Saving Healthcare Costs
Abolishing Facilities Fees Would Free Billions Instantly

By PL JETER

On page 19 of Maine Gov. Paul LePage’s proposed budget is a line item that captured the attention of lawmakers in the tiny northeastern state of 2.3 million — and legislators in other states looking for meaningful ways to cut corners without removing social services: “Elimination of separate facility fees for hospital-based physicians: $11.4 million.”

The sizable cut reflected a significant change in the state’s Medicaid program, MaineCare. “Imagine if that scenario occurred in all 50 states … and if we stripped it out of Medicare and commercial insurance,” said Marni Jameson Carey, executive director of the Practicing Physicians of America in the Library of Congress, in Washington DC, on Feb. 2. “Real money — hundreds of billions of dollars — could be restored instantly.”

The Medicare Payment Advisory Commission (MedPAC) has suggested that if hospital facilities charged the same as independent doctors for the same services concerning 66 groups of services, taxpayers would save $900 million a year in Medicare costs alone.

Facilities fees, Carey pointed out, are added costs that provide zero value to patient care, but show prices upward. “By eliminating them,” she emphasized, “we could move toward site-neutral payments, and require payers to pay doctors the same amount for the same procedure, regardless of where it’s done.”

Hospitals have convinced lawmakers that facilities fees are necessary to help offset ever-rising overhead costs and operating hours. “However, facilities fees … incent hospitals to buy independent doctors because they can then charge more, which in part makes hospitals able to pay doctors more than they can make in an independent practice,” explained Carey.

Compounding Factors
Hospitals have significant funds to finance practice acquisitions — and successfully lobby their arguments to lawmakers — because of the cash flow afforded by their tax-exempt status, which AID would like to see reversed in abusive situations. Nearly two-thirds of hospitals in the U.S. are tax-exempt, including Florida Hospital and Orlando Health.

“They pay no property tax, no tangible personal property tax, no sales tax and no income tax, state or federal … in exchange for providing charitable care,” said Carey, noting the “exchange” was set up decades ago when market conditions were quite different. “If Florida Hospital and Orlando Health weren’t non-profits, they would’ve owed a combined $50 million in taxes last year on more than $2 billion of property across five counties. Fifty million dollars buys a lot of healthcare, police officers, classroom teachers, Little League.”

(Continued on Page 5)

The Missing Link in Autism
Test early to improve future prospects

By BETH RUDLOFF

As a member of the medical field, and the parent of two adult children with Aspergers, I think it’s fair to say that most of us know something of autism. We know that it is a cluster or spectrum of symptoms, including verbal, social, and intellectual impairments stemming from differences in the brain and/or a genetic condition. We know that autism can result in capabilities that range from those with severe challenges to those with remarkable cognitive gifts. Most of us may even know that April is Autism Awareness month.

What you may not know
The American Academy of Pediatrics recommends that 100 percent of children be screened for ASD by the age of 18 months, yet the CDC estimates that less than 20 percent are completed for children 5 years and younger.

Autism Spectrum Disorder (ASD) now includes autistic disorder, pervasive developmental disorder not otherwise specified (PDD-NOS), and Asperger syndrome; conditions that used to be diagnosed independently. Autism is far from a static, hopeless condition, but early screening and intervention are the key to improving future prospects for children with ASD.

As Dr. Michael E. Kelley, the executive director of The Scott Center for Autism Treatment at the Florida Institute of Technology stated, “If we can get our hands on (Continued on Page 4)

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**Specialties**
- Demyelinating Diseases
- Epilepsy Syndromes in Children
- Headaches

Pediatric Neurology

Dr. Diana Balsalobre is a board-certified neurologist with more than 20 years of experience and advanced, subspecialty training in clinical neurophysiology. She specializes in treating adult patients diagnosed with neurological disorders including headaches, dementia, Multiple Sclerosis, and Parkinson's Disease. Dr. Balsalobre is fluent in English and Spanish.

**Specialties**
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- Multiple Sclerosis
- Movement Disorders
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Harinath Sheela, MD
Internist and Partner, Digestive and Liver Center of Florida; Medical Director, Endo-Surgical Center of Florida

Making sure Medicaid patients have access to medical care, bringing Medicaid reimbursement in alignment with Medicare reimbursement, and making sure reimbursement rates follow cost-of-living increases are the top advocacy priorities for Harinath Sheela, MD, a partner in Orlando’s Digestive and Liver Center of Florida since 2005, medical director of the Endo-Surgical Center of Florida, and a passionate leader of the Orange County Medical Society Political Action Committee (OCMS-PAC).

