

EP Lab Digest

20 YEARS

A product, news & clinical update for the electrophysiology professional



EP Lab Spotlight

Monument Health Rapid City Hospital

Cassie Brandsted, RN, BSN, Manager,
Cath/EP Lab
Rapid City Hospital
Rapid City, South Dakota

When and by whom was the electrophysiology (EP) program started at your institution?

The EP program was started in 1993 by Jose Teixeira, MD. He started as a locums physician, but transitioned to a full-time electrophysiologist for this facility in 1995.

What is the size of your EP lab facility?

We currently have two EP labs, with room for growth in the near future. Our volumes have increased considerably within the last three years with the addition of two electrophysiologists from New York state: Ethan Levine, DO, FHRS, and Saverio Barbera, MD, FHRS, Director of the EP Lab.

continued on page 16

In This Issue

Incorporating Advanced Intracardiac Signal Information Into the Clinical Workflow

Q&A with G. Joseph
Gallinghouse, MD
page 22

Innovative Post-Transcatheter Aortic Valve Replacement Monitoring Program to Detect Arrhythmias and Heart Block

Q&A with Karen Ream, PA-C,
Wendy Tzou, MD, and John
Messenger, MD
page 26

Utility of Local Impedance to Guide High-Power Short-Duration Radiofrequency Catheter Ablation for Atrial Fibrillation

Ziad F. Issa, MD, MMM
page 30

Benefits of an Early Cryoablation Approach for Atrial Fibrillation

Q&A with Denise Sorrentino,
MD, FACC, FHRS
page 34

Role of the Clinical Pharmacist in EP

Q&A with Kristen Campbell,
PharmD, CPP, BCPS
page 38

Physiologic Pacing in a CRT-D Platform

James Kneller, MD, PhD, FHRS
page 40

Podcast Interview

Same-Day Discharge After Atrial Fibrillation Ablation



Podcast discussion hosted by Jodie Elrod

In the next episode of The EP Edit podcast, we're featuring a discussion on same-day discharge for atrial fibrillation (AF) ablation. Andre Gauri, MD, Chief of Electrophysiology at Spectrum Health in Grand Rapids, Michigan, is joined by Marc Deyell, MD, MSc(Epi), FHRS, FRCPC, EP Lab Director at St. Paul's Hospital in Vancouver, British Columbia, to discuss their approach to same-day discharge.



continued on page 8

Cover Story

Multidisciplinary Ventricular Arrhythmia Program: Novel Approach Combines Expert EP Care With Psychosocial Support

Interview by Jodie Elrod

In this article, we speak with Babak Nazer, MD, cardiac electrophysiologist and Director of the Ventricular Arrhythmia Program at the Oregon Health & Science University (OHSU) Knight Cardiovascular Institute in Portland, Oregon.



continued on page 12

Monument Health Rapid City Hospital

Cassie Brandsted, RN, BSN, Manager, Cath/EP Lab

Cardiologists John Heilman, MD, and Christian Gaissmaier, MD, also keep the department busy with device implantations. Even during the COVID-19 pandemic, volumes have remained at record-high numbers. I foresee the potential for another physician and a third room in the next couple of years.

What is the number of staff members? What is the mix of credentials at your lab?

We split into two separate departments (cath and EP) nearly 12 years ago. As recently as three and a half years ago, the EP department had only four staff members (two techs and two RNs) as well as an occasional float staff member from the cath lab. Within the last two and a half years, we have expanded to six RNs and six techs specifically for the EP lab. The majority of our nurses in EP, whose experience level ranges from two to 22 years, have previous cath lab experience. One of our seasoned nurses has solely been in EP for 21 years. Our techs, whose level of experiences ranges from four to 27 years, are RT(R)/RCES, RT(R), RT(R)/RCIS, RCIS, and RCIS/RCSA credentialed. Due to the continual increase in volume, we recently added staff members, with the potential to add more in the near future.

What types of procedures are performed at your facility?

