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Looking at the Pros/Cons of a Cloud Service Provider for Medical Practices

By RON FRECHETTE

The demand for healthcare practices to adopt cloud computing solutions has become extremely popular, almost to the point of necessity for building a profitable practice and providing optimal patient care. This cloud adoption phenomenon in the healthcare industry will only continue to grow as we journey further into the Digital Age. There are many benefits to be gained by transitioning to the cloud. There are also several security and compliance risks to consider.

Starting with a high-level overview of the benefits and risks of cloud computing, followed by looking at a security and compliance checklist will help determine if cloud service providers are right for your practice.

CLOUD COMPUTING DEFINED

Cloud computing is a model for enabling on-demand network access to a shared pool of configurable computing resources such as, networks, servers, storage, applications, and services that can be rapidly provisioned and released with minimal management effort or service provider interaction.

ADVANTAGES OF CLOUD-COMPUTING

- **Cost** – the most significant benefit to cloud computing is IT cost savings. Healthcare practices can eliminate in-house client server storage and application requirements. This also eliminates associated costs such as power, air conditioning and administration.
- **Accessibility** – cloud computing allows healthcare providers access to

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HEALTHCARELEADER

Chris Cosby, CEO

Poinciana Medical Center

Chris Cosby recently took the helm of Poinciana Medical Center, a 76-bed facility serving the communities of Osceola and Polk counties as part of HCA's North Florida Division.

Cosby brings with him more than 14 years of experience in healthcare management, having previously worked for five years as chief operating officer at HCA's Doctor's Hospital in Augusta, Ga. He holds a bachelor's degree in health administration from Auburn University, a master's degree in health administration and an MBA from the University of Alabama at Birmingham.

In his off time, he loves challenging himself physically – having competed in countless triathlons and even half Ironman and full Ironman races. He lives in Celebration with his wife and two young children, and since moving here, he's visited Disney World "more times than I ever thought I'd go."

We talked with Cosby about his leadership style, his vision for Poinciana Medical Center and what changes we can expect in the near future:

Q: ***What drew you into the field of hospital management?***

My mother was an administrator for a healthcare company, and my father runs his own business. Watching those two got me interested in what they do. I wanted a career where I could influence the health of a community and actually help people.

Q: ***What makes a good leader? What's your own personal management style?***

A good leader is a servant leader, not someone caught up in titles or resumes. As far as my style, I want everyone around me to be successful. If they are, then I will be successful.

Part of making that happen includes recognizing that although our team comes

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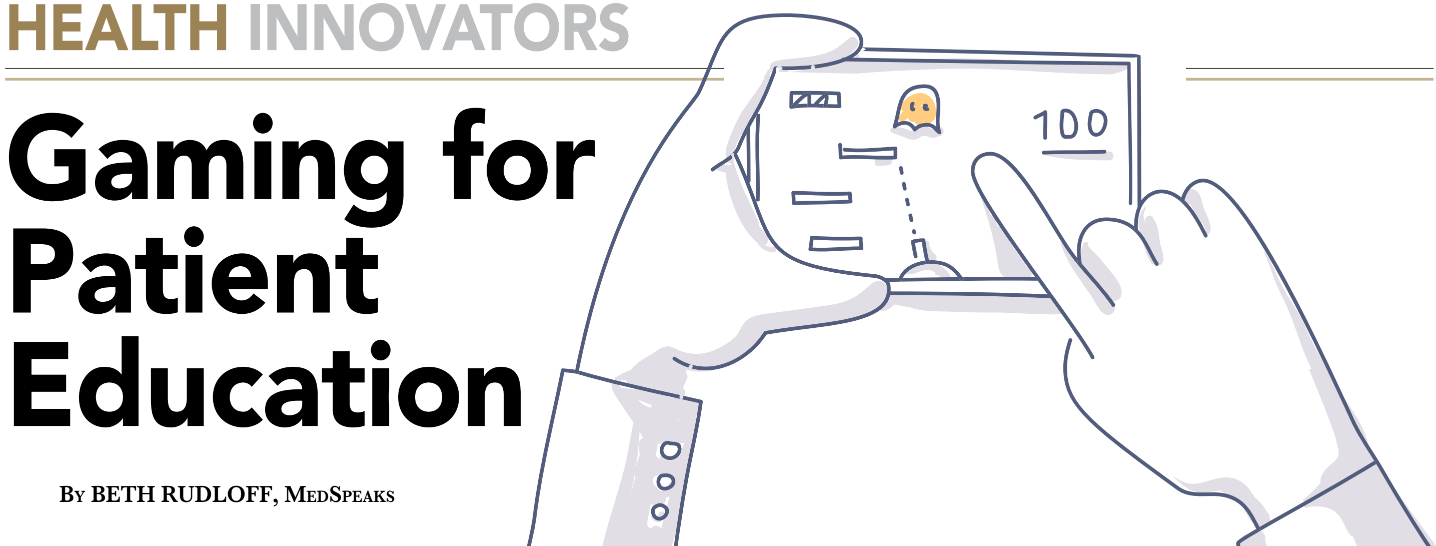
Gaming for Patient Education



By BETH RUDLOFF, MedSpeaks

Gaming in Healthcare?

Healthcare has been going through a major transformation; integration of new business models, emerging technologies, computerization, artificial intelligence, and now gaming? Really?

Yes.

It's time to embrace gaming in healthcare as another tool to achieve patients' healthcare goals.

For example, patients receiving chemotherapy. Those of us that have had chemotherapy have a love/hate relationship with the treatment. We love the fact that it is killing cancer cells, but we hate the side effects. And the side effects can be very strange and difficult to manage. I remember the repeated reminder from my chemo nurse, Mike: "Don't freak out when your urine turns red, it's a normal side effect of Adriamycin." Thank goodness for Mike's warning, or I would have been so worried! However, with all the pre-medications, stress and treatments during chemo, it is very difficult for patients to remember all that your medical team is telling you.

Oncology nurses are taking on this challenge with a creative approach; gaming. Vicki Loerzel, PhD, RN, OCN, a nurse scientist at University of Central Florida explains, "We knew that older adults have a higher symptom burden during chemotherapy. Our prior research has shown that 17 percent have nausea and vomiting, and fifty percent of readmissions in older cancer patients are for nausea, vomiting, and dehydration." Loerzel has received a National Institute of Nursing Research grant for her novel intervention to reduce the severity of these side effects. "We developed an electronic educational simulated experience using an avatar that looks just like the patient who goes through chemotherapy. The player goes through a three-day scenario making choices for the avatar that affect how they will feel during and after chemotherapy."

What Loerzel has found from talking to older adults that have been through chemotherapy is that patients did not follow evidence-based practices for various reasons. Maybe they didn't believe those strategies would work, or they thought the symptoms were temporary and would just go away. Maybe they didn't understand the importance of hydration, or even more simply, they just didn't want to take any more pills. The gaming approach overcomes these obstacles by visually reinforcing real and relevant cause and effect relationships. "Patients who have participated in the study told us that what happened in the game happened to them at home and they knew what to do to improve their symptoms."

Loerzel believes that gaming is an innovation needed for patient education and can be much more effective than handouts or other passive teaching tools. "Gaming is in-

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What if Prevention is the Cure?

By SINDY PHELPS, MedSpeaks

Clinical research historically spends more money studying the cure for diseases, rather than studying preventive medicine for those same conditions. America is plagued with violence, accidents, substance abuse, HIV/AIDS, obesity, teen pregnancies, lung disease, heart disease, and disabilities. The National Institutes of Health (NIH) are responsible for funding studies on all those topics and more. The mission of the NIH is to gather knowledge on nature and behavior of living systems and how to apply that knowledge to enhance health, life longevity, and reduce illness and disability. The mission of the Center for Disease Control (CDC) is to provide health information that protects our country from dangerous health threats and respond when these arise.

If both of these organizations are built to find answers, then why is America still spending so much money on treating conditions if the majority of them are preventable in the first place?

The bulk of NIH funding goes into clinical research studies; last year $12.6 million went into funding clinical research topics like alcohol, depression, tobacco use, cancer, and HIV. In a majority of these studies, researchers are either looking for new ways to treat or to cure existing conditions. But what about prevention? If we were to invest at least half the amount of money that goes into researching cancer treatment and instead spend it researching key cancer risk factors, such as obesity research, could we begin to turn the tables on how people see food and exercise, and thus lower their risk for cancer? An example: It costs an average of $10,000 a month to treat a heart disease patient. If just one third of that cost each month had been applied to preventive measures, like regular check-ups with lab work, exercise regimens, or food education, they would have a better chance of staying disease free. People who are born with cancer cells can even avoid the high cost of tertiary treatment by applying prevention measures as simple as keeping up-to-date on screenings. Preventive medicine focuses on protecting, promoting, and maintaining health as well as preventing disease, disability, and death. But what about the conditions that have already been studied, and we know how to prevent? The NIH and CDC should study why the afflictions rates haven't dropped if we are already aware of the prevention methods, and how to stop a waterfall effect of co-occurring conditions. For example, obese patients will often develop diabetes, heart disease, and sleep apnea. If we could track a standard progression path for these co-occurring conditions, isn't possible we could prevent at least of few of them in future patients? In 2017 approximately $7.8 million were spent on studies relating to preventive medicine. While President Trump is cutting nearly six billion dollars in NIH funding, the prevention budget is going to be slashed by at least 14 percent. But if we can elevate ourselves to a higher understanding and acceptance of preventive medicine, we can more appropriately allocate the funds that are still available. We need to start understanding the culture divide between the older and newer generations. Both are stubborn when it comes to understanding and implementing preventive care into their daily lives. The newer generation wants a quick, painless fix to virtually everything and the older generation wants to continue to live their lives the way they always have, their own way. There can and should be studies on how we can change this or even adapt to each population. If the NIH and CDC come together to work on more studies revolving around preventive care, it will make a huge difference in people's lives.

FEATURED INNOVATORS:

ARCHER FIRST RESPONSE SYSTEMS™

Founded by Orlando local, Gordon Folkes, ARCHER utilizes drone technology to support cardiac emergencies. The emergency first response system deploys a commercial-grade drone to deliver an Automated External Defibrillator (AES) device and instructions. This allows bystanders to more rapidly assist patients during sudden cardiac arrest while ambulance services are in route. Learn more at www.archerfrs.com

Based in UCF's Research Park, SegAna Phantom Technologies creates an exact 3D printed replica of a cancer patient's lung and captures breathing patterns. This copy creates a simulated, breathing lung that works exactly as it does in the individual patient. This allows oncologists to "practice" more accurately targeting the tumor in a moving lung to reduce damage to non-cancer cells during therapy. Learn more at: www.seganatech.com

An Orlando-based telemedicine platform company led by CEO, Matt McBride is paving the way to help physicians and patients connect remotely. Claiming affordability, seamless EMR integration, and positive revenue impact on MACRA:MIPS/APM Initiatives, this company seeks to transform the patient visit experience by reducing the friction of access, ease of use, and overhead tasks. Learn more at: mendfamily.com

Disclosure: *Readers, please take note that the companies featured in the Health Innovators section have not paid for or bartered for these acknowledgements. All companies are selected based on merit, intrigue, and their potential to move healthcare forward towards the Quadruple Aim. In a noisy and biased market, we believe this to be a valuable distinction.*

UPCOMING EVENTS

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American Geriatrics Society Scientific Meeting & Exhibition
MAY 3-5, 2018 | ORLANDO, FL
meeting.americangeriatrics.org
Showcases products and services for clinical geriatrics, aging research, pharma, and more.

MedSpeaksTM showcases the most exciting experts, events and innovations in Central Florida by bringing together the state's largest community network of Health Innovators. We have converged over 1,400 healthcare professionals including clinicians, entrepreneurs, and technologists to discuss and promote the problems facing healthcare today and the innovations reshaping the future. www.medspeaks.com

By WENDY SELLERS, MHR, MHA, SHRM-SCP, SPHR

Orlando Medical News is pleased to bring our readers this Human Resources Q & A in our continuing series for practice managers.