“It can be very difficult for Medicaid patients to get care when they need it, due to reimbursement issues; many local physicians do not take Medicaid,” explained Sheela. “This often results in those patients resorting to the hospital emergency room for care often, which is difficult for patients and costly for the system. There is no continuity and they often end up in the emergency room again seeking care or relief for their symptoms.”

Sheela’s advocacy work extends beyond Central Florida, as the OCMS-PAC seeks significant positive change at the federal and state levels. “To help Medicaid patients to get access to care when they need it, due to reimbursement issues; many local physicians do not take Medicaid,” explained Sheela. “This can result in those patients resorting to the hospital emergency room for care often, which is difficult for patients and costly for the system. There is no continuity and they often end up in the emergency room again seeking care or relief for their symptoms.”

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Making sure reimbursement rates follow cost-of-living increases would help ease the financial burden of physician practices. “Most physician practices pay higher costs every year for medical supplies, phone services, employe salaries, etcetera,” he said. “The list goes on and on and many services’ costs increase at least to accommodate the cost of living.”

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Sheela’s goals for the OCMS-PAC through 2018 are to continue to strive to increase access to care to as many residents as possible in Central Florida. “The system needs to be more efficient and allow physicians to focus more on medical care and less on administrative work to get reimbursed for services provided,” he said. “This is an ongoing work and we believe that by organizing ourselves and creating awareness of the issues we all face daily, we can make a difference and increase the quality of life.”

A native of Hyderabad, India, Sheela completed medical school at Spartan Health Sciences University in St. Lucia, followed by an internal medicine and gastroenterology residency at the University of Connecticut. He completed a three-year fellowship followed at Yale University School of Medicine before he relocated to Orlando to join the five-physician practice, Digestive and Liver Center of Florida.

At the Digestive and Liver Center, Sheela treats internal conditions including inflammatory bowel diseases, irritable bowel syndrome, hepatitis B and C, metabolic and other liver disorders. As chairman of Florida Hospital’s Department of Gastroenterology through 2016, he was also a teaching assistant professor at the University of Central Florida School of Medicine, and a teaching assistant professor for Florida Hospital’s internal medicine and family practice residency programs, he’s typically the go-to guy for unexplained abdominal pain, the most common reason for hospitalization behind chest pain.

Sheela and his brothers, also physicians in the practice, rotate travels to their homeland to work with state and local governments to provide access to healthcare in rural villages. They helped build a 30,000-square-foot healthcare center with a walk-in clinic and an emergency room for acute care. Fellows and medical students staff the center around the clock, but its remote location 100 miles from a commercial hub has its drawbacks. “No one wants to live there; they go for three-month rotations,” explained Sheela, whose family raises money and connects medical students with teaching hospitals. “We created that model with the professors. Our goal is to be self-sustaining.”

Regardless of whether at home or in his homeland, Sheela said the best ROI of his medical career is seeing the relief on the faces of patients and their families after he determines a liver-related problem and implements a solution. “It’s immediate gratification,” he said, to find the problem, treat it and ease or eliminate the pain.

There are many ways you could be wasting money on your malpractice insurance

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kids before elementary school, 50 percent will be indistinguishable from their peers by the time they enter school – and most of the remaining 50 percent will also show significant improvement. Without early intervention, only 2 percent will show such improvements. Unfortunately, only 19.5 percent of children are screened by age four, so a lot of these kids aren’t going to get the services early enough to make a significant impact.”

So, what is the best age to start screening for autism?

The American Academy of Pediatrics (AAP) recommends pediatricians screen all children for developmental disabilities using a standardized screening tool during routine 9-month, 18-month, and 24-month wellness checks. Dr. Ivy Chong, director of Autism Services and Training at the Scott Center recommends the Ages and Stages Questionnaire (ASQ) as the best evidence-based tool for developmental milestone screening. If a social or emotional delay is suspected, the Modified Checklist for Autism in Toddlers (MCHAT) screener should also be used.

Chong said that, “Parents will report that their child doesn’t respond to their own name or to sounds, that they don’t like to be held, or they’re not smiling. Clearly these are red flags at as early as 6 months, not just of ASD, but potentially other developmental disorders as well.”

According to the CDC’s website, parent concerns are generally valid and are predictive of developmental delays. Research has shown that parental concerns detect 70-80 percent of children with disabilities.

