the NICU.

DCH has 24 Giraffe OmniBeds, which provide a stable temperature with humidity, and quiet environment for the baby as the infant grows.

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Pearce, Bevill, Leesburg, Moore 2016 Member Firm of the Year

The National CPA Healthcare Advisor's Association (HCAA) has recognized Pearce, Bevill, Leesburg, Moore P.C. as Member Firm of the Year for 2016.

PBLM Partner, Hal "Buzz" Coons, is completing his term as president of the HCAA and was present to receive the award on PBLM's behalf. "We are proud to be associated with such a distinguished national network of CPA Firms."

The HCAA is a nationwide network of over 60 CPA firms devoted to serving the healthcare industry.

First HIFU Procedure in Alabama at Grandview

Grandview Medical Center is the first hospital in Alabama to offer a minimally invasive treatment option for men diagnosed with prostate cancer.

While traditional treatment options have included surgery and radiation, HIFU (high intensity focused ultrasound) eradicates prostate cancer cells through

the focusing of sound waves to a targeted location. The process results in the creation of heat to destroy cancer cells.

"Because this is a non-surgical approach and does not require radiation, the risk of side effects that accompany traditional treatments, such as erectile dysfunction and incontinence, is significantly decreased," said Andrew Strang, MD with Urology Centers of Alabama. "Additionally, this is a minimally invasive outpatient procedure."

Not all prostate cancer patients are excellent candidates for HIFU. Patients would need to discuss this option with their urologist.

HIFU has been available outside of the United States since 1995. In 2015, HIFU received FDA approval making it available for the first time in the US.

Minnich, MD Joins Princeton Heart & Thoracic Services

Douglas J. Minnich, MD has joined the Brookwood Baptist Health Princeton Heart & Thoracic Services group, which is located on the Princeton campus.

Minnich earned his medical degree from Indiana University School of Medicine before doing a general surgery residency at the University of Florida / Shands Hospital, followed by a fellowship in cardiothoracic surgery at Massachusetts General Hospital.

Minnich is one of only three tho-



Andrew Strang, MD

racic surgeons in the state of Alabama. He emphasizes the use of minimally invasive technologies and has developed one of the largest surgeon experiences with electromagnetic navigation bronchoscopy in the world.

Princeton Names New Chief Financial Officer

Princeton Baptist Medical Center has selected Amanda Dyle as their new chief financial officer.

Dyle most recently served as the chief financial officer at Walker Baptist Medical Center and prior to that at Coastal Carolina Hospital in Hard-eeville, South Carolina.

She has also served as assistant chief financial officer at the Atlanta Medical Center in Georgia. She began her career with Tenet as controller at Northshore Regional Medical Center in Slidell, Louisiana.

Dyle holds a Bachelor of Science degree in Business Administration from the University of Southern Mississippi and a Master of Business Administration from William Carey College.



Amanda Dyle

Parnell and Batson Join OB-GYN South

In 2016, Brent Parnell, MD and Maurine Batson, MD joined OB-GYN South, P.C.

Parnell earned his Bachelor's Degree from Samford University and his Medical Degree from the UAB School of Medicine. After residency training at Greenville Health Systems, he then completed a three-year fellowship in female pelvic medicine and reconstructive surgery, also known as urogynecology, at the University of North Carolina at Chapel Hill.

As a board certified Urogynecologist, Parnell focuses on the treatment of pelvic floor disorders including pelvic organ prolapse, bladder and bowel incontinence using a wide array of conservative, medical and surgical treatments. He has extensive experience with robotic surgery, sacral neuromodulation, Botox for overactive bladder and other minimally invasive techniques.

Batson earned her Bachelor's Degree from UAB and her Medical Degree from the University of South Alabama College of Medicine. She completed her internship and residency training at the University of Florida in Gainesville. She has an interest in adolescent gynecology, high risk obstetrics, and laparoscopic surgery.



Brent Parnell, MD



Maurine Batson, MD



Cullman Regional 5th Floor Groundbreaking

Cullman Regional Medical Center (CRMC), TRO Healthcare Design architects and Doster Construction held a groundbreaking ceremony for a hospital expansion that won't actually involve any broken ground. Having found that the original hospital plans could accommodate future vertical expansion, a fifth floor will be added to the main hospital building. This expansion will add 30 new beds to CRMC, and should increase the number of private rooms. It will also add 30 new jobs at the hospital initially, and more when the expansion is fully complete.

Construction has begun with the relocation of CRMC's antennas and removal of exterior bricks from the elevator mechanism housing on the roof. The project is expected to be completed by the fall of 2018.



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Alabama Allergy & Asthma Center offers Treatment Option for Food Allergy

Alabama Allergy & Asthma Center announces a new treatment option available for peanut allergy sufferers through their new OIT(Oral Immunotherapy) Program. Peanut desensitization, also known as oral immunotherapy, is an up-and-coming treatment option that, under the careful supervision of the allergist/immunologist, introduces a specific amount of food allergen to a patient daily in escalating doses escalating doses in order to create immune system tolerance.