Q: ***Do I have to provide a written offer letter for new hires at my practice?***

Technically, no. However, it is advised as an HR best practice. Simply put, you will avoid any false claims down the road, such as, "I was told I would be paid $24 an hour versus $18 an hour". Putting the legal risks to the side, an offer letter starts the working relationship out on the right track with transparency and clear communication. An offer letter does not need to be lengthy but should have several components: Job title, Pay amount; Pay type (exempt/ non-exempt); Pay schedule (weekly; bi-weekly); Name of manager; Start date; At will employment (This is not a contract; you may quit or be terminated at any time); Your signature; Acceptance line for their signature. Attach any necessary documents such as a job description, a benefits package or guide, a non-disclosure agreement and/or anon-compete policies (all requiring signatures).

Q: ***My employee has been with the company for three years, is 55 years of age and has numerous performance issues. These issues have been discussed and were very well documented in the past 3 months. Should I be concerned about age discrimination if I terminate him?***

In Florida, employees (and job applicants) are protected by the Florida Civil Rights Act (Florida Statutes Section 760.10) and the Age Discrimination in Employment Act of 1967 (ADEA). This protection is in place to prevent employment decisions that are based on age. The ADEA specifically protects individuals aged 40 and older from employment discrimination based on age. The ADEA applies to employers that have 20 or more employees. The Florida Civil Rights Act protects individuals (of any age) against unlawful employment practices on the basis of age, along with numerous other characteristics.

Since you have clearly documented the performance issues your employee is exhibiting, you have proof that the termination is based on performance and has nothing to with age. With that said, I advise, you to have an HR Consultant or an employment lawyer review your documentation prior to the termination. Why? Sometimes managers unintentionally discriminate by using statements referencing or referring to age. Intentional or unintentional, this is still discrimination. Performance conversations and documentation should only focus on ability, performance, and behavior; nothing else.

Q: ***What is all this talk about employee engagement? Why should I care if they are 'engaged'? I just need them to do their job.***

First, let's address what it means to be engaged at work. It means fully understanding the goals and expectations of the manager, what challenges and successes are occurring in the department and what the overall vision is for the department and/or company. Simply put, engaged employees know—they know what is going on, and feel confident with the decisions and communication from above. It doesn't mean they agree with or even like the decisions, but they trust that the leadership team did their due diligence and is making the right decision for the future of the company.

Second, it is important to note that somewhere around 60% or 70% of employees are simply not engaged in any manner. Gallup data shows that only 30% of employees are "engaged." Towers Watson data shows 35% are "highly engaged." Dale Carnegie data shows 29% are "fully engaged."

Why should you care? Engaged employees are high-performers who positively affect the bottom line. What can you do to determine your employee engagement and improve upon it? Employee engagement surveys and interviews are useful to gather information before making any changes. With survey results in hand, you'll be able to see what's working, what's not, implement changes and track improvements over time. If you want to know what the problem is, ask! If you want your culture to change, take action.

Q: ***My practice is growing so quickly. We have doubled in size in 6 months. I feel we have no time to strategize about and work on the business because we are too busy working in the business. What advice can you give me?***

My advice would be to take one day, even if it is a weekend day, to host an interactive corporate retreat. A retreat is an amazing tool for a team that has something important to work on whether it relates to annual strategic planning, a new initiative, training, or sales planning. Not all of your employees need to be there for the entire retreat. Key employees and any board members must be there and be deeply involved. In order to be truly involved as a participant, one should not be facilitating the session. Often, retreats have outspoken attendee's, a full agenda and a short time period, which may leave you feeling frustrated with the lack of results. Hire a consultant (such as BlackRain Partners) to provide retreat facilitation services to help make your retreat impactful. And remember that business retreats do not have to be boring. They should be fun yet purposeful. After all, who wants to come in a weekend without a guarantee of fun?

Wendy Sellers, "The HR Lady" is the COO of BlackRain Partners, a business consulting company. She has a master's in healthcare administration, a master's in human resources, SHRM-SCP and SPHR certifications and is also a licensed Florida 2-15 life and health agent which she uses solely to advise and educate BlackRain's clients. Visit www.blackrainpartners.com

Sam Atallah, MD, FASCRS, FACS

Dr. Sam Atallah is among the most well-known colorectal surgeons in the world, and is currently serving as the Director of Research and Clinical trials at The Digestive and Liver Center of Florida, Director of The Division of Colorectal Surgery at The EndoSurgical Center of Florida, and beginning in March, 2018, the Director of Colorectal Surgery at Oviedo Medical Center.

He moved to Orlando in 2007 after completing training at Houston's Texas Medical Center with Surgical Oncology training at MD Anderson Cancer Center where his training had earned him double-board certification in General Surgery and Colorectal Surgery. Two years to the day after completing fellowship training in colon & rectal surgery, Atallah performed the world's first TAMIS operation in Winter Park. This created a new approach to treating rectal cancers and polyps, that is now being practiced in more than 50 countries world-wide. Atallah is also a pioneer of robotic transanal surgery and was the first in the world to perform this technique. He is one of the leaders in advanced technology for rectal cancer surgery and has developed the technique of stereotactic navigation for transanal total mesorectal excision (taTME) — an important step forward in the evolution of computer-assisted surgery. Complex treatment of rectal cancer and surgical management of this disease through the new techniques of TAMIS and taTME represent Atallah's principle interests in colorectal surgery; and he is currently in the works of producing a textbook on these topics on schedule to be published in 2019 by Springer Nature. He is also actively involved in the design and assessment of feasibility of next generation robotic systems that will be smaller, sleeker, and able to work in places and spaces never before imagined.

Other areas of Dr. Atallah's research interest include understanding the tumor biology of colon cancer at the molecular level. He is the principle investigator of a major study looking at biologic tumor markers that can lead to a better understanding of cancer tumors. This study is in collaboration with Sanford & Burnham Labs in La Jolla, California.

Atallah has become internationally recognized for his pioneering work in rectal cancer surgery and has trained hundreds of surgeons nationally and internationally. He has also performed live surgery and lectured globally — traveling to six continents in 2017 alone. He has given lectures at the European Association of Endoscopic Surgeons' 14th World Congress in Paris, France; The Natural Orifice Surgery Consortium for Assessment and Research in Chicago; The Society of Robotic Surgeons held in both Orlando and Miami; The American College of Surgeons in Washington, DC., The Peking University Conference on Advanced Rectal Cancer Surgery, Beijing, China, and several other international society meetings in worldwide destinations — including the 30th annual Japanese Society of Endoscopic Surgeons in Kyoto (2017); The Colorectal Surgical Society of Australia and New Zealand in Sydney and a taTME Workshop held in Brisbane, Australia; The 90th Annual Surgical Congress held in Pucon, Chile; The Rectal Cancer Summit held in Mexico City, Mexico; IRCAD Colorectal Masters Course held in Strausburg, France.

In this month's In Other Words forum, Dr. Atallah discusses the inherited nature of some colorectal cancer.

IN OTHER WORDS

with Sam Atallah, MD

Inherited Colorectal Cancer

Most colon and rectal cancer is not inherited, but rather occurs sporadically. Although 80 percent of all colon cancer is sporadic, the remaining 20 percent is considered inheritable colon and rectal cancer, and there are two main categories of this. The first is called Familial Adenomatous Polyposis Syndrome or FAP, the second is termed Hereditary Non-Polyposis Colorectal Carcinoma (HNPCC). Both FAP and HNPCC are inherited via an autosomal dominant pathway, so that offspring have a 50 percent chance of developing the disease if a parent is afflicted. In FAP, the gene responsible for the disease is the APC gene, and mutations in this gene result in the phenotypic expression of disease, usually during early adolescence. A gene test for the APC mutation can be performed in early childhood, however, the demonstration of hundreds of adenomatous polyps carpeting the lining of the colon and rectum is pathognomonic for FAP making gene testing unnecessary.

Once the diagnosis is made, surgery is recommended which consists of removal of the entire colon and rectum will ileal pouch-anal reconstruction, thereby avoiding a permanent stoma. In 2018, this is most often performed laparoscopically or robotically in a one or two stage operation. Timing of surgery is important as many young adults are still in high school or college when the surgery is performed for FAP, and so typically a surgeon and the patient will wait for a school break, such as summer or spring break to schedule the operation between semesters. Patients with phenotypic expression of FAP who do not receive surgical therapy will uniformly develop invasive colorectal carcinoma by age 40. This is true for classical FAP, however not for its genetic variants – AFAP and MUTYH/ MYH. These are similar to FAP but the phenotype and genetic mode of inheritance differs. In attenuated FAP (AFAP), the gene defect is inherited in an autosomal dominant fashion, however the phenotypic expressivity is diminished. Hence, in patients with AFAP, there are much fewer polyps throughout the colon and there is typically rectal sparing. Surgical intervention is often delayed, and in some instances a subtotal colectomy rather than a total proctocolectomy may be a better option, as such a procedure is less likely to result in urogenital and bowel dysfunction post-operatively. With MYH and MUTYH mutation, the expression is more analogous to AFAP. However, in contradistinction, the inheritance pattern is autosomal recessive, and this is often described as 'autosomal recessive form of FAP.'

HNPCC does not manifest until adulthood, but typically at a younger age than patients with sporadic colorectal cancer. Thus, patients with HNPCC develop this malignancy classically in their late 30s and early 40s. Because this is before the screening age of 50m the so-called Amsterdam criteria or 3-2-1 rule can be helpful in determining who may be at high risk for HNPCC. This rule is as follows: 3-persons with colorectal cancer; 2-consequtive generations; 1-relative with colorectal cancer <50. Persons who meet

(CONTINUED ON PAGE 9)

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Looking at the Pros/Cons of a Cloud Service, *continued from page 1*

electronic health records, test results and other important info from any PC or mobile device.

- **Continuity of Care** - The ability to access the system outside of the office allows physicians, staff, patients and authorized third party administrators to collaborate more effectively in a secure environment and provide better continuity of care.
- **Dependability** – cloud computing is much more dependable and consistent than in-house IT infrastructures. Most providers offer service level agreement (SLA) guarantees of around the clock access and little to no downtime. Medical practices can benefit from redundant IT resources and quick failover mechanisms - if a server fails, hosted applications and services are transferred to back-up servers.
- **Scalability On-Demand** - healthcare practices can expand and contract their IT needs by simply making a call or sending an email. This makes it easy to add new services, users or locations.
- **Shared Security and Compliance** – most cloud service providers have a full time IT security and compliance staff to ensure they are providing their clients state of the art security and they are up to date on all compliance mandates. It is the responsibility of the practice manager to ask the cloud service provider to share their security standards and compliance certifications.

DISADVANTAGES OF CLOUD COMPUTING

- **Outages** - cloud service providers manage several clients simultaneously. This can create support challenges. There is also the risk of the cloud service provider experiencing technical outages. This can lead to services being temporarily suspended.
- **Accessibility** – If your practice experiences a power outage, you will not have access to applications, server or data from the cloud services provider.
- **Security** - Although cloud service providers are mandated to implement the best security standards and industry certifications, storing data and important files on external service providers always opens up risks. The ease in procuring and accessing cloud services can also give bad actors the ability to scan, identify and exploit loopholes and vulnerabilities within a system. However, such exploits and loopholes are not likely to surface if cloud service providers have a sound security program in place.
- **Limited Control** - Since the cloud infrastructure is entirely owned, managed and monitored by the service provider, it transfers minimal control to the customer.

SIX QUESTIONS TO ASK CLOUD SERVICE PROVIDERS:

1. What type of compliance certifications does your company hold?
   - HITRUST certification would be of most interest in healthcare providers.
   - Also, ISO 27001, SSAE 18 (SOC1, SOC 2, SOC 3 Reports) are important to have
   - PCI DSS Report on Compliance should be required if they process, store or transmit credit card data on behalf of your practice.
2. Can you share third-party auditor reports?
3. Do you perform annual security risk assessments? Can you provide the results?
4. Do you perform annual penetration testing? Can you provide the results?
5. Do you have a disaster recovery and business continuity plan in place?
6. Is your facility open for a physical walk-through inspection?

The answers to these questions can determine quickly if a cloud service provider is worth pursuing as a partner.

PROTECTING PATIENT HEALTH INFORMATION

Protected Health Information (PHI) records are especially valuable to cyber criminals due to the amount of data each record possesses and the diverse ways in which they can be exploited. We are all patients. As custodians of protected healthcare information, patients trust healthcare providers to uphold their professional and moral obligations to protect their medical records from getting into the wrong hands.

As the data breach trend continues to rise in the healthcare industry, especially in smaller practices, patients are beginning to ask the hard questions about how the practice is protecting their personal healthcare information. Not having the right answers could lead to a loss of patients.