Chong continued, “Primary care providers often do not give enough credit to parents reporting these concerns. Parents are told to wait until the child is two years old or worse, until they go to school. When these early warning signs are ignored, parents often feel bewildered and frustrated by their child’s behavior.” Parents who suspect or wish to rule out that their child may have a disorder should be encouraged to request screening procedures at any time from their pediatrician.

For pediatricians seeking to refer parents to evidenced-based treatment organizations, The Scott Center for Autism Treatment located in Melbourne, Florida, is unique. It offers an innovative telehealth option for consultation, diagnosis, and intervention. By utilizing telehealth services, “we can overcome the constraints of traditional approaches (onsite clinic) and still provide the screening, diagnosis, care planning, intervention and parent training for children experiencing social and emotional delays,” said Chong. In addition, this spring, the center will be launching an online screening bundle that will help providers and parents with personalized diagnosis, therapeutics, and educational materials.

Parents and children come from around the world to The Scott Center for the most advanced Applied Behavior Analysis (ABA) autism treatment methods available, and it ranks among the best in the world for its research contributions to the field of behavior analysis. The Scott Center is also actively involved in clinical research, constantly contributing to the body of literature on autism.

“We are also actively training practitioners in telemedicine techniques and developing new, empirically proven protocols for ASD treatment that can be delivered via telemedicine,” said Kelly.

Although it can be a difficult and long journey, the future for children with autism is getting brighter. Innovative therapies and services are shaping the treatment landscape around us, and it’s heartening to see how far we have come in just the last 10 years. With that being said, as the parent of two children with ASD, I know we as a medical community can do better. We can always lead parents to places like The Scott Center at FIT for evidence-based treatment and resources. If we want to give children with autism the best chance at living a fully-realized, fulfilling life, we need to commit ourselves to early diagnosis and intervention. We need to find creative ways to ensure that every child is screened at their wellness checks, or as soon as a parent expresses concern.

The healthcare community as a whole needs to accept and encourage a mantra of early screening and intervention. The missing link in the early intervention of autism is you, the provider. What will you do to make a difference?"
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Sports Innovation in the Sunshine State

BY ANDREW WIXSON, MEDSPEAKS

Spring is in the air and the sports industry in Central Florida is blossoming! This time of year brings a combination of youth, college, and professional sports to our area. From Orlando City Soccer kicking off the season at their brand new stadium and USTA’s grand opening of 100 courts in Lake Nona, to Major League Baseball’s Grapefruit League under way with spring training, Florida attracts people from all over the nation to watch America’s best athletes perform for their cities.

With so many sporting events and athletes surrounding the area, sports related injuries are inevitable. Sports injuries aren’t just for professionals, but also for weekend warriors and novices alike. Thus, positioning Orlando as a magnet for sports medicine enthusiasts and healthcare specialists looking to showcase the latest therapeutic innovations in a thriving medical ecosystem. Their objective—to help athletes achieve maximum performance by getting them back to their highest level and enjoying what they love most, competing.

For athletes, sports medicine has helped regain and/or improve performance, but it is also advancing in areas of monitoring and prevention. For example, CDG, LLC (aka: Cool Down Gear) is an Orlando-based company that developed a new layer of thermo-cooling wearable technology in athletic wear called Shiva. Its technology is designed to cool the body’s core temperature when signs of heat exhaustion, heat stroke, or heat cramps are present. With Florida producing extreme temperatures during the summer months well over 100 degrees, this device is an optimal fit for those who need to cool off. Its innovative cooling technology captures heat and moisture from the body to monitor, record, and report the individual’s vital signs, which is then transmitted to their proprietary app and uploaded to any smart device. The result is a patented vest that is able to adjust to properly cool the body’s core temperature.

Saving Healthcare Costs, continued from page 1

League fields. Buying small businesses (physician practices) that were paying taxes hurts the community.”

Hospitals’ buying spree of physician practices has left remaining doctors with weakened negotiating power. Circa 2000, two of three physicians were independent. Today, it’s one in three. When it’s time for contract renewal, hospital-employed physicians’ bargaining sway is diluted because of non-compete clauses and other conditions.

“Hospitals also make more money from employed doctors because buying doctors expands hospitals’ market share, which allows hospitals to negotiate higher reimbursements from payers, which contributes to the upward cost spiral,” she explained.

Complicating matters, hospitals bargain with insurance companies and Medicare for higher reimbursements to save money, cut fees to independent doctors, and make it more difficult for independent doctors to remain in practice.

