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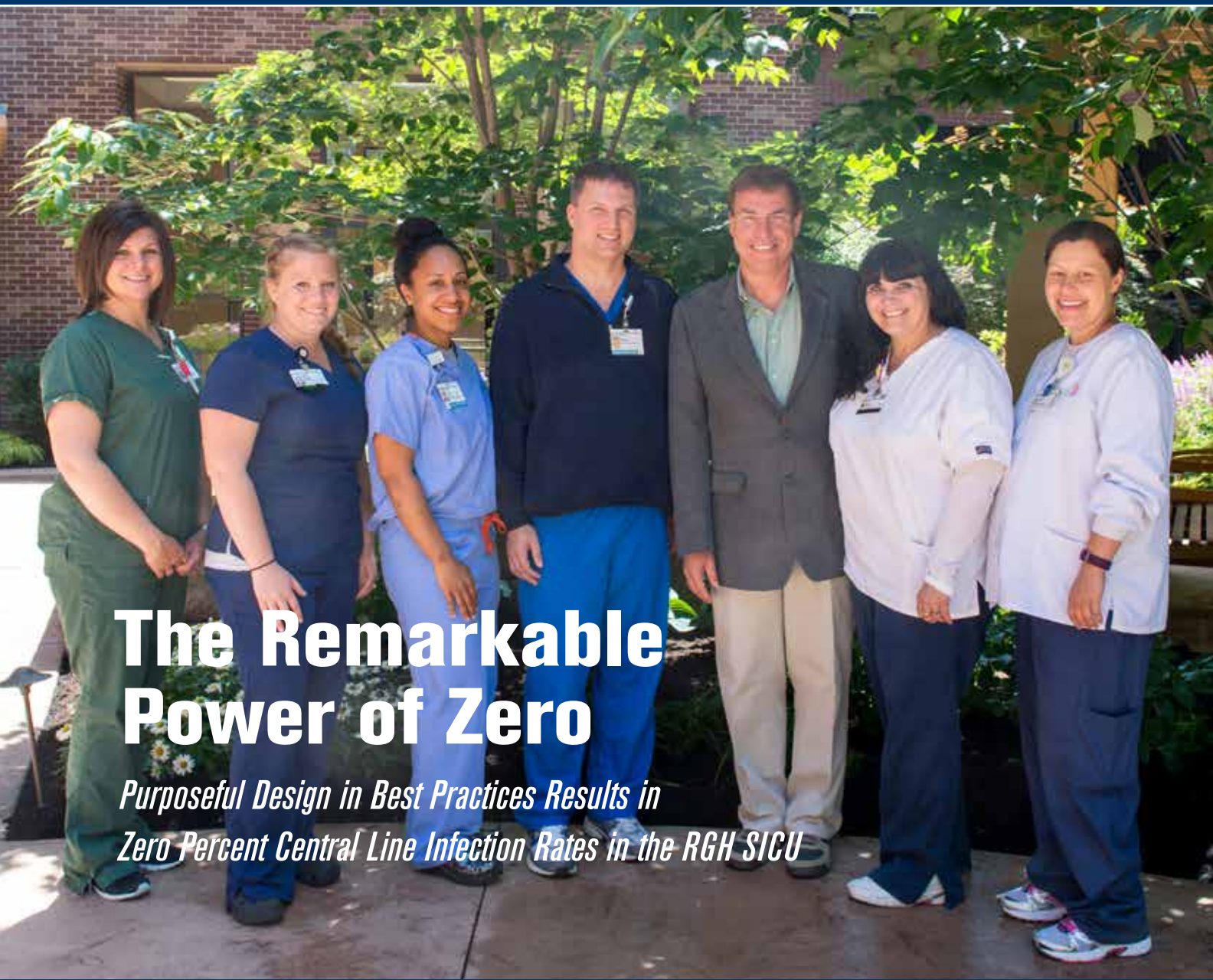

The Remarkable Power of Zero

Purposeful Design in Best Practices Results in Zero Percent Central Line Infection Rates in the RGH SICU

Health Meets Wealth Across the Generations

Skin Cancer Rates are on the Rise:
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Cover Photo: Lynne Tseng

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Welcome to Volume 3 of Western New York Physician where you will find informative stories and articles about and for physicians in western NY.

Each year, an estimated 30,000 patients will develop a central line associated bloodstream infection (CLABSI) while recovering in an ICU or acute care facility in the U.S. With mortality rates of 18-25% and an approximate price tag of $40,000 per infection, prevention of CLABSI has become a National Patient Safety Imperative.

Rochester Regional Health System has recently emerged as a national leader in CLABSI rate reduction; most notably with its most fragile patients in the Surgical Intensive Care Unit (SICU.) Under the direction of Dr. James Szalados, the RGH SICU has achieved a Zero percent infection rate for four years running.

Looking ahead at some of the stories under development:

- Cancer Care in Western NY – The latest in Diagnostics and Treatment
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- Medical Marijuana – Expert Opinions and Discussion
- Expert Discussion - Financial Strategies to Chart Your Course

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Sharing your expertise is a valuable way to communicate with your medical colleagues. If you would like to be a part of an upcoming story or wish to submit an article, please email or call me to discuss timing and submission criteria. In the meantime, please enjoy the numerous other articles within the issue.

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In good health –

Andrea

Andrea

Western New York
PHYSICIAN

THE LOCAL VOICE OF
PRACTICE MANAGEMENT AND
THE BUSINESS OF MEDICINE

PUBLISHER
Andrea Sperry

CREATIVE DIRECTOR
Lisa Mauro

WRITER
Jenn Bergin

PHOTOGRAPHY
Lynne Tseng
Department of Surgery
Rochester Regional Health System

CONTRIBUTORS
Jenn Bergin
Cindy Lapoff
David M. Privitera, MD
Alok D. Gandhi, DO
Kim K. Petrone, MD
Pamela C. Smith, EdD, RN
Craig R. Sellers, PhD, RN
Elizabeth Hughes, FNP, DNP
Michael J. Schoppmann, Esq

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WNYPhysician@gmail.com
Phone: 585.721.5238

Reverse Total Shoulder Replacement
An Advanced Approach for Patients

Q & A with Dr. David Privitera

Q. *What are some of the more common issues you see affecting the shoulder joint?*

A. I see a wide spectrum of shoulder disorders in patients of all ages. Since I typically see patients as young as 15 and my oldest being 95, diagnoses tend to cluster by age groups. In the younger population, I often see shoulder instability—anterior, posterior, and multidirectional. These problems are often accompanied by labral tears, capsular laxity or collagen laxity. Additionally, I see AC (acromioclavicular) joint injuries, commonly referred to as "shoulder separations" in many contact athletes. In the middle-aged weekend warriors and the actively retired, I more commonly see rotator cuff tears and flare-ups of AC arthritis from repetitive overhead activities. In the older population, tendons degenerate, cartilage breaks down, and bones become osteopenic/osteoporotic. In this 65-70+ age group I more commonly see arthritis in two forms: standard glenohumeral arthritis and rotator cuff arthritis/arthropathy. The difference is the position of the humeral head within the glenoid. In regular glenohumeral arthritis, the rotator cuff is functional and keeps the humeral head down, generally centered within the glenoid. Whereas, rotator cuff arthropathy occurs when a large chronic rotator cuff tear cannot keep the humeral head depressed and centered within the glenoid, so the overpowering deltoid causes the humerus to migrate proximally, causing wear of the superior glenoid and inferior surface of the acromion. Proximal humerus fractures are a common fragility fracture due to a fall with underlying osteopenia/osteoporosis. I frequently see these fractures referred from the ER or urgent care.

Q. *How is the Reverse Total Shoulder Replacement (TSR) approach different from Conventional TSR?*

A. The Reverse TSR (commonly referred to as "the reverse") was approved for use in the United States by the Food and Drug Administration in 2004. Despite this relatively recent release, it has been around for decades, used widely throughout much of France and other areas in Europe. Concerns for early failure led to a slow acceptance in the United States. As the implant design improved, the US allowed its use as early as 1998 for custom prostheses.