In a 300-mile radius, we are a “one-stop shop” for everything related to the electrical system of the heart. We consider our program to be very progressive. We are currently the top implanter in the nation for the LUX-Dx insertable cardiac monitor (ICM) (Boston Scientific), and nearly the top implanter in the nation for loop recorders altogether. Our procedures consist of loop recorder insertion/removal, temporary pacemakers, permanent pacemakers (PPMs), implantable cardioverter defibrillators (ICDs), biventricular (BiV) pacemakers/defibrillators and upgrades, subcutaneous ICDs, Micra (Medtronic) leadless pacemakers, and His bundle pacemakers. We perform ablations for atrial fibrillation (AF) (radiofrequency [RF] and cryo), atrial flutter, supraventricular tachycardia (SVT), atrial tachycardia, premature ventricular contractions, Wolff-Parkinson-White syndrome, atrioventricular nodal reentrant tachycardia (AVNRT), AV node, and ventricular tachycardia. We also perform lead revisions and extractions, phrenic nerve stimulators, diagnostic EP studies, and cardioversions. In the last year, we performed our first left bundle branch pacing (LBBP) case. One of our electrophysiologists is also in the process of Watchman FLX (Boston Scientific) training; these procedures are primarily done in the cath lab.

Approximately how many catheter ablations (for all arrhythmias), device implants, lead extractions, and LAA closures are performed each week?

In 2020, we performed 8.2 ablations and 7.5 devices per week, including BiVs, ICDs, PPMs, upgrades, and lead extractions. We also performed an average of nearly 3 loop recorders/week, accounting for 149 for 2020. We did 60 EP studies in 2020.

As of September 2021, we have already performed 464 ablations/EP studies, 361 device implants, and 157 loop recorder implants. Within the last year, we also recently started performing convergent procedures for the treatment of AF, and have performed 25 convergent procedures to date. We are predicted to perform up to 75 of these procedures within the next year. Monument Health also performed 25 Watchman FLX procedures in 2020 and 30 thus far in 2021.

Our major adverse events percentage for Monument Health is 1.1%, compared to 3.8% nationally. Also, the ICD/PPM infection rate for Monument Health is 1.26%, compared to 1.87% nationally.

What types of EP equipment are most commonly used in the lab?

I would estimate that 95%+ of the implantable devices that we insert are from Boston Scientific, but we have also used some Medtronic devices. We utilize three different vendors for loop recorders: LUX-Dx (Boston Scientific), LINQ II ICM (Medtronic), and BIOMONITOR IIIm (Biotronik). Our mapping system is the Carto system (Biosense Webster, Inc., a Johnson & Johnson company), while



Front, from left to right: Amber Potts, RN; Jennifer Logan, RCIS; Donna Needham, RT(R), RCIS; Jon McMachen, CRN; Cassie Brandsted, RN (Manager); Charisima Straatmeyer, RT(R). Back: Brandee Nelson, RCSA; Becky Wilkening, RT(R), RCES; Lisa Brown, RN; Robert McCormick, RN; Saverio Barbera, MD, FHRS, Director of the EP Lab; John Weber, RN; Dean Gillen, RN; Todd Sorenson, RCSA (Supervisor).



From left to right: Shannon Weickum, RCIS; Cassie Brandsted, RN (Manager); Amber Potts, RN; Brandee Nelson, RCSA; John Heilman, MD, Chair of Cardiovascular Medicine.



Pictured are Cassie Brandsted, RN, (Manager) and Todd Sorenson, RCSA (Supervisor).

the stimulator is the Bloom2 platform (Fischer Medical). We use equipment by Biosense Webster for RF ablations, along with their Vizigo sheaths. We also use some diagnostic catheters from Abbott. Our cryoablation equipment is from Medtronic, and our primary transseptal equipment is from Baylis Medical. The x-ray equipment in both rooms is Siemens, with one room having a biplane system. We have a CardioLab EP Recording System (GE Healthcare), and also use GE for ultrasound. We document our procedural logs in the Epic electronic medical record (EMR) system. We also use the S-CATH esophageal temperature monitoring system (Circa Scientific).

Who manages your EP lab?

Both the cath and EP labs are managed via a collaborative team approach, including a clinical director (Jake Kleinschmidt), nurse manager (Cassie Brandsted, RN), and department supervisor (Todd Sorenson, RCSA).

Tell us about your device clinic, including its staffing model.

Our device clinic functions out of the Monument Health Heart and Vascular Institute. The clinic follows nearly 6000 patients with pacemakers, defibrillators, and implantable loop recorders. Both the device clinic and EP lab staff have the ability to perform device checks. The EP staff performs all inpatient, conditional/nonconditional MRI, and preprocedural device checks. All outpatient device checks are performed on the clinic side, occurring remotely every 90 days and in-person at least once/year. The device clinic has a mix of techs and nurses, and has a different management team.