The challenge many physician offices face is access to qualified security professionals to provide accurate and affordable guidance. Performing an independent security risk assessment is a great first step toward identifying vulnerabilities within the practice and ultimately reducing the risk of a data breach.

As physician practices are forced to rely more on cloud computing in the Digital Age, beginning to assess the security posture of a practice, which includes thoroughly vetting and identifying cloud service providers will help keep patient data safe and secure in cyberspace.

Ron Frechette, is managing partner of GoldSky Security, a cybersecurity and healthcare firm. Questions: ron.frechette@goldskysecurity.com

FOR MORE INFORMATION:
https://www.hhs.gov/hipaa/for-professionals/special-topics/cloud-computing/index.html
https://en.wikipedia.org/wiki/Cloud_computing_security

Chris Cosby, *continued from page 1*

from many different backgrounds, we're all here for the same reason: our strong desire to help people. I also do my best to treat my co-workers like part of my family — because we all want our family to be successful.

I try to be a transparent leader and make sure everyone understands the hospital's vision and the direction we are headed. Some things I've found that work are checking in with employees consistently and treating them the way I want to be treated.

Q: ***What is your guiding healthcare philosophy?***

My main philosophy is that patients always come first. "Every Patient, Every Time" is the motto we have instilled at Poinciana Medical Center. We're here to make sure patients feel confident they're going to get great medical care, whether in the emergency room, in surgery or elsewhere.

Q: ***What makes Poinciana Medical Center unique?***

Our hospital serves a very diverse population. We have a community of active retirees nearby, a vibrant and growing Puerto Rican population, and residents who have lived in the area for their entire lives.

I personally visit 20 to 30 patients each day, and I've seen this diversity firsthand. What I've learned is that each segment of our community has unique needs, and it's our job as a hospital to offer unparalleled care and compassion to everyone who walks through our doors.

For example, hospitals have a way of sending a patient's anxiety level through the roof, and that's compounded when English isn't your first language. We're doing all we can to train our team to help alleviate that anxiety.

Many of our staff members are bilingual, and we also have a computer that works like FaceTime, providing an on-screen, real-time translator. And our "blue phones" feature two handsets — one for the patient and one for the medical provider to use while a third party on the other end translates.

We're also exploring "Spanish for Healthcare Workers" classes at Valencia College's Poinciana campus as well as conversational Spanish classes for our hospital's leadership team.

As far as our active senior community, Poinciana Medical Center strives to make sure our entire medical staff is trained to care for patients experiencing dementia, sensory decline and rigorous medication schedules.

We're especially proud of our NICHE designation. NICHE stands for Nurses Improving Care for Healthsystem Elders and shows our commitment to providing excellent care to older adults.

Q: ***What's new on the horizon at Poinciana Medical Center?***

This year, we're breaking ground on a $10.1 million expansion of our emergency room, which treats more than 50,000 patients a year. We're adding nine more examination rooms and expanding the waiting room. Overall, the footprint of our emergency facilities will almost double.

Our emergency room already moves people in and out quickly. If you look at our ER metrics, we do it better than anybody in the area. We even beat the national wait-time average. This expansion will help us continue to do so as our community grows.

The hospital lab will also be expanding to catch up with rest of our medical center, which turns 5 years old in July and has grown from 30 beds to 76 during that time.

Since my arrival, we have added several new service lines including orthopedics, thoracic surgery, gastroenterology, and urology, and we're in the process of adding vascular surgery and gynecology

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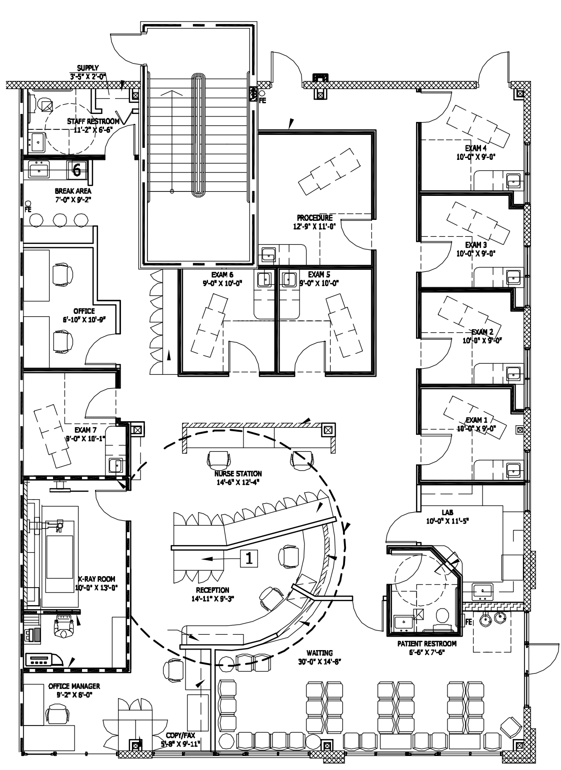

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Video Brochures:

Advanced Marketing Technology, Unique Prospects

By MARTIN PURMENSKY

In our modern age, the speed with which new technology emerges and integrates into our lives is nothing short of impressive. Each year products evolve, fly off the shelves and in no time, we adopt them and can't imagine our lives without the latest and greatest products. If you know what it means to "ask Alexa", then you fully understand our current state of techno-addiction.

Just as new technology impacts our personal lives, it also totally changes the way companies promote their products and services and communicate with their customers. This is evident when it comes to promotional products for marketing. As our lives revolve more and more around visual content, the market for static printed pieces has declined. However, businesses still encounter situations where a printed promotional product is ideal to give to their customer as a takeaway. The question remains, how has new technology influenced this traditional marketing technique?

A DIGITAL UPGRADE FOR PRINT PRODUCTS

The answer is a logical conclusion – give the printed product a digital upgrade. This is currently happening with technology that integrates video into the printed piece. Companies are using this inexpensive technology to create custom video business cards, video brochures, and video displays to replace static print that customers traditionally throw away.

These promotional products are perhaps the latest evolution of the not so long-ago novelty of receiving a birthday card that actually sang Happy Birthday. The enhanced version of this technology has given rise to custom video cards and video brochures, which are quickly becoming the go-to tools of marketers and salespeople alike. Their application is flexible and practical for use in many industries, including various fields within the medical world.

WHAT IS THE VIDEO CARD?

The video card is a simple electronic unit with a small LCD screen, speaker, battery, a few buttons for use, and an electronic board with installed software. All this is wrapped in a custom printed package that includes a company's brand and contact information. Videos are loaded with ease from a computer, and when the end-user opens the card the video starts playing. When the card is closed, the video stops.

This simple electronic device is available in a variety of sizes and achieves a powerful goal: deliver video content to the eyes of potential customers without the need for wires, Wi-Fi, passwords, or cell phone connection. For this reason, video cards appeal not only the young, video-hungry Millennial audience but, thanks to its ease-of-operation, to a more mature audience as well.

APPLICATION IN THE MEDICAL INDUSTRY

In the medical industry, the potential use of video cards is quite vast. When loaded with appropriate content, video cards can explain a procedure, help prepare a patient for surgery, or introduce a new service, facility or medication. In addition, video business cards are typically used as a tool to introduce new physicians at conferences and symposiums.

Perhaps one of the most interesting uses of video cards is in an Obstetrics and Gynecology practice with Ultrasound exams for pregnancy. While moms-to-be look forward to receiving videos and photos of their unborn child, the use of that content is limited when provided on a DVD. In today's culture of sharing content instantaneously across all social media accounts, it's an outdated practice to offer a DVD with zero means for immediate viewing.

Modern parents want instant access to the images of their child, and OBGYN offices benefit from updating their services with a new technology. This demand was recently met with the creation of Ultrasound Video Cards. Launched last year in Orlando, Florida, photos and videos from ultrasounds are uploaded by the technician to the Ultrasound Video Card. The complete package with all video and images is handed to the parents at the end of an appointment.

The parents can instantly watch their video, share it with their friends and colleagues wherever they go, and send it to family anywhere in the world. Some moms even send the video cards to their military spouses stationed overseas so they too can enjoy the views of their son or daughter.

(CONTINUED ON PAGE 9)

all three criteria have a significant probability of having HNPCC.

HNPCC cancers are more likely to be right-sided and more likely to be associated with other cancers, the most important of which is endometrial carcinoma. Women with HNPCC have an 80 percent lifetime risk of developing colorectal carcinoma; they also have an 80 percent lifetime risk of developing endometrial cancer. Thus, genetically proven HNPCC females should be counseled about hysterectomy once they have completed their family to minimize cancer risk later in life.

HNPCC occurs secondary to mutations in the DNA mismatch repair (MMR) genes, of which there are several. Thus, cell replication may contain errors that lead to dysplasia and subsequent carcinoma formation. HNPCC is not the only disease process to result from a defect in DNA repair mechanisms. The best example of this is probably a disease called xeroderma pigmentosum. Here, the mechanism of cells to recover from UV light damage is not functional, leading to multiple skin changes and dermal cancers. This is often so severe of a condition, that patients with xeroderma pigmentosum cannot be exposed to any sunlight at all.

The surgical approach to patients with HNPCC is typically individualized based on comorbid conditions, age, and other factors. In some instances, a subtotal colectomy is recommended, especially in good surgical risk patients, or in patients who simply are not willing to undergo aggressive surveillance post-operatively. However, in patients who may be too infirm to undergo a radical, subtotal colectomy, then a more limited resection is often performed instead. As stated previously, radical hysterectomy may also be recommended in females who exhibit MMR mutation.

Although HNPCC and FAP both result in colorectal cancer, they do so via radically different genetic pathways. Interestingly, both can result in similar combinations of malignancies via yet to be fully understood mechanisms. For example, patients with HNPCC and FAP both can develop brain tumors. The combination of a neurologic malignancy and inherited colorectal carcinoma (either HNPCC or FAP) is termed Turcot Syndrome. Oddly with this syndrome, patients with HNPCC are more likely to develop glioblastoma multiforme, while FAP patients would be more likely to develop a different type of brain tumor, classically medulloblastoma. This is an important example of genetic heterogeneity and demonstrates that we still do not understand all of the complexities of inherited disease.

Video Brochures,

continued from page 8

When it comes to sharing the content online, the video and photos are easily downloaded to a computer for use on social media.

THE VALUE TO THE BUSINESS

Besides the instant emotional value to the parents, the video card technology provides a promotional value to the OBGYN office. The card is custom designed to highlight the logo, contact information and other elements of the practice. As the card is shared, it provides the OBGYN office cost-effective advertising directed to their target demographic.

Development of this technology has not stopped. The video card product is evolving to offer a better experience for the parents. The upcoming edition of Ultrasound Video Cards will also have the capability to record the baby's heartbeat as an added feature.

Using the video card technology for pregnancy ultrasound is just one application that has multiple benefits to the patient and the practice. As a sales and marketing tool, video cards provide businesses and professionals with a memorable promotional product that gets noticed. Due to the novelty of video cards in the market, new and effective uses will continue to emerge within the medical industry and as the technology advances.

Martin Purmensky is the owner of Arrow Studio – a photography, videography, and creative business in the Orlando area. He has more than 20 years' experience specializing in the digital arts for the vacation ownership, hospitality, entertainment, and medical industries. In 2016, Martin started theVideoCards LLC, a company producing video cards.