The conventional TSR predates the Reverse and aims to restore the normal anatomy by replacing the arthritic humerus with a ball prosthesis, and the arthritic glenoid with a socket implant. A conventional shoulder replacement is used for surgically treating glenohumeral arthritis and its success relies on an intact rotator cuff. The Reverse replaces the anatomy of the ball-and-socket to be a socket-and-ball in order to create a mechanical advantage. In the Reverse replacement, instead of being replaced with a ball, the humeral head is converted into a socket, and the glenoid becomes the ball (called a glenosphere). By reversing the anatomy, the shearing forces of the proximal migration of the humerus caused by a deficient rotator cuff compresses the socket into the well-fixed glenosphere creating a rotational force that allows for forward elevation with an intact deltoid muscle. This motion is possible because the Reverse is a semi-constrained device. The depressing, stabilizing force of the rotator cuff is no longer required for forward elevation. Specifically, patients without a functioning supraspinatus, subscapularis, or part of their infraspinatus rotator cuff tendon/unit can have excellent overhead functional motion and pain-relief. The teres minor and part of the infraspinatus is still needed for rotational elevation that allows patients to touch the top of their head. The disadvantage of the prosthesis is that since it is a more constrained device, it creates higher stresses and forces at the bone/implant junction. Lifting a 20lb weight with a reverse total shoulder puts a lot more force at the bone/implant junction than a convention shoulder replacement, and therefore heavy lifting can cause the Reverse to prematurely loosen.

Q. *Is this approach becoming the new gold standard or is this approach indicated in certain patient types?*

A. The literature is showing that the Reverse Total Shoulder Replacement is an excellent and often superior option compared to alternative surgical interventions for many specific shoulder disorders in an older, lower-demand patient population. Within the patient population, the Reverse TSR is a great option for patients with rotator cuff arthritis/arthropathy, some types of 3-4 part comminuted proximal humerus fractures, a failed prior shoulder replacement, large irreparable rotator cuff tears, and other select circumstances with a functioning deltoid muscle. The Reverse is not an ideal prosthesis for younger patients, heavy laborers, or those patients leading a high-demand, heavy lifting lifestyle. Once the Reverse implant loosens within the bone, sometimes it can be revised again if there is enough bone stock. However, often the bone stock can be insufficient for revision. Salvage revision options include conversion to a hemiarthroplasty or removing the prosthesis—a resection arthroplasty. Both of these last two options are not optimal options for an active patient, so the Reverse is often saved for older patients. Ten year implant survivorship (measured by need for a revision surgery) is recently being published around 85-90%. General age recommendations are 65-70 years and older. However, this is not a strict guideline. The appropriateness of the implant and consideration for other treatment options are made on a case-by-case basis.

Q. *What are the benefits to the patient with regard to outcomes, recovery and rehabilitation?*

A. The average patient with rotator cuff arthropathy will have better pain relief and better overhead motion with a Reverse when compared to a hemiarthroplasty. Similarly, in patients with certain comminuted proximal humerus fractures, the Reverse will more

Dr. David Privitera and Mike Stanton, PA performing a Mini Open Rotator Cuff Repair.

consistently provide better active range of motion when compared to a hemiarthroplasty for fracture. This is due in large part to the fact that tuberosity healing is less critical for a good outcome in a Reverse, whereas having a good outcome with a hemiarthroplasty is reliant on tuberosity healing and rotator cuff function. The Reverse is also a better option for a patient with glenohumeral arthritis with a large rotator cuff tear, offering significantly better pain relief, active range of motion, and lower revision rates than previous attempts at treating these patients with a conventional total shoulder.

Collaboration between the surgeon and physical therapist is essential to ensure appropriate postoperative management. Factors that can affect the postoperative rehabilitation include: the indication for Reverse (ex: for fracture vs. rotator cuff arthropathy), glenoid and humeral bone quality, type of implant used, integrity of the remaining rotator cuff, and concomitant rotator cuff or tendon transfer (for external rotation deficiency). In general, patients can expect to regain in excess of 105 degrees of forward flexion/elevation, often up to 140 degrees. Many surgeons, including myself, place dislocation precautions on patients for a Reverse which includes avoiding adduction, extension, and internal rotation. Simply, this means making sure the patient can see their elbow, including avoiding activities such as tucking in the back of their shirt and bathroom hygiene with the operative extremity. Due to the constraint of the device, many surgeons ask patients to avoid lifting greater than 10-15 pounds with the upper extremity, to avoid overstraining the structural integrity of the prosthesis to prevent premature failure.

***Q.** What drew you to specialize in orthopaedics and further to subspecialize in shoulder reconstruction?*

A. My decision to pursue orthopaedic surgery was a culmination of life experiences and interests that naturally fit well with medicine and orthopaedic surgery. I was an athlete in high school and tore my ACL and meniscus. I had my ACL reconstructed and meniscus repaired and had an excellent result, giving me an early exposure to the field of orthopaedics. As a Biology-Physiology major and psychology minor, I loved the science and humanism of medicine. In college, as a personal trainer I enjoyed the dynamic intricacies of the musculoskeletal system. In medical school I gravitated toward anatomy, surgical techniques, and diagnosing and treating musculoskeletal disorders. I enjoyed the mix of radiology, surgery, the orthopaedic patient population, taking ownership of the musculoskeletal system from nonsurgical to surgical management, and contributing to the orthopaedic literature. Once I knew orthopaedics was my career choice, I selected my sub-internship while at Columbia to be on the Shoulder and Sports Medicine Service. On this rotation, I received unparalleled didactical training. I was drawn to the complexity and variety of shoulder disorders, and had the privilege of observing Dr. Louis Bigliani—a pioneer in shoulder surgery—performing one of the early Reverses in the country. Since then, I have been very fortunate to be mentored by shoulder replacement experts throughout medical school, residency and fellowship. As a surgeon it's important to know the limits of what a surgery can offer and to set realistic expectations for patients. There is nothing as good as your own functioning anatomy. Customized physical therapy routines, therapeutic injections, rest and NSAIDs and other nonoperative treatments can solve a lot of shoulder problems. For when these measures fail, surgery can be an excellent option to restore function. Whether its minimally invasive arthroscopy to open shoulder reconstructions with a tendon transfer, orthopaedic surgery is an exciting, constantly evolving field and I am quite fortunate to be a part of it.

Dr. Privitera earned his MD from Columbia University College of Physicians and Surgeons and completed his residency in orthopaedic surgery at the State University of New York at Buffalo. He subsequently completed a fellowship in sports medicine at Harvard Medical School, Brigham and Women's Hospital, where he cared for high school, college and professional athletes.

In the course of this fellowship he received subspecialty training in complex shoulder, hip, and knee arthroscopy. He also received extensive training in total and reverse total shoulder replacement, shoulder fractures, and complex shoulder instability. At the pioneering forefront of biologic joint preservation, he is also well-trained in cartilage transplant, autologous chondrocyte implantation, and corrective osteotomies for the treatment of cartilage injury and early arthritis in the active patient.

Dr. Privitera's practice specializes in shoulder reconstruction and sports medicine, including joint preservation procedures.

The Remarkable Power of Zero

Purposeful Design in Best Practices Results in Zero Percent Central Line Infection Rates in the RGH SICU

by Jenn Bergin

Dr. James E. Szalados, Director of Surgical Critical Care and the SICU.

Indwelling vascular catheters are often necessary for patient care. Hospitalized patients may require intravenous access for fluid and medication administration, nutritional support, dialysis, chemotherapy or hemodynamic monitoring. The Joint Commission estimates that 300 million vascular catheters are used each year in the United States. Nearly 3 million of these are central venous catheters (CVCs), also known as "central lines." CVCs are placed into larger veins that can handle larger volumes of fluid, are less susceptible to irritation from medications or concentrated nutrients, and are necessary for complex hemodynamic monitoring.

Dr. Szalados and his team in the RGH SICU at bedside patient rounds.

Healthcare-associated infections (HAIs) affect 4 to 5 percent of patients hospitalized in the U.S. each year – meaning that approximately 1 of every 25 hospitalized patients in the U.S. will develop an HAI, which equates to 650,000 patients annually. Central line-associated bloodstream infection (CLABSI) represents one important cause of HAIs. Although any catheter can introduce bacteria into a patient's bloodstream, CLABSIs are one of the most deadly and costly HAIs, according to the Institute for Healthcare Improvement. A CLABSI is a primary bloodstream infection in the presence of a CVC central line, identified 48 hours or more after a catheter was placed, with no other evident source for the blood infection.