In what ways did the pandemic impact your hospital, EP lab, or practice?

South Dakota did not “shut down” during the pandemic. We did stop performing electives in April 2020, but due to low COVID numbers, we were able to start performing necessary procedures by mid-summer. While our staff members currently do four 10-hour shifts, we devised a schedule during the pandemic in which the staff was divided into two teams with a designated physician. The teams would rotate between two and three shifts/week. To decrease COVID exposures between teams, it was recommended the staff stay within their teams,

but because of staff compliance in the use of protective equipment in the labs, COVID exposure to staff was limited. We performed COVID tests on our patients prior to their procedure. Post-clinic follow-ups were primarily performed via telemedicine visits. We did eventually get to the point that if a patient showed proof of vaccination, we did not require COVID testing.

As of September 2021, we are seeing increased COVID numbers again, and we have resumed pre-COVID testing of all patients, whether vaccinated or not. We continue to thrive, but are performing procedures with safety measurements in check. It has been an experience, but we take each challenge one step at a time.

What new initiatives have recently been added to the EP lab, and how have they changed the way you perform procedures?

Our EP department has expanded significantly in the last three years, but even with this expansion, our focus has remained and will always continue to be on the safety of our patients. We are continually improving processes, whether it is through decreased radiation dosing, improved technology and equipment, or involvement in multiple registries for tracking our progress and statistics.

We are also active participants in the American Heart Association's Get With The Guidelines initiative as well as the American College of Cardiology's (ACC) National Cardiovascular Data Registry (NCDR) EP Device Implant Registry. We have an amazing cardiology quality team that inputs and extrapolates data for the program.

Another new initiative is through an added role in our lab. Approximately four years ago, we incorporated a charge person in the lab, and that role has been a game changer. They manage the day and keep daily operations running efficiently. This impact is shown in our room turnover times. The national average is less than 24 minutes, and we excel by an average monthly turnover time of 16-18 minutes.

Another essential safety measure we practice is esophageal temperature monitoring. We use the temperature probe from Circa Scientific to monitor for increased esophageal temperatures and prevent thermal lesions.

Our electrophysiologists and cardiologists collaborate with the neurology department on cryptogenic stroke patients. A protocol is followed that leads to loop recorder implantation for patients who present with stroke of unknown cause.

Finally, our EP department is made up of not only EP staff and physicians, but we rely on a team approach with other ancillary departments such as anesthesia. Everyone works well as a team and keeps the patient as the focus. We are always striving for excellence and have a great team!

Tell us what a typical day might be like in your EP lab.

Staff arrives at 0600 to stock rooms and get started



Front, from left to right: Lisa Brown, RN; Amber Potts, RN; Cassie Brandsted, RN (Manager). Back: Dean Gillen, RN; Robert McCormick, RN; John Weber, RN; Brandee Nelson, RCSA; Todd Sorenson, RCSA (Supervisor); Ethan Levine, DO, FHRS; Becky Wilkening, RT(R), RCES; Donna Needham, RT(R), RCIS.

for the day, with the first case typically starting at 0700. We have one electrophysiologist assigned to the lab every day, and occasionally will have a second physician in the other EP lab at 0700. At least a few days each month, one of our cardiologists will schedule a full day of device implant cases in the second room. The staff is scheduled until 1630 each day, with an assigned late team for cases that run late into the day. We have anesthesia block coverage in both rooms.

A typical day for a patient starts in the preadmissions department for teaching. Patients receiving more complex procedures such as AF ablations will receive education and information before their scheduled procedure day. Once teaching has been completed, labs are drawn, and they are sent to the preprocedural area for case prep. After the procedure is completed, more than 90% of patients will discharge from the postoperative area known as the Cardiac Prep Unit (CPU).

We also perform procedures on inpatient add-ons on a near-daily basis. Utilization of the two labs combined is greater than 70%. We work to be efficient and utilize the time and space provided.

Do you utilize a same-day discharge approach for AF ablation cases?

The majority (90%+) of our outpatient AF ablation cases have same-day discharge. These patients are discharged from the 8-bed postoperative CPU.

How do you ensure timely case starts and patient turnover?