HEALTH INNOVATORS

Gaming for Patient Education

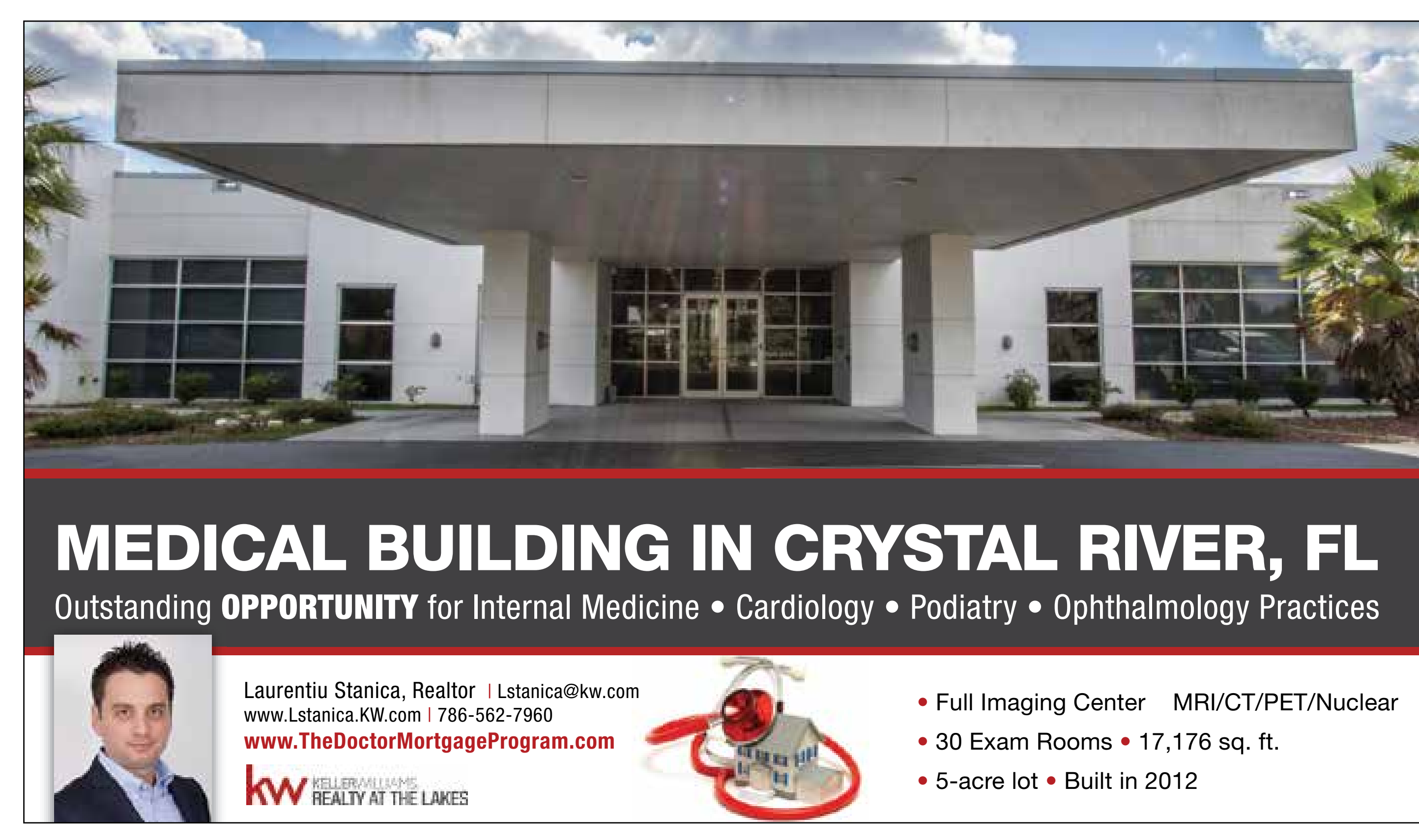
continued from page 3

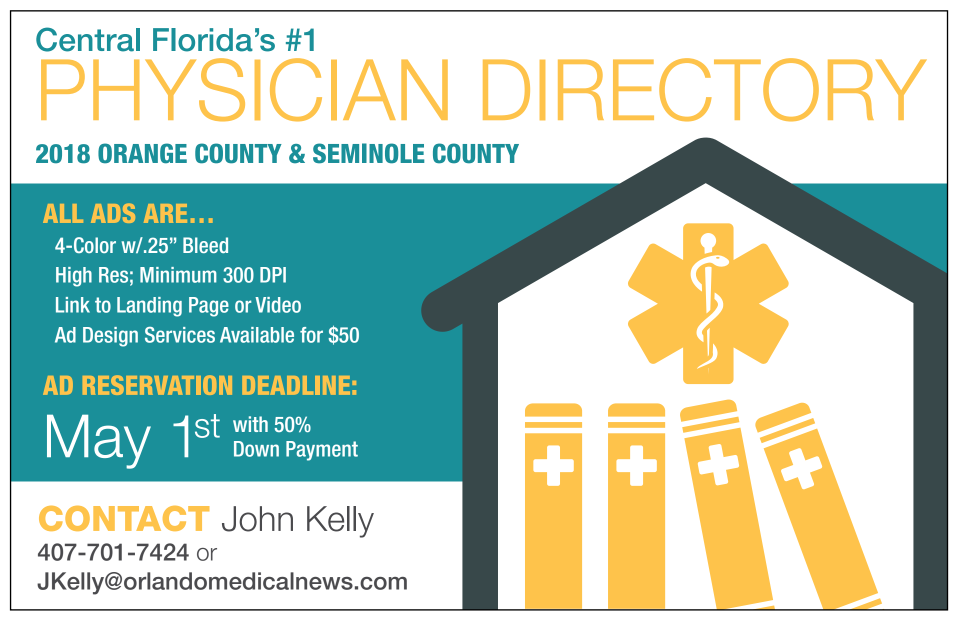
teractive and involves patients in their care. You can choose your adventure, you can go back to try other scenarios. With gaming, patients realize the power they have to see what happens and learn from it."

Gaming not only improves patient education but can also be expanded across other areas of healthcare. It can be used to encourage patient compliance by giving rewards for healthy behaviors, and it can teach medical and nursing students how to diagnose and treat conditions rapidly. Even healthcare administrators can learn about the downstream effects of their decisions. All of this innovation, and we have only just begun to touch on the advantages of virtual reality for patients and clinicians.

Want to open your mind about gaming in healthcare or pitch an idea for developers to work on? Join Health Innovators April 12th at the Orlando Science Center Cinedome to hear from Dr. Loerzel at "Night of Talks & Comedy - Reinventing Medicine with Gaming Tech".

Find more information at www.megahealthjam.com





Florida Hospital Expands Program for Patients with Autism, Developmental Delays

Giving blood is an uneasy experience for many people. But for those with autism and other special needs, the simple procedure can be outright terrifying.

Sean Sikora, a 15-year-old with Down syndrome, was so distressed when he came for bloodwork as part of his treatment for kidney disease, physicians and nurses had to sedate and forcefully restrain him.

But not anymore.

Florida Hospital for Children developed a new program that provides customized treatment plans for patients with special needs, which allows caregivers to learn about the patient's triggers, how to keep them calm, and deescalate issues before they can arise.

The program — called S.T.A.R. — has been so successful with pediatric patients that Florida Hospital is now beginning to expand the initiative and make training available for all Florida Hospital clinicians.

"Hospitals can be scary, especially for our patients who can't communicate how they feel or understand what's happening around them," said Chantelle Bennett, Child Life manager at Florida Hospital for Children. "We're dedicated to providing compassionate care to all of our patients, and in my heart, I know that this program has made a life changing difference for so many of our patients in their families."

In Sean's case, the simple act of being touched was a trigger for panic and aggressive behavior. But now there's a formulated routine with Sean for each of his visits — he knows he will watch "Tom and Jerry," have numbing cream applied to his hand to help ease the discomfort, and Child Life specialists will be by his side.

Jenn Sikora, Sean's mother, said that prior to the S.T.A.R program, Sean had to be held down during procedures, a difficult situation for her to witness. "Now, he's now happy to come to the hospital, and talks about the people and the procedure. He looks forward to coming in. I tell everyone I know because this has made a drastic change in our lives."

The S.T.A.R. program (named for "Sensory, Tactile, Auditory Rock stars") is built on specialized training for Child Life specialists, nurses and other clinicians, and a standardized treatment form accessible by the entire care team.

PONTE HEALTH Selects Lydia Hendrix Executive Director of Operations for VMC

Lydia Hendrix, a seasoned Healthcare Executive, a Registered Nurse -RN, and a Certified Rehabilitation Registered Nurse -CRRN, has been selected and announced by PONTE HEALTH as the Executive Director of Operations for VERTICAL MEDICAL CITY coming to downtown Orlando.

Holding this position, Mrs. Hendrix will help develop the Operations of the Complex Facility during the Pre-Construction and Construction Phases, as well as will proceed to lead VMC ORL once open and running. VMC ORL, in the possibility of becoming the largest Assisted Living Facility built and operating in the United States, will pose a great professional and creative challenge for its newest Team member.

"Lydia is an amazing resource with an unparalleled wealth of knowledge in the continuum of care, who is driven primarily by patient experience, and we are very lucky to have her" said Ponte.

Mrs. Hendrix spent 25 progressive years with Florida Hospital, rising from Clinical Nurse Manager, through Chief Nursing Officer of Medicine, Oncology, and Emergency Services, to Assistant Vice President of Clinical Operations and Resources; as such, she ultimately developed a system and its processes for "care traffic control" to identify and mitigate variability, fragmentation, and waste in overall clinical operations, and to implement best practice strategies. Outcomes included near real-time reporting, reduced utilization of discharge holding, and decreased expenditures.

Mrs. Hendrix specializes in Leaning and Integrating Health Care and Healing Systems and Processes -holds a Lean Six Sigma Green Belt, and earned a Bachelor's of Science Degree in Nursing, and a Master's in Science Degree in Strategic Leadership

Puerto Rican leaders declare Florida Hospital physicians 'heroes'

Referring to them as "heroes," Puerto Rican lawmakers honored a group of Florida Hospital emergency physicians for their selfless acts following Hurricane Maria.

In a declaration recently issued, the island's leaders stated: "…A group of heroes arrive in the island, and set aside their work obligations to be able to volunteer and treat patients in various communities…The House of Representatives thank you for your aid and interest displayed for the wellbeing of all Puerto Ricans ..."

Florida Hospital sent multiple teams of physicians to Puerto Rico and the U.S. Virgin Islands after Hurricane Maria ravaged the islands. The emergency physicians were the first to receive provisional licenses to practice medicine in Puerto Rico — their license numbers 001, 002, 003, 004 and 005, respectively.

"It is an honor to receive this recognition, and I want to thank the hospital for all its support," said Dr. Katia Lugo, who led the first response team. "Without it, our endeavors wouldn't have had the same reach."

Dr. Stephen Sevigny is Running for Congress
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Community Health Centers Opens New Center in Clermont at South Lake Hospital

Community Health Centers, Inc., opened a new medical center on the Orlando Health South Lake Hospital Campus at 2140 N Don Wickham Dr, Suite C, Clermont, FL 34711. The center will offer Family Medicine, including same-day appointments for ages 4 years old & up. In addition, patients at the center will be able to take advantage of Community Health Centers other services in the area including low-cost Pharmacy, Optometry, X-Ray, Obstetrics/Gynecology and more.

"Having Community Health Centers on our main Clermont campus will allow for additional healthcare services to be easily accessible to all south Lake County residents, including children and adults that are uninsured and underinsured," commented John Moore, South Lake Hospital President. "The new medical center will expand the availability of appointments and services that were previously provided by the South Lake Health Clinic for over 20 years."

Community Health Centers, established in 1972, operates 12 other centers throughout Central Florida. Community Health Centers accepts Medicaid, Medicare and most private insurance plans. A Sliding Discount Program is available for those meeting income guidelines. To schedule an appointment at the new location or other locations in Central Florida, or for more information, please call 352-314-7400.

CMS Lowers the Cost of Prescription Drugs for Medicare Beneficiaries

Today, the Centers for Medicare & Medicaid Services (CMS) finalized polices for Medicare health and drug plans for 2019 that will save Medicare beneficiaries money on prescription drugs while offering additional plan choices.

"The Trump Administration is taking steps for seniors with Medicare to save money on prescription drugs," said CMS Administrator Seema Verma. "The steps we are taking will drive more competition among plans and pharmacies to meet the needs of seniors and lower costs."

The final policies announced today further the Trump Administration's commitment to lowering drug prices. CMS is finalizing a reduction in the maximum amount that low-income beneficiaries pay for certain innovative medicines known as "biosimilars." Other actions that CMS is finalizing to lower the cost of prescription drugs include:

- Allowing for certain low-cost generic drugs to be substituted onto plan formularies at any point during the year, so beneficiaries immediately benefit and have lower cost sharing.
- Increasing competition among plans by removing the requirement that certain Part D plans have to "meaningfully differ" from each other, making more plan options available.
- Increasing competition among pharmacies by clarifying the "any willing provider" requirement, to increase the number of pharmacy options that beneficiaries have.