The Society for Critical Care Medicine (SCCM) estimates that more than 5 million patients are admitted annually to ICUs in the U.S. On average, 50 to 75 percent of critically ill ICU patients receive a central line, and many are already at high-risk for infection or complication because of the complexity of their injuries and pre-existing diseases. According to the Centers for Disease Control (CDC), more than 30,000 CLABSI infections occur in ICUs and acute care facilities across the U.S. annually. The mortality associated with a CLABSI ranges from 18 to 25 percent, and therefore almost one out of every four patients who develops a CLABSI during their hospitalization will not survive. CLABSIs are also expensive, costing as much as $40,000 per infection. Thus, the prevention of CLABSI infections has become a National Patient Safety Imperative, led by the Agency for Healthcare Research and Quality (AHRQ), the CDC, the National Quality Forum and the Centers for Medicare and Medicaid Services (CMS).

Despite the sobering national statistics regarding CLABSI infections, Rochester Regional Health System has emerged as a national leader in CLABSI rate reduction – surpassing benchmarks even where risk of CLABSI has traditionally been the greatest – in the Surgical Critical Care Unit (SICU) at Rochester General Hospital. Elimination of CLABSIs reflects a high quality of care, therefore the Unit's zero-percent central line infection rate – maintained over four consecutive years – means that the SICU at RGH competes nationally with the best healthcare institutions.

"CLABSIs are, for the most part, a preventable complication," says Dr. James Szalados, director of the SICU at RGH. "We are determined to continue our quality focus on CLABSIs, and other HAIs. Because our patients in the SICU are so highly complex and vulnerable, we are dedicated to treating and protecting them, and to seeing them through their hospitalization as safely and expeditiously as possible and without complications." The RGH SICU's record of achievement did not happen by accident, and Dr. Szalados credits his multidisciplinary team with the Unit's success.

PERSISTENCE IN BEST PRACTICES

"We have identified and developed best practices which we consistently and universally use in every patient intervention," Dr. Szalados says. "Each member of our team is a dedicated and focused professional – including our support staff, patient care technicians, our respiratory and physical therapists, pharmacist, nutritionist, the critical care nurses, advanced practice providers, and, our attending physicians."

The Unit strictly adheres to protocols, checklists and standardized procedures, treating the process of central line insertion as a surgical procedure. The process of CVC line insertion begins with communication and a plan; the teams agrees that the procedure is necessary, obtain the necessary supplies and equipment, and obtain consent. The patient is readied by the nursing team and positioned and prepared as if they are having surgery. The team adheres to strict hand-washing and sterile technique: the provider(s) performing the procedure wear a surgical mask, surgical hat, surgical gown and sterile gloves; every team member in the room wears a surgical mask and surgical hat. The patient is then again prepped and a head-to-toe surgical drape is used to create a sterile surgical field. Spotters in the team watch closely for any potential breach in sterility, and if this occurs, the process begins again from the start.

Dr. Szalados notes that "the cost of supplies is trivial compared with the emotional and financial cost of a CLABSI." The procedure is completed with the use of ultrasound guidance to localize the target vein at every step of the procedure, so as to minimize the number of skin punctures, and to minimize the risk of catheter malposition or injury to surrounding structures. The strict principles of sterile technique remain in place from before line insertion through dressing application and then regularly in every instance of catheter access by the nursing staff and in regular dressing and catheter care. Nurses are essential to the elimination of CLABSIs because they respect the sterility of the catheter and understand the importance of sterile technique in every encounter; nurses wear masks and sterile gloves every time a catheter dressing is changed and use clean the access ports with alcohol before and after every use. Finally, the team evaluates the need for each and every catheter daily; catheters deemed no longer essential are removed as soon as possible.

"Ours is a reproducible model," Dr. Szalados says. "Hospitals which have a CLABSI problem need to take a close look at their processes; they are likely to find that at some critical point they have a breakdown in one or more elements of their process."

IT TAKES A TEAM

"The level of ownership for the outcomes that we have demonstrated is so important," Dr. Szalados says. "The SICU at RGH is successful because we have a dedicated and skilled team. The ICU attendings and physician assistants have performed thousands of these procedures. When we are teaching the procedure to visiting providers, residents or students – it is strictly supervised. Not only is every one of us under the scrutiny of the team when we perform these procedures, but if someone is doing it for the first time, a SICU expert is right there, holding their hand, adhering to best practices every step of the way."

IT'S ALL ABOUT THE PATIENT

"The purpose of our team is to provide the best possible medical treatment to each patient" Dr. Szalados says. "Delivering the highest quality of patient care is the focus of everything we do." The SICU daily routine consists of a multidisciplinary team of specialists who bring their expertise to assess and reassess each complex patient's individual needs on, at the very least, a daily basis. "Every patient deserves individualized care; when it comes to catheters and tubes or drains, we reassess the need for every device, to ensure that the patient's best interest drives our decision-making," Dr. Szalados says. "In my experience, I have seen too many instances where a catheter is kept in place for convenience. But not in this ICU – if it's not necessary, it dangerous and it comes out."

"The risk of a CLABSI infection increases incrementally with each day the catheter stays in place," he explains. "Every member of our team is empowered to ask and question: What catheters does this patient have? What risks in this individual do we need to address? What are we doing that increases the patient's risk and what can we do to minimize them?

As the director of the SICU, Dr. Szalados has driven a culture of teamwork and continuous team learning. "We are always looking for a better way to do routine things and we have generated a true atmosphere of passion for what we do – with professionalism, caring and compassion," he says. "Some people lead by fear, I hope to lead by inspiration."

COMMITMENT TO A CULTURE OF SAFETY

"Quality of care is led by organizational leadership," Dr. Szalados says. "It comes from the top of our organization. I know I have the commitment and support of the hospital medical and administrative leadership to get the resources we need to get best outcomes possible."

He celebrates the success of the RGH SICU and strives to keep up the momentum. "We want to expand it to everything we do, any device that could cause a complication," Dr. Szalados says. "This is only one of the ways that Rochester Regional is demonstrating our commitment to excellence – there is more to come."

WHAT BETTER CARE MEANS TO THE BOTTOM LINE

"Improved quality of care is in everyone's best interest," says Jim Redmond, regional vice president of communications at Excellus. "Part of our fundamental mission is to make sure that patient's have access to safe, quality care at an affordable price. Measures that help to control overall cost help to guarantee that more patients do."

Forty-five upstate New York hospitals and health centers earned $2.6 million in quality improvement incentive payments last year from Excellus BlueCross BlueShield as part of the health insurer's Hospital Performance Incentive Program (HPIP), which was launched in 2004. Incentives have exceeded $197 million over the past 10 years. Areas targeted for improvement include clinical processes of care, patient safety and patient satisfaction.

"The program is aimed at improving quality of care," he says. "We applaud our hospital partners for their willingness to collaborate on improving health outcomes and patient safety. Connecting those outcomes with financial incentives drives focus to our mutually agreed upon goals. This focus results in fewer readmissions, a decrease in mortality rates and enormous savings to hospitals and insurers," he says. "But the emotional savings are the greatest reward."

In 2010, New York State reported approximately 108,000 HAIs, including 24,000 in upstate New York. Over 5,000 of these infections resulted in death. If upstate New York hospitals could lower the number of hospital-acquired infections by just 20 percent, there would be 5,000 fewer infections and 200 fewer associated deaths annually, according to an Excellus BCBS report. That would save upstate New York hospitals an estimated $68 million annually – and more importantly, save lives.

"There's more than one way to measure cost," Dr. Szalados says. "The first mark of success is that the patient has an improved quality of care which in turn, improves quality of life. That's the true bottom line."

Elizabeth Varland, R-PAC placing a right internal jugular central venous catheter using sterile surgical technique in the RGH SICU.

Health Meets Wealth Across the Generations

Cindy Lapoff, Legal and Regulatory Consultant, Manning & Napier

As health care spending has grown to represent a larger portion of the overall economy, and in turn a larger portion of employers' and employees' budgets, the wealth effects of health spending have become clear. For employers, plan design strategies have been converging as health and retirement plans have both moved to a defined contribution approach, with employers capping their contributions to the plans and employees bearing responsibility for funding a larger portion of both their health care expenses and their retirement income.