Our charge person manages the day-to-day operations of the labs. We are also fortunate to have accountable, proficient, and efficient physicians

who believe in customer and staff satisfaction and starting on time. Since we use anesthesia blocks, it is a joint effort with the anesthesia team in communicating any issues that may arise and delay cases. Ultimately, communication is key. The charge person is in constant communication with physicians, anesthesia, pre/post areas, advanced practice providers (APPs), and all others that may be involved during cases. Management also tracks start times and turnover times, and if trends arise, the concerns are shared during monthly EP operations meetings, where interventions for continued improvement are developed. We also hold weekly “charge” meetings between EP leadership and lead EP staff to discuss the next week’s cases, concerns, and staffing.

What are the best features of your EP lab’s layout or design?

For many years, we only had one EP lab, which was small and dysfunctional. In 2015, we built a new lab with a more functional layout, with anesthesia positioned at the head of the bed, and the physician, scrub, and monitor person in the room. The recording, stimulator, and mapping systems are positioned behind a control room with lead-lined windows. Communication between the control room and procedure room occurs using a headset system (Quail Digital). All staff involved in a case use this headset system, so each member can communicate and follow case progression.

Within the last two years, a second lab was built with initial plans for more of a device lab design; however, we decided there was more of a need for an additional EP lab. The layout is not as ideal as the first EP lab but functions to meet our needs. Overall, the equipment in both labs is

from top-ranked vendors, and we strive to provide high-quality technology to best serve our patients.

In what ways have you cut or contained costs in the lab?

In the last five years, we added a supervisor position to manage supplies and equipment. We also hired an excellent supply management tech. With the incorporation of Epic in 2017, we have been able to track charges and revenue daily. Our supply management tech frequently runs usage reports so we can track missing supplies/charges.

In the management position, I am in frequent contact with the physicians regarding revenue and expenses. This communication has aided in cost containment, and physician awareness of this information has been key to our success in budgeting.

Of note, the cath/EP lab supply list is the largest in the entire Monument Health system across any other department or area in the hospital. Annually, we perform a complete physical inventory check, and in the summer of 2021, we were off by less than .075% for both departments combined. Essentially, this number shows the combination of everyone’s hard work at checks and balances.

What types of continuing education opportunities are provided to staff? What options for continuing education are available to your mid-career staff?

Every year we budget for at least two caregivers to attend a conference of their choice. Unfortunately, the pandemic has halted that benefit in the last two years, but we have great vendors and physicians who are continually teaching and providing education in the labs. The vendors are frequently offering



Jennifer Logan, RCIS; Brandee Nelson, RCSA; and Shannon Weickum, RCIS.



Amber Potts, RN; Donna Needham, RT(R), RCIS; and Robert McCormick, RN.

much-needed education and providing CEUs. We have also held educational dinners after-hours in more relaxed environments.

We recently offered to cover the cost of the Registered Cardiac Electrophysiology Specialist (RCES) examination, and offered additional compensation to those who successfully passed. Becky Wilkening, RT(R), RCES, was our first staff member to complete this examination within the last year.

In October of every year, the Monument Health system holds their annual Cardiovascular Disease and Wellness Symposium, where caregivers can receive CEUs. This conference has gained great publicity in past years for being a top conference in the Midwest region. Since the start of the pandemic, this conference has taken place in a virtual setting.

Education is a huge component to the success of a department, and having the opportunity to offer this to staff is essential.

Describe a particularly memorable case from your EP lab and how it was addressed.

One memorable case was an atrial flutter and pulmonary vein isolation procedure that took place this past winter. The case was going well, but about 10 minutes after we began to ablate the cavotricuspid isthmus, the patient's blood pressure dropped. A pericardial effusion was noted on ICE but without evidence of tamponade. The patient's blood pressure continued to decrease, so one of the interventional cardiologists was called to assist in a pericardiocentesis. Despite removing several

hundred milliliters of pericardial fluid from the pericardium, the effusion continued to reaccumulate, even after discontinuation of heparin, initiation of protamine, and infusions of two units of fresh frozen plasma. The cardiothoracic surgical team was then notified; however, the surgeon was in the OR repairing an abdominal aortic aneurysm. While the surgery team prepared for the case, the electrophysiologist, interventional cardiologist, anesthesia team, and entire EP team did an amazing job of keeping the patient stable. In the end, it came down to successful teamwork. The patient continues to do well in follow-up. This case demonstrates that it takes a collaborative effort among multidisciplinary teams giving their all, with the patient at the forefront.