Today's announcement builds on the work of the Trump Administration to lower out-of-pocket drug prices. In Medicare, a rule implemented for 2018 will help beneficiaries save on coinsurance on Part B drugs administered at hospitals that participate in the 340B program by reducing the amount Medicare pays for those drugs. The 340B program allows hospitals to buy drugs at a lower cost. Due to CMS's policy change last year, Medicare beneficiaries are currently benefiting from the discounts that 340B hospitals receive. Beneficiaries are saving an estimated $320 million on out-of-pocket payments for these drugs in 2018 alone. CMS is also providing new information today to help hospitals implement this change, including how this change applies for Medicare Advantage plans that provide Medicare benefits through private insurance.

CMS is also finalizing policies that respond to the President's call to end the scourge of the opioid epidemic. These policies provide Medicare with additional tools to combat opioid overprescribing and abuse, and to protect families and communities across the nation. For example, CMS

(CONTINUED ON PAGE 12)

Nemours Chief of Pediatric Surgery Promotes Global Education Among Pacific Association of Pediatric Surgeons

Dr. Cynthia Reyes, Nemours Children Hospital's Division Chief of Pediatric Surgery and Surgical Director of Quality, is bringing a unique perspective to the Nemours community. Dr. Reyes has been an active member of thePacific Association of Pediatric Surgeons (PAPS) for more than 20 years, which supports the growth of pediatric surgery around the world, with a focus on the countries of the Pacific Rim.

Dr. Reyes, who was the first Hispanic female to be trained in an accredited pediatric surgery program in the U.S., has served for 10 years as President of PAPS and has been involved in the Global Alliance Program (GAP), which was established to expose young pediatric surgeons in developing countries to the current science and art of pediatric surgery. GAP actively engages these young surgeons, providing a unique opportunity of scientific exchange and mentorship.

"It is such exciting work," said Reyes of her time in the role and her continuing involvement with PAPS. "I have meet pediatric surgeons from all over the world who work in very challenging conditions. Many of these surgeons do not have access to fluids. Some of them have a limited supply of sterile gloves, so they need to re-wash them. They just don't have access to the material resources that they need," according to Reyes.

Formed 50 years ago by a small group of surgeons from the U.S., Japan, China, Australia, and Canada, PAPS's mission is to help pediatric surgeons in developing countries, while delivering a message of global communication and inclusivity within the pediatric surgery community. Today, PAPS has blossomed to a membership of 530 surgeons residing in 23 countries.

PAPS hosts a five-day annual meeting where members exchange information and insights about the latest pediatric surgical research and results, new procedures and techniques, patient clinical management, and the opportunity for networking and engaging discussion. This year's meeting will be held in Sapporo, Japan in May and Dr. Reyes will be a featured speaker.

Each year a GAP fellow is selected to attend the annual PAPS conference and is invited to stay an additional week for an externship at the children's hospital in the community hosting the conference. Over the years, there have been 30 GAP fellows, and both the fellows and the hosting surgeons have found the externship to be incredibly valuable.

"I'm proud of this work," said Reyes. "PAPS members and the GAP Fellows really embrace one another. We embrace our differences: not only our cultural differences, but in the way we practice. It benefits the communities we live in, as well as the communities we serve."

PAPS stays faithful to its dream of diversity, inclusivity, and social responsibility. The organization supports the growth of pediatric surgery around the world. Dr. Reyes hopes to have Orlando host an upcoming annual conference, with Nemours Children's Hospital as the backdrop for the GAP Fellow externship.

...continued from page 11

is finalizing a new authority that permits Part D sponsors to require beneficiaries at risk of addiction or overuse to use only selected prescribers or pharmacies for opioid prescriptions.

As part of today's announcement and guidance, the agency is reinterpreting the standards for health-related supplemental benefits in the Medicare Advantage program to include additional services that increase health and improve quality of life, including coverage of non-skilled in-home supports and other assistive devices. CMS is expanding the definition of "primarily health related." Under the new definition, the agency will allow supplemental benefits if they compensate for physical impairments, diminish the impact of injuries or health conditions, and/or reduce avoidable emergency room utilization.

The final policies also advance the "Patients Over Paperwork" initiative – an effort aimed at removing regulatory obstacles and empowering patients to make informed healthcare decisions; developing innovative approaches to improving quality, accessibility, and affordability; and improving beneficiaries' customer experience. Specifically, the final policies will:

• Authorize CMS to permit plans to use notice of electronic posting (and provision of copies upon request) to satisfy disclosure requirements for certain bulky documents to Medicare beneficiaries.

• Improve transparency of the Star Ratings that give beneficiaries information about each Medicare Advantage and Part D plan's quality rating. The changes put patients first by increasing the weight given to patient experience and access measures.• Streamline government review and approval of marketing materials Medicare health and drug plan use.

For a fact sheet on the 2019 Rate Announcement and Final Call Letter, please visit: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2018-Fact-sheets-items/2018-04-02-2.html. For a fact sheet on the final rule (CMS-4182-F), please visit: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2018-Fact-sheets-items/2018-04-02.html.

The 2019 Rate Announcement and Call Letter may viewed through: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.html by selecting "2019 Announcement." The final rule can be downloaded from CMS.gov at: https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/CY2019-Medicare-Advantage-Part-D-Final-Rule.pdf.

UCF Awarded Grant to Expand Community Nursing in West Orange with Shepherd's Hope

A grant recently awarded from the West Orange Healthcare District will enhance the real-world education for UCF nursing students while aiding in the care of the growing number of uninsured patients at Shepherd's Hope.

A $62,000 grant will fund a new UCF Community Nursing Coalition, or community-focused service learning program for students. The coalition will be specifically dedicated to the West Orange community, with undergraduate and graduate students at the Shepherd's Hope clinic in Ocoee and the new center in Winter Garden scheduled to open in December 2018. Shepherd's Hope, which provides high quality health care for medically underserved and

(CONTINUED ON PAGE 13)

Community Health Centers Adds Judge Gisela Laurent To Board

Community Health Centers, Inc., recently, elected Orange County Judge, Gisela T. Laurent to their Board of Directors. The Honorable Gisela T. Laurent was elected to serve as Orange County's first Female Hispanic County Court Judge in 2016. She currently serves in the County Criminal Division. Prior to Judge Laurent's service on the judiciary, she served the community as a bi-lingual Orlando attorney who advocated on behalf of Orange County's diverse populations. She represented more than 2,000 clients, ensuring they had a clear understanding of the justice system and the impact of their cases.

"Judge Laurent is a great addition to the Board of Directors. As a native resident of Central Florida with a demonstrated track record of service to others, she brings great passion and understands firsthand the needs, issues and opportunities available to every Community Health Centers patient", says Timothy McKinney, Chairman of the Board of Directors.

The Community Health Centers Board of Directors oversees and approves strategic planning, provides financial oversight, reviews legal compliance and reviews and approves the organizations policies. More than 50% of the Board of Directors are comprised of patients of Community Health Centers.

Community Health Centers, a Federally Qualified Health Center established in 1972, operates 13 medical and dental centers throughout Central Florida. Community Health Centers accepts Medicaid, Medicare and most private insurance plans. A Sliding Discount Program is available for those meeting income guidelines.

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...continued from page 12

uninsured, has cared for a growing number of patients from West Orange County. In 2017, the organization provided care to 2,647 adults and children from the region, up from 2,178 in 2016.

UCF will have a dedicated faculty member to coordinate the program in West Orange. "This grant will expand educational opportunities for our students, who will gain experience, knowledge and skills by interacting with the Shepherd's Hope clinical provider team and faculty," said Nursing Associate Instructor Erica Hoyt, MSN, RN, CNE, who will lead these efforts.

Undergraduate students will apply classroom knowledge to provide health screenings, health evaluations and patient education to empower community members to make healthy choices, manage risk factors and improve outcomes. Graduate students will work with clinical leaders to analyze data and work to improve individual and population health, such as decreasing adult tobacco use, decreasing the incidence of low birth weight babies and decreasing substance abuse.

Students will also participate in Healthy West Orange, a grass roots movement to inspire west Orange County to become the healthiest community in the nation.

"This grant is a mutually beneficial opportunity for the community and nursing education," said Mary Lou Sole, dean of the UCF College of Nursing. "We are excited to deepen our relationship with Shepherd's Hope and establish a partnership with the West Orange Healthcare District, as both of these organizations share in our commitment to improving the health and wellbeing of the community through education and high quality, compassionate care."

The West Orange Healthcare District grant is the latest development in the partnership between the UCF College of Nursing and Shepherd's Hope. As the college and community need has grown, so has the partnership. Initially an opportunity for undergraduate students, now both undergraduate and graduate students volunteer at the five health centers throughout Central Florida.

"Since 2014, the impact of the collaborative relationship between Shepherd's Hope and the UCF College of Nursing has been significant for our organization and the uninsured patients that we serve," said Marni Stahlman, president and CEO of Shepherd's Hope, Inc. "It has allowed for the creation of several innovative initiatives that have improved clinical operations and our care standards, and also helped us establish a unique day clinic in Longwood run solely by UCF College of Nursing volunteers and faculty."

For more than a decade, the UCF College of Nursing has made a difference in the lives of residents through its community-based curriculum. Through community partners, like Shepherd's Hope, students have provided more than 30,000 hours of service to some of the region's most economically disadvantaged residents. This new grant will expand the program to 17 Community Nursing Coalitions serving six regions in Central Florida.

Orlando Nonprofit Announces New 'Human Trafficking and Emergency Medicine' Online Learning Module

The Emergency Medicine Learning & Resource Center announces its new "Human Trafficking and Emergency Medicine" online learning module available on EMLRC Online (http://emlrconline.org/). This online learning module aims to educate emergency medicine professionals on how to better identify these victims and help them.

"An emergency department or EMS dispatch may be the only setting in which a trafficked person has an opportunity to be recognized and rescued," FCEP Board member Dr. Danyelle Redden, who is also a member of the Greater Orlando Human Trafficking Task Force. "Because of the complexities of trafficking situations, the victims are not necessarily easy to identify. It is essential for emergency care providers to understand the situational, behavioral, and clinical indicators of trafficking in order to identify the victims and intervene appropriately."

The online module focuses on defining human trafficking and identifying people susceptible to trafficking. It also reviews the signs and symptoms of trafficked persons presenting for medical evaluation; the situational indicators of trafficking; how and when to approach a victim of human trafficking; the guidelines for evaluation of a potential trafficking victim and how to respond to an identified human trafficking victim; and comparing and contrast victims of human trafficking and domestic violence.

The National Human Trafficking Hotline's 2017 Hotline Statistics identified Florida as the state with the third-highest reported cases of human trafficking with 604 cases in 2017. Approximately 30 percent of human trafficking victims encounter an emergency medicine professional during their time of enslavement and are not recognized as being trafficked. Emergency medicine professionals can play a key role in recognizing the signs that a patient is being victimized by human trafficking and are afforded a unique window of opportunity by which to offer help. Resources, like this online learning module, are important because they provide the tools to understand the wide-ranging problem of trafficking for EM and EMS professionals who might be the only individuals to have contact with victims, including when and how to act, can lead to the freedom of many of those currently enslaved.

Established in 1990 by The Florida College of Emergency Physicians, the Emergency Medicine Learning & Resource Center (EMLRC) is a nonprofit organization "advancing emergency care through advocacy and education". The Emergency Medicine Learning & Resource Center provides continuing education to over 5,000 of the nation's emergency care providers each year. EMLRC is accredited by the Florida Department of Health, Bureau of EMS; Continuing Education Coordinating Board for Emergency Medical Services (CECBEMS); Florida Board of Nursing and the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education for paramedics, EMTs, nurses and physicians.

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The NASH Education Program™, Giving Voice to the "Silent Epidemic" Afflicting 25 million Americans

The NASH Education Program-TM launched in March in the United States, focused on bringing awareness to a little-known, asymptomatic disease estimated to affect more than 25 million Americans and about 12 percent of adults in developed countries. NASH, or nonalcoholic steatohepatitis, is a metabolic disease characterized by the accumulation of fat in the liver, along with inflammation and the degeneration of liver cells. In too many cases it leads to liver transplants and liver cancer. It afflicts a growing number of children and teenagers, and particularly strikes the Hispanic population.

The NASH Education Program™, an independent legal entity and a non-partisan initiative, includes an independent scientific committee (made up of EU and US hepatologists and diabetologists) dedicated to raising awareness of this devastating disease. Through the production and dissemination of educational videos, digital content and research conducted by the NASH Global Health Observatory, The NASH Education Program™ seeks to build a non-partisan coalition to inform and equip all healthcare sectors to proactively solve this public health crisis.