Participants at all life stages will need to create a strategy for funding their retirement that includes the cost of health care.

The strategy will need to be flexible enough to accommodate the unexpected twists and turns that life can take. Health care costs can be hard to estimate over the long term and are dependent on many personal characteristics, but for most, the costs are likely to be significant. For example, according to EBRI Issue Brief No. 400 (June 2014), a married couple age 65 in 2013 with median drug expenses is estimated to need approximately $151,000 to have a 50% chance of meeting their retirement health care costs and approximately $255,000 to have a 90% chance.

Planning for the expected is important; planning for the unexpected is vital. While monthly financial needs are relatively predictable, future retirees will need help planning for the unpredictable, potentially significant expenses that are likely to come in retirement. Their retirement savings will need to last longer, and grow more, than any previous generations'.

Setting specific goals and creating a definite financial plan to meet those goals is crucial to the success of participants at all career stages. In this context, understanding the health care implications of various retirement decisions is more important than ever.

The Boomer Breakdown

10,000 people ("baby boomers") will turn 65 every day for the next 20 years. Surveys tell us that baby boomers want to work - or have to work - during retirement but would like less stressful jobs and fewer hours per week. They want to do work that is personally fulfilling. They can expect to live longer than their parents. They want to stay in their homes and out of institutions. They want to start their own businesses. Boomers have big plans for their retirement years, but even the best plan can be derailed by health events, the death of a spouse, the earlier-than-expected loss of a job, the inability to find suitable work, the financial failure of a startup business, or the financial needs of family members.

Generation X and The Millennials

Generation X and the Millennials will have an entirely different set of choices by the time they are ready to retire. Someone who expects to retire in 20 or 40 years will face a much different world than someone planning to retire in the next five or ten. The later retiree will be responsible for funding more of his or her own retirement, including health care costs, than previous generations. Social Security benefits will probably be lower. If traditional pensions still exist anywhere, they will likely offer variable benefits, and a stronger emphasis will be placed on defined contribution accounts. With the financial challenges faced by Medicare, individuals will be responsible for a greater share of their health care expenses. Some estimate that a couple retiring in 32 years will need 190 percent of their social security benefit to cover health care costs. Clearly Millennials and Generation X will need to be informed health care consumers to avoid wasting dollars they cannot afford to lose.

As employers have shifted more of the costs for health insurance to employees, employees have had a harder time sustaining or increasing their retirement plan contributions. According to the 2013 Workplace Benefit Report published by the Bank of America Merill

Lynch, 56% of employees indicated that their health care costs were having a negative effect on their ability to save for retirement. Planning for rising health costs is a must. New tools and approaches for plan sponsors can help improve participant outcomes across the generations.

Health Savings Accounts Appeal to Multiple Generations

A high-deductible health plan (HDHP) paired with a health savings account (HSA) is increasingly popular with younger employees who do not have extensive health care needs.

Enrollment in HSAs has been growing steadily each year since their inception in 2004 and has nearly doubled in the last five years. A primary driver of this growth is the triple tax advantage HSAs afford: Contributions made to an HSA, by employees or employers, are not subject to federal or state income taxes (in most states) or to FICA tax. Investment earnings accrue tax- free, and withdrawals for qualified medical expenses are tax-free. Employees own the accounts, allowing for portability and carry-over of unused balances from year to year and into retirement for funding retiree health care expenses. After age 65, the HSA account may be used to pay Medicare premiums, which are a significant source of the overall cost of health care in retirement.

To be eligible to contribute to an HSA, an individual must be enrolled in an HDHP with minimum deductibles of $1,300 for an individual and $2,600 for a family. HDHPs typically have lower premiums than traditional plans. Contributions to HSAs in 2015 are limited to $3,350 for an individual and $6,650 for a family. Participants age 55 and older are eligible to make a $1,000 catch-up contribution each year. The account may be invested at the discretion of the employee. The employee is responsible for ensuring that the expenditures from an HSA are medical expenses within the definitions provided by IRS; the plan sponsor is not involved in claims processing.

Using an HSA, a younger/healthier member can opt for a lower premium and save the balance in his account for future medical expenses or for retirement. An older member who is closer to retirement can fund the account to cover anticipated out-of-pocket costs and premiums that would otherwise be paid out of his or her monthly income in retirement. Depending on how much of the account is needed for health expenses while active, savings in an HSA may be an important source of funds for medical expenses in retirement.

Plan sponsors may also consider providing decision tools and services to participants to help them make good health plan choices, whether they are retirees or active employees. Choosing a plan on a public or private exchange can be a daunting task. A participant may be presented with a wide array of options, and lack the understanding of how to choose among them. A similar issue is presented with retirees who must enroll in Medicare plans. As choices expand, services that help participants and retirees identify the right options will become more necessary.

The health-wealth convergence, together with the generational shift that is underway with the retirement of the baby boom generation, is changing employee expectations and altering the benefits landscape more significantly than at any other time in recent history. Plan sponsors must adapt to the changing environment in order to meet their goals and increase the plan's chance of success.

OBESITY

Dr. Alok Gandhi performing a laparoscopic sleeve gastrectomy.

Obesity is one of the biggest drivers of preventable chronic diseases and healthcare costs in the United States. Currently, estimates for these costs range from $147 billion to nearly $210 billion per year according to a recent report Trust for America's Health – The State of Obesity funded though the Robert Wood Johnson Foundation.

In 2014, a shocking 25.8 million Americans were diagnosed with Diabetes. 75 percent of all hypertension cases are attributed to obesity and an unfortunate 33 percent of all cancer deaths are linked to and complicated by obesity and the increasingly common inactive American lifestyle.

Related conditions include heart disease, stroke, type 2 diabetes and certain types of cancer, some of the leading causes of preventable death. As the numbers of obese and overweight American's skyrockets there will be a greater pressure on the need for prevention and cost containment.

What trends are your practice seeing in its patient makeup and are these trends unique to western NY?

Nationally, it is widely reported that less than 1% of patients eligible for bariatric surgery seek or pursue this option. There are several barriers to explain this: burdensome insurance prerequisites, social stigma associated with both the diagnosis of morbid obesity and having a bariatric procedure, challenges of discussing obesity with patients by health care providers, and rising insurance deductibles.

Recently, there have been several noticeable trends.

A number of high profile public figures have come forward to share their struggle with obesity and their weight loss surgery stories. These politicians, Hollywood celebrities, journalists and radio personalities have shed light on the obesity epidemic, which crosses all educational, cultural and socioeconomic barriers. It is a disease inspired by the perfect storm of genetics, environment, lifestyle, behavior, and pre-existing medical conditions. This has raised public awareness and has allowed people to seek more information on bariatric surgery and self-referrals.

The increasing number of referrals from our medical and surgical colleagues is supported by the multitude of studies being published in the medical literature validating the positive long term benefits of bariatric surgery on both weight loss and related medical co-morbidities.

What are some of the most promising new therapies available to help patients control their weight?

The pharmaceutical and device manufacturing industries are heavily invested in obesity research. This is a logical investment from their perspective when you take into account 1 in 3 Americans are either overweight or obese.

The bench research in obesity must be supported as we continue to learn the complexities of this disease. This research continues to influence not only the procedures we perform today but also shapes the future and the long term treatment of this disease. We know that obesity is a multifactorial disease and multifactorial problems require a multifactorial solution. This is one of the areas of surgery which is dynamic.

Currently, there are several medications that have FDA approval for short-term use in the treatment of obesity, in conjunction with a supervised program. While they seem to show very modest reduction in weight, they have not been shown to be effective in the long-term remission of weight and obesity related comorbidities. However, due to the public health epidemic of obesity, even the slightest reduction of weight is considered to be beneficial. Most of these medications are not insurance- covered.

Additionally, there are several products in the experimental or clinical trial stages such as the intra-gastric balloon and endoluminal barriers that are being tested to bridge high-risk patients to eventual definitive surgical treatment.

Bariatric Surgery OR group. From L to R: Alok Gandhi, MD, Jane Reinard, RN, S eth Doser, Amanda Anderson, RN, Megan Kellen, PA and Frank Catanzaro, MD.

At what point does bariatric surgery become a viable option? Please describe how your team approaches a new patient.