Key Factor: Transparency

Transparency in healthcare costs, especially if insurance companies were mandated to post costs online for consumers to compare the wide range of prices for the same procedure, would go a long way toward addressing the unlevel playing field, said Carey. For example, an EKG in a free-standing clinic averages less than $400, compared to roughly $1,600 in a hospital outpatient setting. Consumers struggling to understand the new healthcare paradigm are more prone to ask, “Do you take Blue Cross?” than to ask about fees, perhaps assuming incorrectly they are all the same for any given procedure.

For now, Connecticut is the only state with a law requiring facilities charging fees to be made transparent to consumers.

“It’s a vicious cycle perpetuated by bad payment policies,” said Carey. “We respectfully ask the Trump Administration, as they work to replace Obamacare, to require site-neutral payments and to abolish facilities fees. Such moves would level the playing field, eliminate the incentive for hospitals to create monopolies, and save Americans hundreds of billions of dollars a year … money for other needed services.”

Concerning the failure of the Obamacare replacement bill in Congress last month, Carey and AID members weren’t overly surprised. “The game isn’t over,” she said. “Though this bill failed, another one will come along. The process will just take longer than certain members of the administration—and many Americans—had hoped. However, even if this bill had passed, the measures we’ve been asking for—price transparency, an end to hospital-physician employment, and an end to facility fees, all of which contribute to high healthcare costs—wouldn’t have been addressed until the second phase of policy making. The bill that got yanked was only the budget phase of the bill. That said, excessive healthcare costs will persist as long as hospitals get to charge many times more than independent doctors for the same procedures. Until we can cut the glue, and stop the abuses, largely driven by healthcare consolidation, we’ll continue to endure huge price differences. Although we have a long road ahead, I remain hopeful we can fix this.”

Hospitals’ buying spree of physician practices has left remaining doctors with weakened negotiating power.
5 Reasons Why Patient Engagement Means Consumer Engagement

By DAVID LEE SCHER, MD, FACP, FACC, FHRS

There are clear threads between consumer and healthcare delivery with regards to adoption of digital technologies. Many of these threads involve the consumer side of healthcare. I will discuss below how the patient is a consumer (defined as a purchaser of goods and services for personal use) in the healthcare arena and how viewing a patient as a consumer is transforming healthcare.

1. Patients have choices.

In an excellent article in the International Journal of Health Policy and Management Benjamin Ebert makes a key point: Although healthcare users have multiple identities (patients and consumers), the relative weight of these roles is dependent upon outside factors (users’ personality, state of health, values and respective health care decisions to face). Patient choices as to healthcare insurance plans and medical provider and treating facilities (albeit limited in many cases by the health insurance carrier’s ‘network’), assisted living facilities. One must note, however that the extent of choice is decreasing because of consolidations in healthcare. Patients have choices regarding the purchase of many digital health technologies. Awareness (on the part of patients as well as providers) and development of more robust, impactful and integrated technologies will increase those choices in the future. Fitbit, Apple, Samsung, and Google, and others are bringing healthcare closer to the consumer side of society.

2. Patient satisfaction counts.

Patient satisfaction is not a qualitative term equated with patient advocacy. It is a set of standardized questions (in limited language diversity) in the form of patient surveys to formulate metrics upon which payments to hospitals and physicians are based. Though patient higher satisfaction scores have been shown in one study to correspond to higher mortality rates and another to higher hospital readmission rates, they are still seen by some as surrogate of care quality. Nonetheless, the fact that the patient’s perspective is considered at all is a step in the right direction for patient advocacy. Patients may have a choice of points of care and therefore these metrics are certainly playing heavily in marketing campaigns.

3. All stakeholders in healthcare are looking for market share.

Whether speaking about payers, providers, other healthcare services or technologies, the rules of a free economy are in play. Market share rules and is the underlying cause of heavy consolidation in the payer and provider arenas. The number of ‘covered lives’ is the goal of payers, ACOs and healthcare enterprises alike. It is the reason for large companies like IBM, Apple, Samsung and others getting into healthcare. Technologies which appeal to patients as consumers will succeed. Those putting the most effort into user experience UX design translating into adherence and potentially outcomes will succeed in the marketplace. What is different about healthcare from the retail business market is that these efforts need to be driven by studies demonstrating good user experience, adherence, and better outcomes (which can be related to efficiency, clinical or other parameters). The days of walking into a C-Suite with the ‘I’ve got a technology to sell you’ are over. Proof of concept is replaced by proof of efficacy. ROI is defined today as cost savings not revenue generation. As readmission penalties and other quality metrics determine fines and payment, this becomes a critical concept. Some see the need of proof of efficacy via trials (though not necessarily long ones) as a chicken or egg situation. However, a tool which makes a difference and the right development team will find its way into clinical trials which can involve minimal investment and even be performed totally via mobile technology. Investors specializing in digital health technologies (beyond the multitudes of local incubators) are going to become key players. Strategies in healthcare are different because the marketplace, margins, and effects on lives are different. Proof of the momentum of clinical trials is the 1247 studies involving mobile health found on gov.