Officials of The NASH Education Program™ also released results of their new patient "Health Unlocked" survey, via the British Liver Trust & the Fatty Liver Foundation communities in partnership with Health Unlocked. This important survey contains new data on patients' awareness of the disease, feelings on the need for more information on NASH, and the ties to related health conditions patients have (such as high blood pressure and diabetes).

Nemours Furthers Its Promise of Quality Pediatric Care with Physician Engagement

Nemours continues its commitment to deliver quality care to children and families with a sharp focus on physician recruitment, retention, engagement, and well-being.

The Department of Pediatrics welcomed its newest member to the Central Florida community. Dr. Darlene Calhoun, new Chief of Neonatology, is an accomplished neonatologist who delivered critical care to newborns and served as a faculty member at Johns Hopkins All Children's Hospital in St. Petersburg, FL. She also served as medical director of the NICU at Sarasota Memorial Hospital.

Dr. Calhoun is a leader in advances in neonatal care with more than 50 peer-reviewed original research reports and a dozen review articles. She has authored three book chapters and provides peer review for six journals including Pediatrics, The Journal of Pediatrics, and the Journal of Perinatology. Dr. Calhoun is certified in neonatal-perinatal medicine and in general pediatrics by the American Board of Pediatrics. She graduated from the Ohio University College of Osteopathic Medicine and completed a residency in pediatrics in The Ohio State University program at Nationwide Children's Hospital in Columbus. She specialized in neonatology with a fellowship at the University of Florida in Gainesville.

In Radiology, Nemours is expanding Dr. Craig Johnson's role. Dr. Johnson has been named Radiology Chair and will oversee the Nemours Children's Hospital Department of Radiology including the diagnostic and clinical/interventional components to ensure enterprise integration continues to grow. He is a regionally and nationally recognized physician in the field of vascular anomalies and pediatric image-guided therapies. Dr. Johnson currently serves as the Program Director of the Vascular Anomalies Program at Nemours Children's Hospital and will continue his role as enterprise Director of Interventional Radiology, leading the combined largest pediatric interventional group in the nation.

In addition, Dr. Fabiola Weber, will now serve as Division Chief of Interventional Radiology. Board-certified by the American Board of Radiology, Dr. Weber earned her medical degree at the Ponce School of Medicine and Health Sciences and completed an internship and residency at University Hospitals Richmond Medical Center and a diagnostic radiology residency at the Medical College of Georgia. She completed fellowships in pediatric radiology and pediatric interventional radiology at Boston Children's Hospital.

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Medicare Advantage Plans Value Physician Record Reviews

By Jay Baker

To achieve a 5-star rating from CMS, Medicare Advantage (MA) plans must master the ability to integrate with healthcare providers, gain insights from data and demonstrate ongoing improvements. The ranking system is used by Medicare beneficiaries to compare health plans, and by insurers to determine quality bonus payments for plans that earn at least four stars. What began as an alternative to fee-for-service Medicare, MA has gained momentum – with enrollment nearly doubling over the past several years.

In 2017, Florida had five MA plans with 4.5 to 5-star ratings, among the highest in the country, but achieving this requires commitment and consistency.

More than one-third of the Medicare-eligible population is now in an MA plan, and three-quarters of MA-prescription drug program enrollees are in plans that have earned four stars or greater. These ratings are important to consumers and tied to bonuses and benchmark rates for the plans.

Successful MA plans tend to be more integrated with their providers across the board. All of the nurses, doctors, lab techs, pharmacists and others are connected by organizational data, business intelligence and effort. This level of connectivity is the surest way to higher care quality.

For example, a patient arrives for a sick visit and is given a reminder about an overdue blood test, or the provider is alerted that patient has not picked up his or her prescription after three days. It's about finding the care gaps. The number one reason for a patient to be readmitted to the hospital is being confused about medications. At the core of physician integration lies the ability to gain clinical insight into risk-adjusting conditions to enhance traditional analytical platforms.

THE KEY TO PHYSICIAN INTEGRATION

The best approach to optimizing clinical insights is with a Physician Record Review (PRR), a two-stage retrospective chart review process from a 1) certified coder and 2) board-certified physician.

The point of such a thorough review is to give physicians the ability to see progress notes for primary care, specialists' hospital charts, radiology and laboratory results that are not routinely used in standard analytics and gain demonstrable actionable information.

What's more, PRR identifies care opportunities in accordance with evidence-based medicine. The best PRR platforms offer physician staff members who are board-certified in their areas of specialty and have extensive risk-adjustment training to uncover the potential for risk-adjusting conditions left undetected by current programs.

GAINING A COMPLETE PICTURE

PRRs represent one of the best opportunities to focus on Hierarchical Condition Categories (HCCs). Specifically, the PRR platform employs a team of physician reviewers to identify HCCs within each patient chart, annotate risk adjustable conditions (by page number), and integrate these outputs into a broader array of activities.

CMS uses HCCs to reimburse MA plans based upon the health of their members. It pays for the predicted cost expenditures of patients by adjusting those payments based on demographic information, Medicaid status and the severity of illness or patient health status as recorded in medical record documentation.

The PRR platform should also confirm the previous two years of submitted HCCs for clinical confirmation not currently submitted in the calendar year. The goal is to provide a complete picture for the risk-adjustment factor, increasing the accuracy of the patient's risk score and, ideally, creating clean claims and faster reimbursements.

SNAPSHOT OF THE VALUE OF PRR:

- Reviews currently submitted HCCs
- Confirms previous two years of submitted HCCs for clinical confirmation that have not been submitted in the current calendar year
- Identifies new clinically suspected HCCs based on progress notes from primary care, specialists, hospitals, radiology, pharmacy and laboratory results
- Identifies risk factors for clinical interventions for screening of associated chronic illnesses

ACTION PLANS FOR THE FUTURE

For MA plans to reach the top – and stay there – they must go above and beyond. This means planning for the future and preparing for challenges related to patient engagement and quality measures. For instance, CMS's new rule around access standards for consumers would require organizations to add more physicians. When a narrow network grows larger it becomes more challenging to control, which can undermine quality outcomes. Making PRR part of the action plan will be more critical than ever.

Jay Baker is Senior Vice President for Quality and Risk Adjustment Solutions with Advantmed, LLC. He can be reached at info@advantmed.com

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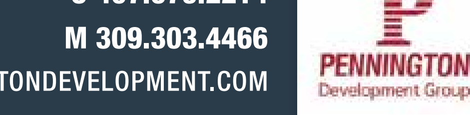

Top Seven FAQs on Planning Your Exit Strategy

By JAY A. SHORR, and MARA SHORR

They say the days are long and the years are short. For medical providers and practice owners approaching the back nine of their careers, you'll notice this quicker than ever. If you're now thinking about retirement in the next five to 10 years, constructing an exit strategy should be in your cards.

Not jumping into things too quickly is key, so be sure to consider the following:

DO YOU WANT TO SELL OR JUST CLOSE YOUR PRACTICE?

As consultants, we find physicians often believe their practice is worth more than it actually is, which hurts the ego when the actual evaluation is completed. The issue becomes personal, as a lot of sweat and hard work went into creating your practice. Your practice may have supported you all of these years, but changes in insurance reimbursements have unfortunately lowered the values of many practices.

Ultimately, you'll want to consider which of the following reasons is causing your retirement:

- Relocation to another city or state
- Maintaining your practice is too much of a physical or financial hardship, and you're now physically or financially unable to meet the demands of the practice
- Lowered insurance reimbursements no longer make it worth your while
- Governmental regulations have changed and it's too much to keep up with
- You no longer want to manage your staff and you want to just practice medicine and let someone else run the business side.
- Finally, if you have been offered a buyout and it seems too good to be true… BEWARE!

HOW MUCH IS YOUR PRACTICE WORTH?

When selling a practice today, the value is more in the tangible assets (capital equipment, supplies and website), real estate and receivables rather than the number of charts you have to sell. The patients came to YOU and may not be interested in going to a new, different provider. Hire a professional who specializes in medical practices to determine the actual value of your business, so you can make a more informed decision about how to proceed, remembering that this process takes planning, accounting, and even involves legal guidance.

Prior to entertaining or discussing the sale of your practice, ensure you have secured a non-disclosure and confidentiality agreement from ALL parties involved. Beyond personal information about to be disclosed, there is also the potential for disclosure of your patients' protected health information (PHI). Ensure any and all information which may be in the possession of any third party be immediately returned and/or destroyed at the conclusion of the negotiation.

When you are negotiating to sell your practice, the purchaser may not want to purchase the stock of your business because as it also assumes the potential and existing liabilities associated with the practice. This can be a positive thing if you are interested in an insurance component, as the insurance negotiated contracts may go along with the sale.

WHO CAN PURCHASE YOUR PRACTICE?

Be sure to understand who may purchase your practice. In many states, regulations which stipulate who can and who is prohibited from purchasing medical practices. In Florida, for instance, it is permissible under certain standards for non-physicians to own a medical practice. Be sure to consult with legal, accounting and consulting professionals who are skilled in this field.

WHAT IF YOU'RE JUST GOING TO CLOSE THE PRACTICE'S DOORS?

If you are just going to close the practice, you will need to ensure you follow proper protocols for the benefit of your patients and the legal guidelines in the state where you practice. This includes proper notification to your patients of your pending retirement where you must terminate your physician/patient relationship. This will eliminate the legal process of patient abandonment. You should give your patients about 60-90 days advance notice of your intent to retire.

Prior to your notification, it is always best to have a referral base of colleagues with whom you can refer your patients. This should go in the letter you send to your patients once you have decided the time is near. Allow your patients the opportunity to pick up their medical records if they so desire. Have a system in place where the patients' records can be maintained, stored and recalled in the event a patient, attorney, malpractice carrier or governmental agency has a need to request them. State laws vary, so be sure to consult the advice of a professional who is knowledgeable in this regard.

DO YOU NEED TO LET THE LICENSING BOARDS KNOW?

Many states require you notify them if you elect to no longer practice medicine. You may keep your license on an inactive or part-time status but be sure to not just let your license expire or lapse. In addition, remember to send proper notification to any medical facility/hospital where you have privileges, so they are not just inadvertently terminated due to lack of renewal, payments, etc.

WHAT ARE YOUR EXISTING FINANCIAL OBLIGATIONS?

As your practice progressed, you had to enter into some type of contractual agreements. These may have included, but not limited to, capital/tangible equipment, such as lasers, your websites, rent/mortgage/lease agreements, employee salaries and retirement obligations including local, state and federal taxes. You'll want to make sure all of these items are properly addressed.

WHO SHOULD YOU HAVE ON YOUR TEAM?

Make sure to assemble a strong team of healthcare associates who are familiar with helping to close or sell a medical practice. We've seen a number of issues when practices try to use a family friend unfamiliar with the issues that come into play. Your team should include, but is not limited to, a healthcare attorney, a strong accountant, a medical practice business consultant and a business/transactional broker. Remember to have non-disclosure paperwork and a business associate agreement signed for all parties involved.

There's a lot to think about, and we've seen analysis paralysis happen before. Getting started is the first step to moving forward towards your next steps.

Mara Shorr, BS, CAC II-XII serves as a partner, as well as the Vice President of Marketing and Business Development for Shorr Solutions, assisting medical practices with the operational, financial and administrative health of their business. She is a Level II - XII Certified Aesthetic Consultant and program advisor, utilizing knowledge and experience to help clients achieve their potential. A national speaker and writer, she can be contacted at marashorr@shorrsolutions.com.

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The Modern Medical Practice: A Case Study in Communication Gone Wrong

Communication ideas to improve your practice and reduce burnout

By RICH CASTELLANO, MD

It's Pajama Time again - a nightly ritual for many doctors today. Time to finish the day's notes and electronic filing, before the hustle and bustle of a new office day begins. Whether or not you call it Pajama Time, we have all experienced the tedious task of filling out electronic health records (According to a recent Forbes article, physicians spend 27 percent of their time in their offices seeing patients and 49.2 percent of their time doing paperwork)

While precision, consistency, and thoughtful documentation are crucial to the job, new requirements for electronic health records are forcing doctors to spend more time documenting care than actually providing it. This not only reduces the amount of time a doc spends with patients, it also cuts into a doctor's personal life. This results in doctors that are stressed, overworked, and resentful, which may not seem like a huge problem on the outside, but it's a ticking time bomb.