Bariatric surgery is an option for patients with BMI > 35 with co-morbidities (e.g. hypertension, type 2 diabetes, dyslipidemia, obstructive sleep apnea, etc) or BMI > 40 with or without comorbidities who have been unable to achieve and maintain weight loss and/or comorbidity resolution through other means such as supervised diet, exercise programs or pharmacotherapy.

The literature is clear – only 1% of patients maintain weight loss after diet/exercise programs after 5 years out. Bariatric surgery has been shown to be an intervention that can achieve, and maintain, long term weight loss and improvement of weight-related medical and metabolic conditions such as type 2 diabetes, high blood pressure, high lipids and sleep apnea.

What we also know that a bariatric surgical procedure by itself does not assure long-term success. Bariatric surgery, combined with nutritional, psychological, exercise and teaching in a multidisciplinary program has been shown to improve not only weight loss, but maintenance of weight loss long-term compared to those patients who are not offered such a program. Like spokes on a bicycle tire, all these factors must be present in equal proportion to ensure a round tire that will be able to go the distance. The foundation of this, of course, is excellent surgical technique and care.

What is new in the way of surgical approaches or instrumentation and what are the benefits to the patient?

I find bariatric surgery to be an exciting and dynamic field of medicine. While variations of weight loss procedures have been performed since the 1960s, we continue to change and modify our procedures as we learn more about the physiology of obesity. Another aspect of bariatric surgery is that there are several surgical options that exist for patients seeking help. We have to understand the patient: their current weight and history of their weight gain, their metabolic issues, lifestyle, socioeconomic factors, expectations and risk tolerance in order for us to tailor a surgical treatment plan for them.

The trend in bariatric surgery has been the movement towards the creation of more physiologic pylorus preserving operations (eg. sleeve gastrectomy, duodenal switch). These operations are minimizing some of the previously seen complications of gastric bypass surgeries such as ulcers, the inability to take certain medications such as NSAIDS, reactive hypoglycemia after meals and food intolerances to certain foods like meat.

Sleeve gastrectomy is a procedure that has become the most commonly performed bariatric operation worldwide, as well as in the United States. It combines the benefits of weight loss - averages about 60% excess weight loss - in a fairly predictable fashion with a safety profile that exceeds other common operations such as gallbladder or joint surgery. This operation can also used as a first step procedure in managing very high-risk patients. Patients today often come to our practice seeking this procedure.

The medical costs for people who are obese are significantly higher than those of normal weight patients. Under Accountable Care, what particular challenges do you project in managing the health and cost of care of the obese patient and how is your practice poised for successful management?

Health care systems, the government and insurance carriers are all seeking ways to reduce health care costs while efficiently delivering quality care to their assigned population.

At this time, assessment of the quality of healthcare that is being delivered are associated to variables that can be tracked by computers, statisticians, politicians and administrators. Such variables include performance thresholds for the management of diabetes, high blood pressure and other common diseases associated with morbid obesity. In order to deliver high quality of care to patients, as well as to meet these variables known as quality measures, physicians will have to not only improve care coordination amongst the various specialties, but also find a way to improve patient participation/engagement. Currently, the burden rests entirely on healthcare providers to meet these measures, but until patients are incentivized to be a willing participant, the outcomes may potentially fall short of the intended goal. All the parties must have the same aligned commitment to be successful.

From a bariatric perspective, studies have gone beyond demonstrating just the medical benefit of these procedures. They have validated the return on investment on these procedures with significant cost savings by reducing the frequency of medical visits, the reduced pharmacy costs as medications are frequently discontinued after these procedures and reduction in the frequency of overall healthcare costs as risks of certain cancers, cardiovascular and pulmonary issues, orthopedic sequelae and gynecological issues are decreased after bariatric surgery.

The implementation of healthcare reform mandates is a slow process as we try to translate flowcharts to practical delivery; the keen and savvy healthcare systems will harness bariatric and metabolic surgery and expedite its role in the algorithm in population based health care delivery.

Alok D. Gandhi, DO, FACOS, FASMBS is a board certified, fellowship trained surgeon specializing in bariatric surgery.

A New York City native, he has been serving the surgical needs of Western New York since 2008 as a bariatric surgeon at Rochester Regional Health System.

He completed an internship and residency at St. Barnabas Hospital and a bariatric surgery fellowship at the University Medical Center at Princeton. He was elected to the Board of Trustees serving in the New York Chapter of the ASMBS by his fellow New York bariatric surgeons since 2010. In addition, serves on several local and state committees focused on improving access to quality healthcare.

Skin Cancer Rates are on the Rise: Prevention and Treatment Approaches

A Conversation with Dermatologic Surgeon, Dr. Sherrif Ibrahim

By Elizabeth Hughes, FNP, DNP

As we move into the summer months in Western NY, talk turns to preventing sun damage in an effort to reduce the risk of skin cancer. We complain about the lack of sunshine in our part of the world, yet the incidence of skin cancer is increasing here and across the US. One in five people will be diagnosed with skin cancer in their lifetime. "Our aging population is a factor in the increasing rates of skin cancer. People become more susceptible simply due to a lifetime of sun exposure and their cumulative UV dose. We are also seeing an increase in UV light exposure from the sun and tanning beds in younger patients," says Dr. Sherrif Ibrahim of the University of Rochester Medical Center. Dr. Ibrahim is a skin cancer specialist who performs Mohs micrographic surgery, a highly effective treatment for skin cancer.

One in 4 skin cancers are treated with Mohs surgery, a highly effective procedure for both basal cell and squamous cell carcinomas. These two types of non-melanoma skin cancers account for about 95% of all cases. The Mohs technique, first introduced in the 1930's, is used primarily for head and neck lesions and other cosmetically sensitive anatomic locations. The surgeon excises the lesion in a thin layer and then immediately examines the margins while the patient waits. Once the margins are clear, the patient then undergoes reconstruction of the site. This technique spares as much healthy tissue as possible, creating the best cosmetic result and the highest cure rate.

The three most common types of skin cancer are basal cell carcinoma, squamous cell carcinoma and melanomas. All are curable if diagnosed early. Basal cell carcinomas, the most common form of skin cancer, are slow growing and can appear as a pearly white papule. They rarely metastasize beyond the original site but can be disfiguring and locally destructive if not treated. Squamous cell carcinoma can appear as erythematous, scaly patches with irregular borders that may crust and bleed. "Patients often complain of a sore on a sun exposed area that fails to heal. The most common description I hear is that of the 'pimple that doesn't go away'," says Dr. Ibrahim. People with fair skin, light eyes and extended sun exposure such as those who work at occupations in the outdoors are at highest risk. Melanoma is the most dangerous of the common skin cancers. "Patients with multiple nevi are at an increased risk for melanoma. These lesions can be identified by the ABCD's: Asymmetry, Border Irregularity, Color variation, and a Diameter greater than 6mm. With any suspicious skin lesion, changes over time are an important factor. Most melanomas can be treated in a dermatologist's office by resection of the lesion. Depending on the size of the tumor, up to 2 cm of healthy margin, down to the fat layer, is removed along with the tumor," says Ibrahim.

Dr. Sherrif Ibrahim University of Rochester Medical Center

Screening and Prevention of Skin Cancer

Prevention remains the best protection against the development of skin cancer. When caught in early stages, surgical or destructive means of treatment yield cure rates that approach 100%. When cancers grow aggressively or are neglected, then potentially life threatening sequelae can occur. Use of broad spectrum sunscreens applied to the skin at least 20 minutes prior to exposure, avoidance of peak UV hours, the use of hats and other protective clothing are all means by which damage from the sun can be reduced.

Patients will often inquire about the need for sun exposure to maintain healthy levels of Vitamin D. It is the viewpoint of the American Academy of Dermatology, that safer alternatives such as supplements and fortified foods should be consumed after a discussion with a physician.

The link between indoor tanning bed use and skin cancers is firm. Patients should be counseled to avoid these facilities. "The cellular signal to activate tanning is damage to DNA," explains Ibrahim. "Therefore, any tan should be seen as a response to DNA mutation – the basis of carcinogenesis. No tan is a good tan. And, the idea of the 'base tan' as a protective factor against further damage is a myth."

The answer is 'yes.' However, he further warns that "spray tans offer little to no protection against sun exposure."