Subcutaneous and sublingual immunotherapy are popular treatments for people with environmental allergies, such as hay fever. With no approved treatments to cure or treat food allergies, families with food allergies must follow strict avoidance with constant observation for any accidental reaction. The decision to offer the innovative treatment option is based on continued positive findings from nationwide studies. The goal of the new OIT Program is to minimize the patient's risk for food anaphylaxis and improve their overall quality of life.

For referrals or more information, or to refer a patient for OIT services please contact Anthony Pallotta, OIT Program Manager, 205-777-7183.

Ambrosia Joins Alabama Orthopaedic Surgeons

Jerry Ambrosia, MD has joined Alabama Orthopaedic Surgeons.

Ambrosia received his bachelor's degree in biology from the University of Tennessee in 2006 before earning his doctor of medicine from East Tennessee State University in 2010.



Jerry Ambrosia, MD

He did a residency in orthopaedic surgery at Marshall University and a shoulder and elbow fellowship at St. Francis Orthopaedic Institute in Columbus, Georgia.

Before joining Alabama Orthopaedic Surgeons, Ambrosia practiced orthopaedic surgery in Columbus, Georgia.

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St. Vincent's To Open New Trussville Facility

St. Vincent's Health System plans to open a new location in Trussville that will house outpatient services including diagnostics, a primary care practice, after hours/urgent care, wellness services and physical therapy, along with a number of specialist physician practices.

The 31,753 square foot site, which will be visible from I-59, is located at 7201 Happy Hollow Road. Construction will begin in the coming months and opening is anticipated for fall of 2017.

The medical services offered at St. Vincent's Trussville will be similar to the St. Vincent's One Nineteen campus in Shelby County. The facility will provide easy access to outpatient services, including convenient parking. In addition, it will provide coordination among the services and hospital-based services.



Gastroenterology Associates Opens New Clinic

Gastroenterology Associates has changed their name to Southeast Gastro.

The group has opened a new clinic in the Strayer Building near Grandview Medical Center. The clinic is approximately 3800 square feet with nine exam rooms.

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Kassouf & Co. Named One of the Nation's 50 Best Accounting Firms for 3rd Consecutive Year

Kassouf & Co., P.C. has been selected as one of the nation's 50 "2016 Best of the Best Accounting Firms" by Inside Public Accounting. Kassouf & Co. is the only Alabama firm selected for this honor.

IPA's annual "Best of the Best" list recognizes superior financial and operational performance based on more than 70 IPA criteria. The right combination of planning, strategy and execution distinguish "Best of the Best" firms from among more than 540 firms that participated in IPA's 26th Annual Survey and Analysis of Firms.

Biddle Retires from St. Vincent's and Alexander Named New Market Leader

Neeysa Biddle is retiring as Senior Vice President, Ascension Healthcare and CEO of St. Vincent's Health System (STVHS), effective June 30. She will continue working with Ascension's newly created Consulting Network, LLC.

Jason Alexander, formerly with Ascension's Providence Health System in Mobile, and most recently with Tenet Healthcare will be rejoining Ascension to serve as President and CEO of STVHS.

Biddle began leading STVHS on an interim basis in September 2014, then assumed the role fully in February 2015. She already was intimately familiar with St. Vincent's, having served there as Executive Vice President and Chief Operating Officer from 2005 to 2011.

Biddle was named one of the Birmingham Business Journal's Most Influential Executives in 2015 and 2016. She has served on the Alabama Hospital Association's Board of Directors and as an adjunct faculty member at UAB's School of Health Professions, where she was selected as the 2001 Alumnus of the Year. She has been named one of the Top 40 Graduates of the UAB Health Administration program and North Alabama Girl Scouts' 2012 Woman of the Year.

Jason Alexander, FACHE has served as CEO of East Cooper Medical Center in Mount Pleasant, South Carolina, part of Tenet Healthcare, since 2011. While at East Cooper the hospital received Tenet's Circle of Excellence recognition, awarded to Tenet's highest-performing hospitals, in 2013, 2014 and 2016. The hospital more than doubled its operating performance and improved two letter grades in its Leapfrog Safety Score, while improving associate engagement and physician net promoter scores.

"Jason has never failed to impress me with his desire to make a difference, his leadership and achievements," Biddle said.



Neeysa Biddle



Jason Alexander

"I am excited to return to Ascension," Alexander said. "It is an honor to follow in the footsteps of Neeysa Biddle, who I have known for over 20 years."

Alexander earned a bachelor's degree in biology from the University of South Alabama and master's degrees in health administration and business administration from UAB. In addition, last year he completed a post-graduate program on Strategy for Healthcare Delivery through the Harvard Business School Executive Education Program, and in 2009 earned a graduate certificate in Catholic Healthcare Ministry Leadership from Aquinas Institute of Theology, St. Louis.

He is a Fellow of the American College of Healthcare Executives and has served on several boards including the local chapter of the American Heart Association.

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