Patients sense this resentment and they add to the dysfunction. They see a stressed doctor and react with a mixture of contempt and fear depending on the situation. The modern medical practice is a case study in communication gone wrong. This results in a negative cycle of dysfunctional communication that ultimately impacts the level of care. In this environment, patients can react, and important symptoms can be missed.

Without healthy communication, it becomes impossible for doctors to motivate their patients to take action. The future of care is behavioral care. Whether it's taking medications, adopting a more plant-based diet, or engaging in physical activity, it is essential that a doctor be able to influence a patient's behavior after they leave the office. If they don't, others have little chance of making a difference.

I have been working to change this trend. I think the solution is found in the world of business. A great deal of the stress and pressure in the modern practice can be attributed to communication skills and customer service issues. My process has received widespread acclaim recently for taming the chaos of the modern practice. Using some of these lessons there may actually be not just relief, but even a cure for the modern burnout crisis.

HERE ARE 4 IDEAS TO IMPROVE THE FUNCTION AND FLOW OF YOUR PRACTICE:

1. **Schedule and Block Time for Staff Training**
   In other industries, weeks are dedicated to training staff (even if it is to simply use a deep fryer!) Yet today, most medical office staff are expected to jump in and perform flawlessly from the moment they start.
   Even highly skilled staff members should have regular training to improve teamwork and efficiency. Communication between staff members and well as communication between patients and staff need to be planned and practiced. Multiple training sessions are the key to eventually create flawless performance.

2. **Have Written Protocols and Policies**
   There is only one known way a person can read your mind: write down your thoughts and show it to them. People are not mind readers. Written protocols are essential to avoid misunderstandings that training on-the-fly can bring. Remember, speaking is not the same as communicating, being understood is communicating. Training also needs to be focused. Many offices practice the art of the "On-the-Fly Training," (They wait for a situation to arise naturally and then respond with a sentence or two about how staff should react.) Imagine if professors taught a class using this method. How could anyone pass? Take the time to go over the ideal way your office should operate no matter the size of the practice. Plan out all the details in writing and commit to proper and regular training. Ultimately, communication is not what we say, it is the response we receive.

3. **Provide Excellent Customer Service**
   We don't often think of a doctor's office as a business, but patients still expect customer service. This is a skill that does not come naturally, and it applies to every single task an office is involved in. Unfortunately, many doctor's offices don't train staff regularly and thus they seem disorganized and short with patients. Make customer service a priority in your office and positive changes will come.
   How do you improve customer service? Smiling, training, "protocol-ing," and cultivating your team over time!

4. **Hire a Person Who Smiles … A Lot**
   Nonverbal communication accounts for the majority of a customer services experience. Attitude and nonverbal skills are measurable, reproducible and predictive of human behavior. The kind of person you want to greet patients is the high smiler. When someone makes eye contact a smile should be instant, setting the entire experience with that patient on the right course.

How is the function and flow of your office? Does it add to your stress or does it help reduce it? Remember, the doctor is the core of a practice and the positive cycle starts with you.

It's true, good communication takes a bit of work – you may even have to spend an extra hour of pajama time planning… but it will save you stress and burnout in the end.

Wall Street Journal best-selling author Rich Castellano MD, (known as The Smile Dr.) is an experienced facial rejuvenation artist, innovator, and highly sought-after trainer. His new book "The Smile Prescription" explores the art of smiling, facial expression, and innovative communication strategies. Dr. Rich now teaches across the country his award winning, online coaching and mentoring program, PracticeProfitabilityMD.com His 2-Day LIVE event in Tampa, Florida offers 15 CME credits to most categories of healthcare professionals www.PPMDLive.com Dr. Castellano has made hundreds of live appearances including guest interviews on The Daily Buzz, FOX, NBC, ABC, CBS, and numerous other media outlets.

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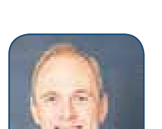

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Knowledge is Power

Lumps and bumps don't always mean cancer

By ROBERT CAPOBIANCO, MD

Breast cancer is a pervasive, highly publicized and very personal disease. Most everyone has a mother, sister, relative or friend who has had a brush with breast cancer – a scare, a survival story, or the memory of a loved one who succumbed to it.

According to the American Cancer Society, breast cancer is the second most common cancer among women, other than skin cancer.

Regular clinical breast exams and mammograms are the first line of defense for all adult women to monitor their breast health and follow up on any changes that their doctor may notice such as lumps, bumps, pain and tenderness, or unusual discharge. Certain changes in the breast tissue are normal and more common as women age, but any unusual symptoms should be shared with your doctor to make sure they are not cancer. Though the value and diagnostic capabilities of breast self-exams (BSE) have been debated both in health care circles and the media, it's agreed that a thorough knowledge of the normal look and feel of one's breasts can help detect any obvious changes.

Research from the Mayo Clinic states that eight of every 10 breast lumps are not cancerous. And, according to the American Cancer Society, the most common physical changes in the breasts – lumps, tenderness or discharge – are usually linked to benign conditions, i.e., conditions that do not lead to cancer. The most common diagnoses related to a breast lump, says the ACS, include fibroadenoma (a benign solid tumor), fibrocystic changes (benign breast changes), atypical hyperplasia (fast-growing abnormal cells), cysts (benign, fluid-filled sacs), or non-invasive cancers, such as ductal carcinoma in situ (DCIS) – a cancer of the milk ducts.

A lump or cyst may be detected by a woman during a BSE or by her doctor during a clinical exam. A lump that is also tender and warm to the touch is likely a breast infection. A cyst is a round or an oval mass, can move when touched, and is full of fluid. Found in about one in three women between ages 35 and 50, cysts are diagnosed by a breast ultrasound or biopsy.

Other breast changes are not visible to the eye and show up during a mammogram, an X-ray that takes a picture of the breast tissue and can detect tumors before they are big enough for your doctor to feel. Beginning at age 40, women should have a screening mammogram once a year – and more often if there is a genetic predisposition toward breast cancer or a breast condition that warrants close follow-up.

A call from your doctor after a mammogram can be a worrisome experience. In most cases, the area in question turns out to be benign. About one in 10 women who get a mammogram will need more pictures taken – but most of these are not malignant or cancerous. Only two to four of every 1,000 mammograms lead to a diagnosis of cancer, according to the ACS.

Common mammogram findings include calcifications, a mass, fibrosis or lipoma. Some of these conditions can indicate the possibility of cancer, and others are completely benign. Your physician will recommend further testing, if needed. Calcifications – tiny mineral deposits in the breast tissue – show up as white flecks on your mammogram film. There are two types: macrocalcifications, which are larger deposits generally caused by aging, injury or inflammation; and microcalcifications, tiny specs of calcium in the breast tissue, scattered or in clusters. The pattern and number of these deposits will help your doctor make a determination about whether cancer is present.

A mass may or may not be cancerous. The size, shape and borders of a mass help to define whether it is benign or malignant. Fibrosis refers to the presence of fibrous tissue, a thickened area similar to scar tissue, which may be tender. Fibrocystic changes do not increase the chance for breast cancer, and any discomfort can be treated with over-the-counter pain relievers or diet changes, such as limiting caffeine. Fibroadenomas, are benign tumors made of both connective tissue and breast tissue. They are more common in younger women under age 40, are round and well defined, painless, and move. Another benign tumor is a lipoma, or fatty tumor, which is not tender and can occur anywhere.

Most benign breast conditions do not raise your risk of developing breast cancer. Depending on your diagnosis, your doctor may wish to perform imaging tests such as an ultrasound or MRI, or more frequent mammograms to keep a close eye on your health.

If you should need additional care after the screening mammogram results, call 407-498-3763 to reach the office of St. Cloud Medical Group Surgical & Vascular Services which specializes in women's breast health procedures.

Robert Capobianco, MD, is a board-certified general surgeon with St. Cloud Medical Group, a multi-specialty medical group affiliated with St. Cloud Regional Medical Center. All providers are board certified or fellowship-trained in each of their specialties and are members of the medical staff. To set up a screening mammogram, call 407-498-3707 or visit www.StCloudRegional.com for more information on women's health services. For more visit StCloudPhysicians.com.

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Five Essentials of a Winning Office Culture

By TRAVIS JACOB

In an environment of an ever-changing workforce and (sometimes daily) changes in technology, the one thing that can and must remain constant in a successful organization is a healthy culture. Organizations are talking more about culture now than any time in the past. In recent years there has been rigorous debate on exactly how important culture is in an organization and what effect it actually has on performance, productivity, and the bottom line.

In his book, The Advantage: Why Organizational Health Trumps Everything Else in Business, Patrick Lencioni addresses the importance of a healthy organizational culture: "The single greatest advantage any company can achieve is organizational health. Yet it is ignored by most leaders even though it is simple, free, and available to anyone who wants it." The well-known researcher and author in the field goes on to say, "Organizational health will one day surpass all other disciplines in business as the greatest opportunity for improvement and competitive advantage."

The great thing about organizational health is that it does not discriminate among organizations since it is all about the people. I have worked with large companies down to smaller clinics with three to five employees and the same principles apply across the board- take good care of your employees, they will in turn take good care of your patients, and everyone wins!

Through my work with various organizations I have found the following five principles essential in building and maintaining a winning culture in your office or clinic. The reality is that they require very little financial investment, yet can have the largest impact on success.

I. BUILD TRUST: Trust is many times taken for granted until it is broken. When it is broken it can take a very long time to regain. Here are three things you can do to make sure you are building trust: (1) make sure your guiding documents (Handbook, Policies, etc.) reflect the culture you desire; (2) make sure pay is fair and free of inconsistencies. People talk and know how much others are paid even if you ask them not to; and (3) do what you say you will do (walk the talk).

II. CULTURE STARTS AT THE TOP: The leaders at the top of any organization are responsible for the culture they desire. These leaders must: (1) model the desired culture, not mandate it. If you want your employees to behave and act a certain way, you must first behave and act in that exact way. I call this "trickle-down" behavior; and (2) build a sub-culture of leadership by developing current leaders and having a surplus of leaders who live and model the culture.

III. FOCUS ON PEOPLE, NOT PROCESSES: When your people are treated with dignity and respect and feel valued they will perform at levels that will surprise you. As a result, your processes will actually improve. Here is how you can begin to focus on your people right away: (1) define the value proposition. That is, define what the meaning of their work is. People love to know that what they do is actually making a difference; (2) create an exciting work environment. Find some things to do in your office or clinic that will make the atmosphere fun and enjoyable.

IV. SPEAK AS ONE: Every leader at every level must speak with one voice. Communication is key. The message from the top must be consistent and frequent. Your people need to know exactly what is going on and how to perform their jobs to your expectations. Speaking as one both limits confusion and allows everyone to be as productive as possible.

V. PROTECT THE CULTURE AT ALL COSTS: In a winning culture everyone acts and behaves in a way that supports the culture and helps to make it stronger. Protecting the culture requires that you: (1) build strong team relationships through training and development; and (2) incentivize those who refuse to fit into the culture to leave. Allowing someone to stay who does not fit the culture will have a negative impact on the rest of the team.

If you begin with these five essentials you will be well on your way to establishing and maintaining a culture in your office or clinic that will result in high morale and productivity among team members, greater levels of patient satisfaction, and overall greater success.

Robert Capobianco, MD, is a board-certified general surgeon with St. Cloud Medical Group, a multi-specialty medical group affiliated with St. Cloud Regional Medical Center. All providers are board certified or fellowship-trained in each of their specialties and are members of the medical staff. To set up a screening mammogram, call 407-498-3707 or visit www.StCloudRegional.com for more information on women's health services. For more visit StCloudPhysicians.com.

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Childhood Cancer: Why Does it Happen?

By LEENA KAMAT, MD

Interestingly, cancer is the second leading cause of death in children less than age 14 with accidents being number one. Childhood cancers make up less than 1 percent of all cancers diagnosed each year.

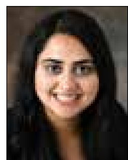
So why do cancers develop in young children and how is it different from adults? Childhood cancers are not strongly linked to lifestyle or environmental risk factors, which are often implicated in adult cancers. In adults, lifestyle-related risk factors, such as being overweight, eating an unhealthy diet, not getting enough exercise, and habits like smoking and drinking alcohol play a major role in many types of cancer. But lifestyle factors usually take many years to influence cancer risk, and they are not thought to play much of a role in childhood cancers.