People should avoid tanning booths and sun lamps as they cause the same amount of skin damage as the sun. NY State has strict regulations for tanning facilities. Operators are required to check photo identification and record user visits, duration of exposure and device used.

Dr. Ibrahim is an Assistant Professor in the Department of Dermatology. He completed his dermatology training at the University of Rochester and a fellowship in skin cancer surgery, laser surgery, and cosmetic dermatology at the University of California, San Francisco. His practice is focused on procedural and surgical dermatology including the management of skin cancer with Mohs surgery.

Elizabeth Hughes is a Family Nurse Practitioner at Highland Hospital, University of Rochester Medical Center.

Simply Observing Men with Very Low- and Low-Risk Prostate Cancer Very Effective, Underused

As many as 40 percent of patients may be overtreated

Monitoring men with very low- and low-risk prostate cancers using watchful waiting or active surveillance, called expectant management, is a useful approach for a large number of men with localized tumors and could spare them the debilitating side effects of aggressive treatments that are too often unnecessarily used in this patient population, a UCLA review of common practices in prostate cancer has found.

Since the initiation of PSA screening tests, most men with prostate cancer are now diagnosed with localized, low-risk prostate tumors that are unlikely to kill them. However, nearly all of these men undergo surgery or radiation, putting them at risk for ongoing side effects such as erectile dysfunction and impaired urinary function. As many as 40 percent of patients may currently be overtreated, said review senior author Dr. Mark Litwin, professor and chair of UCLA Urology.

"This study is the most up-to-date and comprehensive review of expectant management of prostate cancer patients worldwide. This represents an important resource for patients and providers considering surveillance for prostate cancer," Litwin said. "Active surveillance and other observational strategies have produced excellent, long-term disease-specific survival and minimal morbidity for men with prostate cancer. Despite this, expectant management remains underused for men with localized prostate cancer."

The study appears in the July/August 2015 issue of the peer-reviewed journal CA: A Cancer Journal for Clinicians.

The review clearly lays out a number of aspects of expectant management for men with low-risk prostate cancer. First, the UCLA team clarified the definitions of types of surveillance, making it easier for physicians and their patients to decide which is best for them. Active surveillance uses repeated PSA testing and prostate biopsies to monitor for development of more aggressive disease in younger, healthier patients who might benefit from delaying treatment. Watchful waiting avoids aggressive testing and watches for any physical symptoms of progressive disease. It is generally reserved for avoiding treatment altogether for older, sicker patients who will most likely die from something else.

The review describes the current surveillance protocols, and reviews the outcomes for each of these strategies in terms of cancer survival and quality of life. Additionally the review addresses the novel technologies such as prostate MRI and fusion biopsies that may prove beneficial for surveillance patients.

"Considerable questions remain regarding both the identification of optimal candidates for surveillance, as well as understanding the ideal monitoring strategy after the initiation of observational protocols," said Dr. Leonard Marks, study co-author and a professor of urology. "Using strict inclusion criteria for very low-risk or low-risk prostates cancer can select a group of prostate cancer patients for active surveillance who would avoid the side effects of therapy while experiencing comparable survival and quality of life."

Going forward, Marks said, more work is required to optimize the delivery of these expectant management strategies for patients treated in certain settings that may not have incorporated active surveillance into their treatment repertoire. Despite increased adoption of expectant management, active surveillance still remains broadly underused and more data will be needed to clarify the factors contributing to this finding at a population level.

Prostate cancer is the most frequently diagnosed cancer in men aside from skin cancer. An estimated 233,000 new cases of prostate cancer will occur in the United States in 2015. Of those, nearly 30,000 men will die. It's estimated that more than two million prostate cancer survivors are living in the United States today.

"Ultimately, the decision-making process surrounding treatment for a man with localized prostate cancer must take an individualized approach. The risks and benefits of expectant management vis-a-vis active treatment should be reviewed with the patient in light of existing knowledge, potentially with the use of decision aids to help enable a truly shared decision-making process," the review states. "Active surveillance is a viable approach for most men with low-risk prostate cancer, and its broader adoption has the potential to stop the overtreatment of men with indolent lesions and redirect resources to men with more serious cancers."

Source: University of California - Los Angeles Health Sciences

FDA Warns Against Testosterone Overuse

The FDA is warning doctors against over-prescribing testosterone-boosting drugs for men, saying the popular treatments have not been established as safe or effective for common age-related issues like low libido and fatigue.

Testosterone supplements may increase the risk of heart attack, stroke and other heart problems, FDA said. Drugmakers must add information about that potential risk to their prescribing labels and conduct a long-term study to further examine the issue, the FDA said.

The agency says drugmakers must clearly state in their labeling and promotions that the drugs, currently taken by millions of U.S. men to the tune of $2 billion, are only approved to treat low testosterone levels caused by disease or injury, not normal aging.

The FDA action follows years of industry marketing for new gels, patches and injections that promise relief from low testosterone or "Low-T." Promotions from AbbVie, Eli Lilly & Co. and others link the condition to a variety of common ailments in aging men, including sexual problems and low mood.

"There's been a very successful advertising campaign to make men feel that whatever their problem is, the answer is to buy more testosterone," said Dr. Sidney Wolfe of Public Citizen. The consumer advocacy group petitioned the FDA last February to add a boxed warning -- the most serious type-- to testosterone drugs about heart risks. But the FDA rejected the petition in July, saying there was "insufficient evidence" for such a warning.

New Warning on Testosterone: Blood Clots in Legs

Testosterone products can cause dangerous blood clots in the legs, the U.S. Food and Drug Administration says, and makers must include a warning on the label. The risk of deep vein thrombosis comes on top of the suspected risks of stroke, heart attack, and death from taking testosterone pills or using testosterone creams.

"We are currently evaluating the potential risk of these cardiovascular events, which are related to blood clots in the arteries," the FDA said in a statement. FDA approves testosterone products for men who lack or have low testosterone levels because of medical causes such as chemotherapy for cancer or genetic conditions.

Cutting Health Care Costs Isn't Easy

A new study from the University of Iowa is the first to evaluate the relationship between receiving care at federally qualified health centers and the rate of hospital stays and emergency department visits for potentially preventable conditions among individuals who receive both Medicare and Medicaid.

Convincing the nation's most vulnerable citizens to avoid costly emergency department visits is proving harder than expected. A new study from the University of Iowa found improving access to affordable primary care reduced preventable hospital stays for black and Hispanics who receive both Medicare and Medicaid but failed to reduce the number of trips to the emergency department.

In fact, trips to the emergency department went up among all individuals who receive both Medicare and Medicaid, known as "dual eligible," regardless of race or ethnicity.

The study, which appeared July 7 online in Health Affairs, is the first to evaluate the relationship between receiving care at federally qualified health centers, or FQHCs, and the rate of hospital stays and emergency department visits for potentially preventable conditions among individuals who receive both Medicare and Medicaid, the majority of whom are members of racial or ethnic minority groups.

"We've found evidence that increased FQHC use among the dual eligible population might be a very good thing among certain groups of dual eligibles," said Brad Wright, an assistant professor in the Department of Health Management and Policy at the University of Iowa's College of Public Health and co-author of the study. "But it should not be a strategy we pursue until we understand more about the increased use of emergency department visits we observed."

However, a key finding suggests that federally qualified health centers can reduce disparities in preventable hospitalizations for some dual eligibles, Wright said.

"It's always open and therefore more convenient, plus it offers one-stop shopping if they need services such as lab work and imaging tests," he says. "A potentially preventable hospitalization indicates a serious lack of care earlier in the progression of the condition. A potentially preventable ED visit, on the other hand, just indicates inappropriate use of the ED for something that could be done by a primary care doctor, but it's still care earlier in the process.

"So, in fact, the ED visits may end up preventing the hospitalizations, which is why the two results may be seen to move in different directions," Wright explained.

Researchers analyzed Medicare data from 2008 to 2010 for elderly and nonelderly disabled dual eligibles residing in primary care service areas with nearby federally qualified health centers.

According to the study, there were fewer hospitalizations for potentially preventable conditions, especially among blacks and Hispanics who used the FQHCs than among their counterparts who did not use them: 16 percent fewer and 13 percent fewer, respectively. The same was true for nonelderly disabled blacks and Hispanic whose use of FQHCs was associated with 3 percent fewer and 12 percent fewer potentially preventable hospital stays, respectively.