4. Mobile health technology success hinges on social engagement.

Outcomes tied to patient engagement are directly dependent upon the ability of the technology to maintain contact with the patient or caregiver. A recent study found that just 36 health apps accounted for one half of all downloads of the estimated 163,000 health and fitness apps available via Apple and Google. Social engagement will be a significant driver of mobile health engagement. Having a mobile health tool with social will increase interactions and therefore the ‘stickiness’ of the tool. Social media began without a business model. It now makes billions of dollars for advertisers and other digital partners.

There are many reasons why physicians need to be on social media as professionals. Many of these same reasons hold true for mobile health technologies. Mobile health technologies need to harness the power of social to connect patients to each other via support communities, to hospitals, to Pharma and medical device companies, to non-profit and governmental agencies and to their own caregivers. Granted, it will take time for all these stakeholders in the slow-moving world of healthcare to get to social in a significant way. But it will happen and social engagement on mobile apps will be the forum. The excuses of regulatory constraints and lack of models by some stakeholders can be addressed with appropriate investment in internal infrastructure and education.

5. Most mobile health technologies are patient-facing.

The fact that most mobile technologies are patient-facing only speaks to the consumer-oriented approach taken for the quickest adoption and financial success (which doesn’t necessarily reflect long-term adherence or profitability). The emphasis on user experience is paramount. The purpose of the technology needs to be clearly stated and the expected level of patient and/or caregiver participation needs to be explicitly presented. Incentives in the form of gamification and/or healthcare financial incentives by a payer or employer might result in greater adherence.

This remains to be proven. If the patient-facing tool is expected to share information with a provider, it is mandatory that the technology is easily integrated (interoperable) with the electronic health record and that only filtered clinically relevant, important, and actionable data reach the clinician.

In summary, digital technologies are only tools. They will be utilized only if they appeal to patients and caregivers. One might consider mimicking development and marketing strategies of some of the most successful retail and finance tools. Brand loyalty will be established based on the delivery of high quality, reliable, safe, and easy to use tools. There are considerations in healthcare that certainly differ from retail. However, patients are consumers of healthcare. Use of any technology is still a universal human experience. Technology offered to them needs to reflect this.
H. pylori: Diagnosis and New Trends in Treatment

By SRINIVAS SEELA, MD

H. pylori is a spiral shaped, microaerophilic, gram negative bacterium. H. pylori infection occurs when a type of bacteria called Helicobacter pylori (H. pylori) infects the stomach. This usually happens during childhood. A common cause of peptic ulcers, H. pylori infection may be present in more than half the people in the world. These germs can enter your body and live in your digestive tract. After many years, they can cause ulcers in the lining of stomach or the upper part of the small intestine. For example, from H. pylori infection may be present in the stomach. This usually happens during childhood.

But the treatment has changed. Years ago, when H. pylori was discovered, standard treatment involved a 7-day regimen of a proton pump inhibitor (PPI) plus amoxicillin and clarithromycin for patients who could tolerate it. Metronidazole was a substitute for amoxicillin in patients who were penicillin allergic. There has been a component alternative with bismuth-based therapies for patients who have amoxicillin allergy or clarithromycin resistance: a tetracycline/metronidazole/bismuth combination plus a PPI. This is a 10-day regimen.

We have seen, however, that the efficacy of these regimens has declined. This prompted a group of primarily Canadian experts on H. pylori and evidence-based medicine to convene a 2-year analysis that culminated in a final evaluation in Toronto, Canada—the Toronto Consensus Conference on Helicobacter pylori Infection in Adults. This consensus conference resulted in several important take-home messages that should change the way we practice and treat H. pylori.