In recent years, scientists have begun to understand how certain changes in the DNA inside our cells can cause them to become cancer cells. There are some genes that control when our cells grow, divide into new cells, and die. Genes that help cells grow, divide, or stay alive are called oncogenes. Genes that slow down cell division or cause cells to die at the right time are called tumor suppressor genes. Cancers can be caused by DNA changes that turn on oncogenes or turn off tumor suppressor genes. Some children inherit DNA mutations from a parent that increase their risk of certain types of cancer. But most childhood cancers are not caused by inherited DNA changes. They are the result of DNA changes that happen early in the child's life, sometimes even before birth. Every time a cell divides into two new cells, it must copy its DNA. This process isn't perfect, and errors sometimes occur, especially when the cells are growing quickly. This kind of gene mutation can happen at any time in life and is called an acquired mutation.

The most common cancers in children include leukemia, brain and spinal cord tumors, neuroblastoma, Wilms tumor, lymphoma, rhabdomyosarcoma, retinoblastoma, and bone cancer. Many cancers in children are found early, either by a child's doctor or by parents or relatives. But cancers in children can be hard to recognize right away because early symptoms are often like those caused by much more common illnesses. Symptoms may include an unusual lump or swelling, unexplained paleness and loss of energy, easy bruising, an ongoing pain in one area of the body, unexplained fever, frequent headaches, vision changes, or unexplained weight loss.

Childhood cancers are rare, and there are no widely recommended screening tests to look for cancer in children who are not at increased risk. Because of major treatment advances in recent decades, more than 80 percent of children with cancer now survive 5 years or more. Overall, this is a huge increase since the mid-1970s, when the 5-year survival rate was about 58 percent. Still, survival rates vary depending on the type of cancer and other factors.

The radiologists from Radiology Specialists of Florida at Florida Hospital are very well trained and experienced. We have radiologists specifically trained in pediatric imaging who use imaging techniques to diagnose abnormalities in children and assist with staging of cancer. We keep up to date on the latest technology and information so that we can offer patients the best care. The Florida Hospital Care Network delivers seamlessly connected healthcare services for all ages. For more information visit Somedaystartstoday.com.



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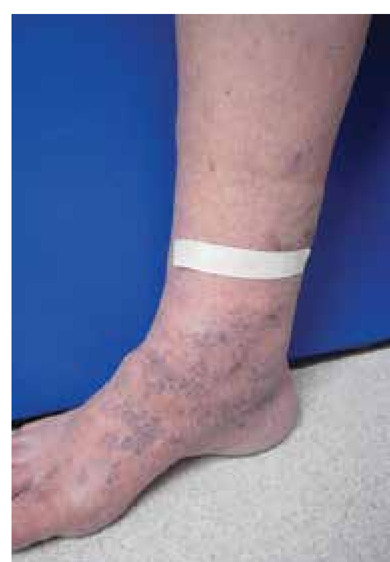
BEST PRACTICES

EVIDENCE-BASED STANDARDS OF CARE

Venous Disease/Pearls and Pitfalls in Recognition and Treatment

Venous disease is estimated to affect 25 million people in the United States. Venous ulcers, the most significant complication, affect approximately 500 thousand people. More than 2 million working days are lost each year and approximately 3 billion dollars is spent treating venous disease. In addition, venous disease is estimated to account for 1 to 3 percent of the total healthcare budget. Although venous disease cannot be avoided, greater awareness in the general population and especially among physicians can diminish the impact.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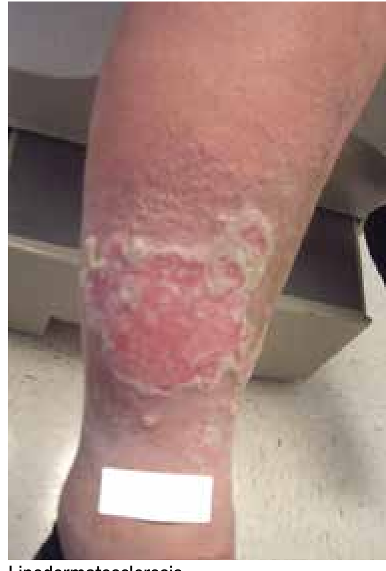

Lipodermatosclerosis

Risk factors include heredity, age, gender (females > males), hormonal (estrogen and progesterone), pregnancy, obesity, jobs with prolonged standing, trauma, and previous superficial or deep vein thrombosis. Graduated compression stockings are the first line of therapy for spider telangiectasias, ankle edema and skin changes, pregnant women, or those who have jobs that entail standing for prolonged periods of time. Patients sometimes complain they are hot or hard to get on, but we must be firm and tell them about the problems that can follow. Insurance companies often insist on 3 to 6 months of conservative therapy with compression stockings prior to approving any treatment.

The majority of patients with advanced skin changes have superficial venous valvular insufficiency. Many will also have perforator or deep vein involvement. Patients with peripheral arterial disease and/or significant type 1 diabetes must be treated cautiously. If pulses can't be detected, or the patient has ankle/arm index less than 0.5, compression is contraindicated. In patients with chronic swelling or pain in an extremity, obvious varicosities, or florid patterns of telangiectasia (spider vein), the vascular lab is the first step in the treatment algorithm. But, a word of warning, when a venous evaluation is ordered, most hospitals and diagnostic labs perform a test for venous thrombosis. One must specifically ask for an evaluation for venous insufficiency, and even then, most exams are inadequate. A study should be performed with the patient standing using valsalva and compression maneuvers to check for valvular reflux. The deep, superficial and perforator systems should be studied and reflux times should be noted along with the vein diameters. This exam reveals whether a patient has evidence of old deep vein thrombosis with scarring or obstruction. Therapy for superficial veins should not be undertaken if there is a significant obstructive component in the deep system. I see a large number of patients who have had a venous evaluation at an outside lab and 99% of these exams are inadequate for evaluation of venous insufficiency. Patients with severe type 1 diabetes or known arterial disease should have an arterial evaluation to rule out significant disease, which might contraindicate compression or venous therapy.

Early skin changes consist of pink to red discoloration which may be blotchy and dry (stasis dermatitis). The underlying tissue may be firm. These areas should be lubricated and massaged at least two times a day. With time, a darker brown discoloration develops and the tissue becomes firmer. This is referred to as a lipodermatosclerosis. The cause is inflammation, secondary to metalloproteinases, lymphocytes, macrophages, and red cells that traverse the capillary membrane because of the hydrostatic pressure of gravity. The brown discoloration is the result of red cell destruction with deposition of feratin. This tissue is very vulnerable to ulceration. Some patients will go on to develop lymphedema with swelling of the foot because the lymphatics in the lower legs are fibrosed by the inflammation. Flare ups of this tissue frequently occur with long periods of standing, and the tissue can become erythematous and even exude fluid. Sometimes this fluid has a scaly appearance or can even appear as a white exudare. It is important to recognize this as an exacerbation of stasis dermatitis, an inflammation, not cellulitis, an infection. In these times of concern about nosocomial and opportunistic infections, we must avoid using antibiotics for this condition. The erythema will often persist for weeks, and if left on antibiotics for that period of time, patients are vulnerable to fungal infections, MRSA, and clostridia difficil colitis. The best treatment is to focus on the underlying veins, but this takes time. Use of hydrocortisone cream, elastic compression, and elevation are bridge maneuvers. Biopsy of the skin should never be an option. The only place for a biopsy is at a site of long standing ulceration, or an ulcer, which is refractory to optimal therapy to rule out cancer.

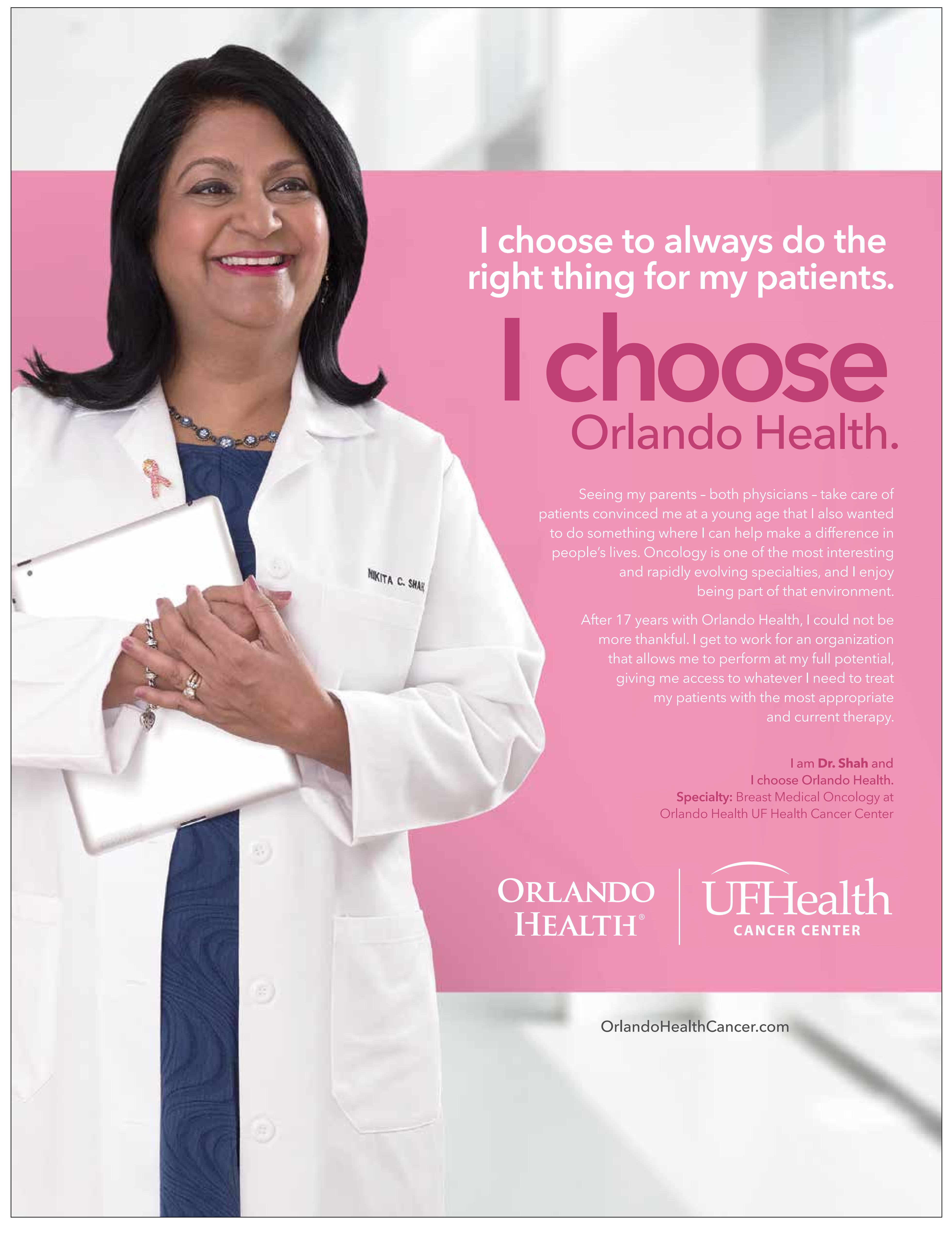
We must be aware of patient's complaints of aching, heaviness in the leg, and swelling as the day progresses. Varicose veins can lead to significant problems and should not treated as merely a cosmetic concern. Early attention can avoid later problems.

Venous Ulcer

Presented in Partnership by Orlando Medical News and Vascular Vein Centers

Dr. Hugo V. Hart

Dr. Hugo V. Hart is a board certified general surgeon with over 29 years of experience. He has been practicing in the Central Florida area for over 23 years and is currently on staff at Orlando Regional Medical Center and Florida Hospital. Dr. Hart is an active member of the American College of Phlebology, the society for vein professionals. Dr. Hart is an active member of the Hispaniola Medical Charity, the medical mission organization that has been established to provide medical care to the impoverished people in the Dominican Republic.



I choose to always do the right thing for my patients.
I choose
Orlando Health.
Seeing my parents – both physicians – take care of patients convinced me at a young age that I also wanted to do something where I can help make a difference in people's lives. Oncology is one of the most interesting and rapidly evolving specialties, and I enjoy being part of that environment.
After 17 years with Orlando Health, I could not be more thankful. I get to work for an organization that allows me to perform at my full potential, giving me access to whatever I need to treat my patients with the most appropriate and current therapy.
I am Dr. Shah and
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