People with dual eligibility are of particular concern to policy makers and health care providers because they have substantial health care needs that often go unmet. That's because they often face barriers to accessing care that have little or nothing to do with having insurance or the ability to pay for services. For example, they might lack transportation or encounter doctors unwilling to accept the low reimbursement rates common to Medicare and Medicaid.

Whatever the obstacle, the dilemma often leads to preventable hospital stays and visits to emergency departments that might have been avoided had this vulnerable population received basic medical care earlier.

"The reason this population gets a lot of attention is because they tend to be in pretty poor health and tend to incur very high health care costs," Wright says. "In short, if we could figure out how to improve care for them, it would mean both better health outcomes for them and tremendous savings to the nation's health care expenditures."

Created in 1965 as part of U.S. President Lyndon Johnson's War on Poverty, federally qualified health centers use a sliding-scale of fees to serve all patients, regardless of their ability to pay and usually provide "enabling services," such as operating a shuttle bus or paying subway fare to overcome issues with transportation.

In 2013, some 1,202 FQHCs provided care to about 21.7 million people in the United States.

Wright said the Affordable Care Act includes substantial provisions in support of federally qualified health centers.

"It recognized that these are very important providers, and that they would be even more important in providing care -- increasing the capacity of the health care system -- as more people gained insurance coverage," he says. "For example, the program was permanently authorized, and funding was substantially increased."

University of Iowa. "Cutting health care costs isn't easy." ScienceDaily. ScienceDaily, 8 July 2015.

The Rochester General Wound Healing Center, an alliance with St. Ann's Community receives full National Accreditation with the Undersea & Hyperbaric Medical Society

Kim Petrone, MD

What was involved in the National Accreditation Process?

The center was surveyed by the Undersea and Hyperbaric Medical Society; the center was granted full accreditation.

Why did The Rochester General Wound Healing Center choose to pursue this elective Accreditation and what does this mean to referring physicians and their patients?

For referring physicians, this accreditation demonstrates our commitment to excellence and quality. It indicates to our potential patients that we are informed, educated, and up to date regarding use and safety of hyperbaric oxygen therapy.

What are some of the greatest challenges in wound care?

1) Obtaining necessary medical equipment can be extremely challenging; many patients cannot afford proper offloading devices, which is often the main cause of non healing chronic wounds. The center works closely with RGH to try to address financial constraints, so that patients can obtain necessary equipment 2) Patient compliance with plan of care

Hyperbaric Oxygen Therapy (HBOT) has long been used to treat decompression sickness, but more recently has been utilized as a primary or adjunctive therapy in wound healing. What are the clinical Indications for HBOT referral?

DFU Wagner grade 3 or higher
Chronic osteomyelitis
Osteoradionecrosis
Compromised skin grafts
Late effects of radiation, including cystitis, proctitis, difficulty swallowing, decreased salivation

What outcomes are you witnessing with HBOT?

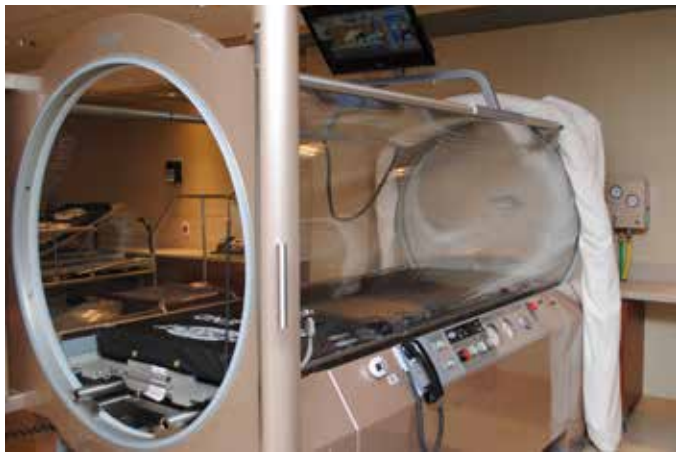
We have seen HBOT improve many of the conditions listed above. In one instance, a patient had a nonhealing wound along a surgical site from a mastectomy that was not healing as it was in a radiation field. HBOT successfully healed this ulcer that had been present for over a year prior to the initiation of the this therapy.

Are there any potential risks with HBOT?

Side effects are generally mild , but possible complications include barotrauma, claustrophobia, oxygen toxicity, and ocular changes.

Patients are taught technique to decrease pressure in ears.

Our chambers are the largest in the region, and confinement anxiety has not been an issue.



The chambers are clear, and patient can see out of chamber; patients generally sleep or watch TV throughout treatment. A certified hyperbaric technician is present outside of chamber throughout entire treatment.

Oxygen toxicity is extremely rare, but results from prolonged oxygen exposure. Risk of this is minimized by giving patient an air break during treatment as appropriate

Patient can experience visual changes. Over multiple treatments, pressure can temporarily affect the lens of the eye; far vision can become impaired. These refractory changes will reverse after HBO therapy series is complete.

From L to R: Heather Collins RN, Frank Laplaca RN, Julie Christopher LPN, Desiree Vasile RN, Jarvis Sanchez MD, Kim Petrone MD, Leanne Mathis RN, Cheryl Eddinger NP, Val Oleksyuk RN and Sue McNamara, Access Associate.

INTERSTATE MEDICAL LICENSE COMPACT CONTINUES TO GATHER MOMENTUM

Question: What is the Interstate Medical License Compact? How does it make it easier for practitioners to become licensed in multiple states?

Answer: The Interstate Medical License Compact ("Compact") will help reduce redundant licensing requirements by creating one place where physicians submit basic information (e.g., education credentials). The Federation of State Medical Boards ("FSMB") reports that 20 states have introduced bills that would authorize their medical boards to enter into the compact. To date, 8 states have passed laws joining the Compact. Later this year, an Interstate Compact Commission, consisting of 2 voting representatives appointed by each state, will meet to determine the management and administration details.

One of the goals of the Compact is to address the physician shortage in rural and other underserved areas, particularly through the practice of Telemedicine. Telemedicine has its critics, such as those who say it too easily facilitates controversial practices; however, its ability to reach patients in remote locations is crucial to reach underserved areas. Recently, the president of the American Telemedicine Association ("ATA") came out saying that while the ATA does not oppose the Compact, it questions whether the Compact will truly speed up the process of providing underserved areas access to care.

Although the Compact has been criticized as a means to perpetuate state medical boards' authority – since it fends off calls for a national license – no one has put up a legal challenge. The American Medical Association endorsed the FSMB's interstate compact and said it "aligns with our efforts to modernize state medical licensure."

PLANS TO EXPAND THE PIONEER ACCOUNTABLE CARE ORGANIZATIONS PROGRAM ANNOUNCED

Question: What is the Pioneer Accountable Care Organizations Program? How does it differ from the current Medicare payment structure?

Answer: The Pioneer Accountable Care Organizations pilot program was created under the Affordable Care Act to change Medicare's payment system. Based on a recent independent report released by the Department of Health and Human Services (DHHS), the pilot program was found to have saved Medicare more than $384 million in 2012 and 2013.

The program is part of an effort to shift Medicare to paying for quality instead of quantity of care. Under the program, groups of doctors agree to accept lump payments under Medicare instead of individual payments for each service they provide, as in the traditional Medicare payment structure. The idea is to discourage healthcare providers from ordering and performing unnecessary tests and procedures and instead to better coordinate care.

Currently, the pilot program applies to about 600,000 Medicare beneficiaries. The DHHS report found that Medicare beneficiaries who participated in the pilot program, on average, (a) reported more timely care and better communication with their providers; (b) used inpatient hospital services less and had fewer tests and procedures; and (c) had more follow-up visits from their providers after hospital discharge.

Based on its initial success, the independent Office of the Actuary of the Centers for Medicare and Medicaid Services (CMS) has now certified that the program can be expanded.

If you have any questions, please contact our Managing Partner, Michael J. Schoppmann, Esq at 1-800-445-0954 or via email at MSchoppmann@DrLaw.com.