First, recognize that drug-resistance patterns have changed during the past decade and a half. Clarithromycin resistance, which was initially quite low, at 1%-2%, has risen to 16%-24%. Metronidazole resistance was relatively high to begin with and has remained relatively stable at 20%-40%. Tetracycline resistance and amoxicillin resistance are virtually unheard of at less than 1% for tetracycline and 1%-3% for amoxicillin, and thus they remain incredibly good drugs.

As we try to proactively restrict antibiotics when we do not need to use them, we need to keep in context our efforts at limiting antibiotic exposure. As we have seen these drugs used repeatedly for a variety of diseases and treatments—urinary tract infections, bronchitis, and so on—the prevalence of secondary resistance for clarithromycin and metronidazole has gone up dramatically. Resistance is up to 67%-82% for clarithromycin and 52%-77% for metronidazole. Thus, the effectiveness of these drugs has been drastically reduced. Once you have used them, you have pretty much used the last bow in the quiver and you cannot use these drugs again.

Consensus Recommendations

It is recommended that extending the treatment from 7 to 10 days to 14 days is the new standard. The eradication rates for the 7- to 10-day regimens have fallen to approximately 50%, whereas with a 14-day regimen by either intention-to-treat or per protocol, the eradication rates were above 95%. Therefore, a regimen lasting 14 days is the new rule across all treatment regimens for H. pylori, regardless of which line of therapy is used.

Specifically, in areas where resistance patterns are known, therapy should be based on the resistance pattern. Now, in clinical practice we do not generally look at resistance patterns and we do not culture our H. pylori. Clinical practice would say that we know the patients have H. pylori and we treat that. So, what do we do?

As mentioned, empiric therapy, the standard 10-day triple therapy with clarithromycin, amoxicillin, and a PPI, should be extended to 14 days. But in areas where clarithromycin resistance is greater than 13% or eradication rates are less than 83%, that therapy should not be used. If you do not know the rate of clarithromycin resistance in your area, you may want to simply put the triple-therapy regimen aside; in that case, quadruple therapy becomes the new standard. The bismuth-based quadruple therapy would include a PPI plus bismuth subalkalicylate, amoxicillin or metronidazole, and tetracycline for 14 days. The alternative, in areas with low rates of clarithromycin resistance, would be a PPI-based triple therapy, with amoxicillin or metronidazole and clarithromycin for 14 days.

If the initial regimen for a given patient included clarithromycin or levofloxacin and had failed, these drugs should not be used at all. Thus, as a response to a failed regimen, you should stay away from those drugs, which would basically default to a bismuth-based quadruple therapy for 14 days.

Similarly, levofloxacin has been used in patients whose initial triple therapy had failed; in that case, triple therapy would include levofloxacin, amoxicillin, and a PPI for 14 days. Levofloxacin does have a fairly high resistance pattern.

The consensus group also addressed the use of probiotics. They said that probiotics were not useful to attenuate side effects of the 14-day antibiotic treatment, nor were probiotics helpful proactively to improve the eradication rate. Probiotics are being proposed these days for a lot of non-evidence-based reasons, and clearly this task force said they should not be used adjunctively in H. pylori eradication.

14-Day Regimen is the New Approach for Treatment

In conclusion, the consensus committee recommends a 14-day regimen and recognizes the high resistance patterns. But be careful when prescribing the bismuth-based therapy. The standard packaging for the tetracycline/metronidazole/bismuth combination drug is for 10 days. The recommendation now is to use this regimen for 14 days. You would have to give a pack and a half.

Substitute one of the standard bismuth subalkalicylate preparations, and prescribe two tablets four times a day plus the PPI, tetracycline, and metronidazole. If you do that, remind patients that their stools will be dark. Moreover, because these are salicylates, take care in patients receiving concomitant non-steroidal anti-inflammatory drugs or those on anticoagulation. These patients may need co-therapy for protection against bleeding.

Think about new treatments, new options. Think about H. pylori as a 14-day-treatment disease. This is the new standard, and we believe the consensus on this is quite strong.

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Using Technology, Data to Turn the Tide on Alarm Fatigue

By DAVID CONDRA

Imagine that your home security system sounds an alarm at random intervals multiple times of the day, often for no urgent reason. Do you think after a while you’d pay less and less attention – or react more slowly – to the alarm?

Now imagine you’re a hospital nurse with hundreds of alarms sounding on your floor for various reasons – many with little-to-no urgency. Except patient lives are now on the line.

A Patient Safety Issue

Alarm fatigue – growing so accustomed to hearing countless patient alarms that caregivers begin to tune them out or slow down their reaction to them – is a serious threat that puts patients’ safety at risk while impacting the stress level of every caregiver and their care environment.