Does your lab use a third party for reprocessing or catheter recycling? How has it impacted your lab?

We use Stryker as our third party for reprocessing diagnostic EP and temporary pacing catheters. It is a very streamlined and smooth process that involves sending in catheters once a week. Once catheters are ready for return, our supply management tech is notified. A report is then run, and an order is sent in based on weekly needs. Essentially, there are no backorders and turnaround time is quick. An example of savings includes a \$500 catheter lowered to a price of \$182. Over the span of a year, the savings are significant.

Tell us about your experience with His bundle pacing and LBBP.

We performed our first LBBP case last spring and have continued to adopt this form of physiologic pacing in those patients that would benefit from ventricular pacing using the native His-Purkinje system. This strategy is gaining new ground, and we anticipate further growth in the future.

Tell us about your primary approach for LAA occlusion.

These procedures are performed in the cath lab setting, but with future plans of expanding into the EP space. In March 2021, we started using the Watchman FLX device (Boston Scientific). We currently perform these procedures under general anesthesia with transesophageal echocardiography (TEE) guidance.

Does your program have a dedicated AF clinic and/or a dedicated lead extraction program?

In January 2021, we started the process of becoming an AF Center of Excellence. We do not currently have a dedicated AF clinic, but we have an anticoagulation clinic that assists in managing these patients until the AF center of excellence is complete. Both physicians and APPs follow up with these patients in the clinic setting.

We developed a lead extraction program approximately one year ago. Our chief cardiologist

created the protocol, and it is a multidisciplinary program with the involvement of electrophysiology, cardiology, cardiothoracic surgery (heart team), anesthesia, echocardiographers, and perfusion. We use laser technology from Philips Healthcare if needed.

What approaches has your lab taken to reduce fluoroscopy time? What percentage of cases are done without fluoro?

Over the past few years, we have used a few different strategies to improve our fluoroscopy times. We utilize the V7 Prime platform for the Carto mapping system, which further addresses all major complex arrhythmias by reducing ablation times, improving mapping capabilities, and obtaining clearer and more accurate visualizations of almost every type of arrhythmia. In addition to V7 Prime, we use Vizigo sheaths. These transducers allow for clear visualization with the Carto system without depending on fluoroscopy. These sheaths also enhance efficiency during positioning of the ablation catheter.

To further reduce fluoroscopy time, we take the opportunity to use ultrasound for vascular access in many of our patients. Intracardiac echocardiography (ICE) is also used for ease of visualization and advancement of catheters and wires. Our electrophysiologists also utilize a fluoroless approach with all right-sided SVTs and typical atrial flutter ablations, accounting for at least 15% of cases. On average, our AF and left-sided ablations require less than one minute of fluoroscopy use, which in the end, protects the patient, staff, and physician. Lastly, device implantations require minimal fluoroscopy use, also accounting for less than one minute per case.

How do you manage radiation quality checks of the imaging equipment?

Staff performs daily checks on the x-ray equipment. We also utilize local Siemens representatives for routine preventative maintenance of the equipment. All staff and physicians are required to wear radiation badges, which are monitored on a quarterly basis. These reports are sent to the department with individual letters to those with elevated exposure readings. The facility has a Radiation Safety Committee that also meets quarterly; the EP lab supervisor is a member of this committee and continually monitors radiation exposure levels to both patients and staff. If there is elevated exposure, a report is generated from the PACS system (Sectra Medical) to our supervisor, who then communicates the information to the involved parties. Staff lead aprons are also inspected at least twice each year for damages. Lastly, a medical health physicist does an annual inspection of the fluoroscopy equipment.

What are some of the dominant trends you see emerging in the practice of electrophysiology?

Just like in all areas of cardiology, the EP arena



Becky Wilkening, RT(R), RCES.

is growing and continuing to advance with new and improved technologies. Dominant trends that we see happening in EP, especially in our region, are more complex atrial and ventricular ablations. We have recently seen many atypical flutter ablations in the last few months. Our electrophysiologists are also looking forward to seeing if pulsed field ablations pan out as anticipated. Dr. Barbera believes this new technology “can improve success rates while minimizing potential for complications, even more so, combined with faster procedural times, which leads to less anesthesia time and increased utilization/efficiency in a day’s work.”