It is so serious that in 2015 The Joint Commission (TJC) added clinical alarms to their list of national patient safety goals. And the problem continues to make the ECRI’s (formerly the Emergency Care Research Institute) list of top 10 health technology hazards.

A study of the alarms at one typical medical/surgical hospital in the United States found that, in most cases, only 10 percent of alarms were actionable. Which means that caregivers were spending time responding to alarms that, nine times out of 10, were non-actionable.

Of course, the care team had no way of knowing the severity of the situation until they tracked down where the sound was coming from and physically entered the room. So, it’s probably logical that after responding repeatedly to non-actionable alarms in a patient’s room, a nurse might naturally assume that any given alarm from that room might also be a false positive: until it isn’t … and an event occurs.

Many hospitals are now harnessing new technology and data capture to get a handle on the burgeoning safety problem. Hospital staffs hear hundreds of alarms per patient per day. As heavy workloads increase the likelihood of burnout, nurses are more at risk for developing alarm fatigue. The challenges contributing to the issue are threefold:

1. Equivalent alerts for unequal levels of urgency make it difficult for caregivers to respond appropriately to emergency situations.
2. The absence of a unified system of alarm management engenders miscommunication, or lack of communication, between caregivers.
3. As alerts go unheeded, further alarms are created, worsening the problem.

Without a unified way to monitor, prioritize and escalate alarm activity to the appropriate person, the nursing team has no choice but to depend on its sense of hearing to differentiate between the beeps and bings of various alarming devices. Unfortunately, as alarm fatigue grows, care facilities see decreased HCAHPS and patient satisfaction scores, as well as increases in injury-producing falls and patient call volume, thus worsening the problem.

Four Steps

There are four key steps facilities should take to address alarm fatigue, ease the care burden on nurses and staff, and improve patient quality, safety and experience.

• Hospital executives must fully understand the magnitude of the alarm issue in their facility. That requires an accurate, detailed assessment of the number of alarms that staffs are exposed to each day, segmented by device, alarm type and duration.

This begs the question, where does alarm data come from? Some devices can be connected through a common server, but more often than not, alarm data is being housed inside the specific device. Right now, that means someone has to physically go to each piece of equipment and download or print something out of the memory. Then there are the devices that are not connected and don’t store any information – what about them?

Standardized medical device connectivity has been a major challenge for hospitals since so many different equipment vendors can be involved. The Nashville-based Center for Medical Interoperability has established a coalition of leading hospital organizations with the goal of changing how medical technologies work together.

Conquering alarm fatigue depends on systematically tracking and analyzing alarm volume over time. Alarm management technology currently on the market can do this, eliminating the need to manually collect such data while ensuring accuracy.

• The facility must develop a team and a plan to address the problem. The team should be multidisciplinary, including hospital leaders, physicians, nurses, as well as members of the Safety, Quality, Risk Management and Biomedical departments.

One important component of the plan will be figuring out which alarms are actionable and which are not. In other words, having a way to identify and filter out false alarms and/or those with clinically appropriate wait times before they must be addressed. The team then needs to easily configure alarm parameters to match any new alarm protocol, collect more data, tweak parameters and repeat as needed to optimize every alarming device. Another example where technology and data are helping hospitals achieve and sustain success.

• After identifying the magnitude of the problem, consider adopting communications technology that will help address it. Hospitals need a standardized way to not only capture data but also deliver patient alarms to the right caregiver at the right time rather than having caregivers go room-to-room chasing phantom sounds.

Leading-edge alarm management tools today can route specific alarm messages from specific rooms to the specific caregiver who knows when he/she receives that message it is their patient and something they need to pay attention to with the appropriate sense of urgency. These same tools can also unite alarm data into visualized, actionable reports that can be accessed and analyzed on demand.

• Hospitals must then foster a culture of openness to new technology. Problems could arise when staff members do not respond well to technology changes, despite the potential of these solutions to make their jobs easier.

“Culture is probably the hardest part of alarm management because staffs are used to doing things in their own way,” explained Rikin Shah, a senior consultant at ECRI Institute. “Thus, it is important to explain the benefits of new technologies and the ways in which they can improve staffs’ ability to provide quality care (and better ensure patient safety). Culture change can be difficult, but with determination and clear goals, it can be done.”

When all is said and done, alarm fatigue is not about improving patient satisfaction or HCAHPS scores or less stressful work environments – all three of which can be addressed by today’s alarm management systems. It’s about ensuring the safety of patients.

Alarm fatigue is a real danger. But by leveraging technological advances and a strategic, data-driven approach to address it, hospitals can better ensure patient safety, significantly decrease adverse medical events, increase HCAHPS and patient satisfaction scores and greatly improve employee work environments.

David Condra is founder and executive chairman of AmpliaAlert. Founded in 2003, AmpliaAlert is a group of companies with a focus on medical technology that has connected hospitals and health systems to a single source of medical device data. The AmpliaAlert family is made up of Amplia, Biomedical departments.

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Discussing Nutrition with Patients and What’s Really in Food

By AMBER HARMON

When talking with your patients about nutrition are you making them aware of the impact on their health of ingesting vegetables treated with pesticides and even buying organic? Do they really have enough information to make an educated decision about the nutritional value of our vegetables, even those labeled organic, by the time it reaches the dinner plate?

There are many factors that contribute to the nutritional content of vegetables so help them keep this in mind the next time they read the nutritional information on a label. The way to know the nutritional value of a vegetable has been maximized is to know the source and the lifecycle of that vegetable. One hundred years ago when vegetables were grown locally, this was an easy task. It is quite a bit more complex today as a particular vegetable could have been picked before it was ripe, traveled thousands of miles in a truck without humidity and temperature control over several days, just to sit on a grocery store shelf for three to five days before being purchased. That same vegetable can then sit in the refrigerator for another three to seven days before being consumed. These are all factors that contribute to the overall nutrient content of vegetables. Can the consumer really trust what’s on a label?

In addition, organic vegetables purchased from the grocery store are typically treated with organic pesticides that have been approved by the Organic Materials Review Institute (OMRI). The list of approved pesticides is deemed organic because they are plant based chemicals. However, recent studies show that up to 50 percent of plant based organic pesticides are carcinogenic as well. Growing vegetables by using organic practices without the use of pesticides is the safest way to grow and consume vegetables.

Many other factors also affect the nutrient content of vegetables including the variety of vegetable, growing conditions, post-harvest handling, preservation, and home preparation. Ensuring the variety of vegetable selected for a region meets the growing requirements for the region is step one. Then growing the vegetable in nutrient rich soil with the proper exposure to the sun and water creates a healthy plant that will thrive and meet its nutrient and anti-oxidant content. Frequently vegetables are harvested before they are ripe so they can be shipped and then artificially ripened before being put on grocery store shelves. The vegetables are artificially ripened by exposing them to propylene or ethylene, which are chemicals produced by plants to induce their own ripening. This impacts the flavor and texture of the vegetables. This process also inhibits the vegetables ability to reach its peak ripeness and nutritional value.

Uncooked fruits and vegetables eaten soon after harvest have the highest nutrient content. Vegetables are typically frozen shortly after being harvested, which largely preserves the nutritional content of the vegetable, at that time. When considering other factors, freezing vegetables can lead to a higher nutritional value of the vegetables at time of consumption, as opposed to those on grocery store shelves. This process will typically sacrifice the fresh taste of the vegetables.

An option to ensure that vegetables are grown and treated in a manner to support the highest possible of nutritional content, without the use of pesticides, and an optimum flavor profile is to grow your own vegetables. Growing your own vegetables by traditional means can require daily attention as well as a great deal of education on overcoming the challenges of gardening in Florida.

Understanding where your vegetables came from and what they have been through on the way to your dinner table is nearly an impossible task. If this is taken too much time, effort and uncertainty consider encouraging patients to grow their own vegetables. Fortunately, there are now, low-maintenance options for growing your own vegetables. There are local businesses that will setup and plant a backyard garden as well as offer a garden service while educating the consumer on how to grow their own vegetables with a self-sufficient supply of vegetables.

If the taste and nutritional value of fresh, organically grown vegetables is important, then vegetables should be eaten the same day they are harvested, whenever possible. This quality of vegetable cannot be purchased in a grocery store. The only way to know if this is true, is to experience fresh vegetables and draw a conclusion based on one’s own experience. Experiencing the superior taste of freshly picked, organically grown vegetables raises the bar and grocery-store-bought vegetables will never be the same.

Amber Harmon is a Master Gardener; she has a 15-year career in technology with a Bachelor’s Degree in Computer Science and an Executive MBA from UCF. Contact her at My Nona’s Garden at service@mynonasgarden.com

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