The use of LAA occlusion is also growing rapidly, so we could see increased volumes of these procedures and more potential for them to be performed in the EP space. Another procedure we believe has gained some ground is the convergent procedure; we have performed 25 of these procedures since January 2021 and expect that number to continue to grow. Lastly, physiologic pacing using His bundle pacing and LBBP continues to increase.

How do you utilize digital tools or wearable technologies in your treatment strategies?

Wearable technologies such as the Apple Watch, FitBit, and Kardia (AliveCor) are continually increasing in popularity and are often used in our physician practices. It is estimated that 30% of our EP patients under 55 years old are using wearable technology of some sort. Recently, a 32-year-old female patient had documented atrial tachycardia on her Apple Watch, so she was referred to an EP and had a successful ablation.

Activity trackers are also beneficial for all areas of cardiology. All patients are asked their activity level in clinic visits and these devices allow patients to easily track their activity on a day-to-day basis.



John Weber, RN, (left) and Robert McCormick, RN.

These devices provide behavior change techniques and other insights to patients, with hopes of better outcomes for our patients.

These devices have also become very important during the COVID pandemic as the landscape of patient care changes to telemedicine visits as well as a greater reliance on wearable technologies to provide real-time data. We will continue to follow these new technologies.

Describe your city or general regional area. How is it unique from the rest of the U.S.?

Rapid City, otherwise known as the “The Gateway to the Black Hills,” sits on the eastern slope of western South Dakota. From this great area, visitors can explore the Black Hills, Badlands, Mount Rushmore, the Crazy Horse Memorial,

Bear Country USA, and much more. Rapid City has been voted one of the best places to live in South Dakota. Many people appreciate our area because it offers a dense suburban feel. This midwestern city defies anyone's expectations, with downtown entertainment, some serious elevation, and a few European touches.

Geographically, most of South Dakota is forever flat. However, downtown Rapid City actually sits at a peak of 3202 feet, with the area's highest elevation of 7242 feet, so people can understand why they have difficulty catching their breath when walking around downtown. In the end, many of us think of Rapid City as a little piece of heaven on earth.

What specific challenges does your hospital face given its unique geographic service area?

As essentially the only EP service in a 300-mile radius, we are considered a remote area. The distance in and of itself poses a challenge, as it is difficult to receive transportation due to treating some of the highest poverty neighborhoods in the nation. Many patients need to receive as much of their care as possible in one visit and setting, as they may face challenges returning for additional care due to transportation, finances, etc.

Geographically, we are isolated from the larger cities, which poses challenges for physician and staff recruitment as well as impacts bed availability and access to care. Like many facilities in the nation, we have a nursing shortage and are having to staff units with travelers. Luckily, in our specialty area of EP, we have been fortunate to have a core group of nurses and techs with minimal need for traveling staff.

The pandemic has also introduced us to further obstacles. Many people relocated to the area, thus increasing our population, which then challenged the health system with access to care. Similarly, we continue to face issues with shipment of supplies and equipment because of company backlogs and staffing shortages. Fortunately, we have great relationships with vendors to work through these delays. Learning to work through the challenges and keeping the patient at the forefront has allowed us continued success during these difficult times.

Please tell our readers what you consider special about your EP Lab and staff.

The EP staff at Monument Health is an amazing group of people. They are family. They take each day as it comes. This team deserves every

recognition because of their dedication to each other, the physicians, and most importantly, the patients. People outside this field typically do not understand the special world of EP and the vast knowledge that is required for this job. This team works hard, and they do it with pride. Going from a staff of four to 12 people shows how significantly the program has grown, and they have faced every challenge with poise. Our case volumes are the highest they have ever been — we recently completed a record of 18 ablations in one week. I would put this group of caregivers and physicians up against any EP department in the nation. Let's put this team on the map and introduce to the world the amazing EP physicians and staff at Monument Health. ■

Dedication: I dedicate this article to my EP staff and physicians. Much love, Cassie.

Cassie Brandsted, RN, BSN, Manager, Cath/EP Lab
Rapid City Hospital, Rapid City, South Dakota

For more information on how to participate in EP Lab Digest's Spotlight Interview feature, please contact Managing Editor Jodie Elrod at jelrod@hmpgglobal.com.