RN First Assistants

A Collaborative Approach to the National Surgeon Shortage

by Pamela C. Smith, EdD, RN, ANP and
Craig R. Sellers, PhD, RN, ANP-BC, GNP-BC, FAANP

The United States (US) healthcare system is undergoing substantive transformation due to the implementation of the Patient Protection and Affordable Care Act (PPACA; 2010), commonly known as the Affordable Care Act (ACA). The ACA is designed to improve quality and lower healthcare costs, provide new consumer protections, and increase access to care (HHS.gov, n.d.). While these goals may be achievable, healthcare in the US still costs in the trillions of dollars, accounting for 17.4% of the gross domestic product (GDP), or nearly one-fifth of the US economy in 2013 (Centers for Medicare & Medicaid Services [CMS], 2013).

Many reasons for the skyrocketing costs of healthcare have been described and include, but are not limited to: increasing administrative costs, an aging population, technology for diagnosis and treatment, hospital costs, lifestyle choices, and chronic diseases (Goodman & Norbeck, 2013). In addition, according to CMS, hospital care, coupled with physician and clinical services, are by far the two largest components of health spending, accounting for 32% and 20%, respectively. While healthcare costs and spending continue to increase, a national shortage of primary care physicians, as well as other specialty providers, such as general and orthopedic surgery, remains. According to Harris, "general surgery is predicted to be among the hardest hit, with a shortage of 21,400 surgeons by 2020 (n.d., para. 3).

Reasons for the national surgeon shortage have been attributed to the decline in reimbursement for general surgical procedures, an increase in the use of medical technology for surgical patients, the restricted number of work hours for surgical residents, and medical students not choosing surgery as a career because they desire a more balanced lifestyle causing an impending crisis for Americans requiring surgical care. One proposed solution to this surgical crisis is the use of Registered Nurse First Assistants (RNFAs).

BACKGROUND AND SIGNIFICANCE

A Registered Nurse serving as a first assistant in surgery is not new to healthcare. In fact, for centuries, nurses have assisted during surgical procedures and can be traced back at least to the Crimean War, of 1845, where Florence Nightingale and her colleagues were noted to prepare patients having wounds for surgery. Nightingale and her nurses would assist with the procedure and then assume responsibility for the post-operative care of the patient to prevent infection and promote healing.

Almost 40 years ago, the American College of Surgeons issued documents supporting Registered Nurses (RNs) as a first assistant in surgery. In 1984, the Association of Operating Room Nurses, now known as the Association of periOperative Registered Nurses (AORN), formally defined and described the scope of practice, educational requirements based upon the nursing process, qualifications, and criteria to establish privileges for the RN First Assistant (RNFA), thus formalizing the role.

WHAT IS AN RNFA?

An RNFA must first be a Registered Nurse. RNFAs are RNs or Advanced Practice RNs, which include Nurse Practitioners and Nurse Midwives, who have successfully achieved additional academic and clinical preparation beyond their basic nursing degree, based upon the nationally recognized AORN Standards for RNFA Education Programs. For credibility, and to ensure safe, high quality, efficient and effective healthcare, educational programs are designed to provide RNFAs with the cognitive, psychomotor, and affective skills that promote responsible and accountable practice and are necessary to assume the role of the first assistant in operative and other invasive procedures. Additionally, RNFAs who exceed the requirement for competent practice can become certified, and use the credential CRNFA.

BENEFITS OF RNFAS

During their educational program, which includes didactic and surgeon-precepted clinical components, RNFAs develop a set of cognitive, psychomotor, and affective behaviors that they can apply in practice in accordance with national RNFA Standards of Practice. These standards encompass the pre-, intra, and post-operative phases of the surgical process. The standards, initially developed in 2005 and revised and updated in 2013, serve as a guide to the day-to-day peri-operative role of the RNFA in a variety of practice settings, in accordance with regulatory requirements and healthcare facility policies.

RNFAs serve as a valuable member of the surgical team and can provide safe, high quality, continuity of care throughout the three phases of the surgical process. In collaboration with the surgeon, the RNFA can provide the surgeon a sense of improved quality of life by working with the other members of the surgical team to ensure that the preferred instruments, supplies, and other resources are available for the surgical procedure. During the intra-operative phase, the RNFA first-assisting techniques can include using instruments and medical devices, providing surgical site exposure, handling tissue, and providing hemostasis. In addition, the RNFA will have first-hand knowledge of the surgical procedure performed, which will further enhance the post-operative care and treatment of the patient.

RNFAs can often replace a second surgeon, resulting in cost savings. The current rate of reimbursement for an RNFA is 85% of 16% of the allowable amount for a surgical procedure. This percentage is determined by the Centers for Medicare and Medicaid Services (United Health Care, 2014). Reimbursement for RNFAs vary, depending upon state laws and insurance company regulations, and whether or not the RNFA is an advanced practice nurse (NP or CNM). Currently there are ten states with laws pertaining to reimbursement by Medicaid for non-advanced practice (i.e., RN) RNFAs (Florida, Georgia, Kentucky, Louisiana, Maine, Minnesota, Rhode Island, Texas, Washington, and West Virginia). Given the current climate of managed care in a pay-for-performance reimbursement environment, along with significant efforts to reduce healthcare costs and improve the quality of care, RNFAs provide a cost-effective alternative for surgical residents, who are now restricted in their number of hours worked, based on Accreditation Council for Graduate Medical Education (ACGME) criteria.

CONCLUSION

As the ACA continues to be implemented in the US healthcare system, adding RNFAs to the surgical team is one option to address the national surgeon shortage. RNFAs provide a safe, high quality, and cost-effective way for surgeons to ensure that the surgical needs of their patients are met, while increasing their own quality of life. RNFAs are formally educated in specialty programs and possess the cognitive, psychomotor, and affective skills that promote accountability and responsibility in the perioperative setting, which will lead to improved quality and lower healthcare costs, as well as increase access to care for Americans with surgical needs.

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WHAT'S NEW in Area Healthcare

URMC

Foxe Appointed to Head Neuromedicine Research at URMC

John J. Foxe, PhD, a nationally-regarded scientist in the field of neurobiology, has been named the research director of the DelMonte Neuromedicine Institute (DNI) and the Kilian J. and Caroline F. Schmitt Chair of the Department of Neurobiology and Anatomy at the University of Rochester School of Medicine and Dentistry.

"The University of Rochester has long been home to some of the nation's most innovative and groundbreaking research in the field of neuroscience and neuromedicine," said Joel Seligman, president of the University of Rochester. "John's appointment signals our determination to make this field a centerpiece of our progress as a University and Medical Center."

As research director of DNI, Foxe – who currently serves as the director of Research for the Children's Evaluation and Rehabilitation Center at the Albert Einstein College of Medicine – will be responsible for bringing together the leaders of the multiple departments and centers across the University that focus on the nervous system. He will oversee the creation of a broad strategic plan that coordinates and expands research and education programs and accelerates the translation of scientific discoveries into new treatments.

As chair of the Department of Neurobiology and Anatomy, Foxe will be responsible for recruiting 6-10 new scientists to create a critical mass of new research activity in the Department.

Foxe's appointment will be effective October 1, 2015, pending the approval of the University Board of Trustees

Foxe is a translational researcher with more than 20 year of experience studying developmental disorders such as schizophrenia and autism. The core mission of his research is to understand the underlying biological mechanisms of these diseases, with the goal of developing more effective treatments and interventions.

Foxe has received more than $20 million in research funding from the National Institutes of Health, the National Science Foundation, the Department of Defense, and numerous corporations and foundations. He has served on several National Institutes of Health study sections, which help guide federal research priorities and review grant applications.

Before joining the faculty at Albert Einstein College of Medicine, Foxe served for six years as the director of the PhD program in Cognitive Neuroscience at The City College of New York. He received his PhD in Neuroscience from Albert Einstein College of Medicine in 1999 and his MS in Neuroscience in 1996.

ACM MEDICAL LABORATORY

FIT Test Screening for Colorectal Cancer

Fecal immunochemical testing (FIT) will be available through Rochester General Hospital Laboratory, ACM Medical Laboratory, and Newark Wayne Community Hospital Laboratory.

Why use FIT for colorectal cancer screening?

- More sensitive and specific than guaiac
- Requires only one specimen
- Better patient compliance
- No dietary restrictions
- Acceptable screen for patients who cannot or will not undergo colonoscopy

Limitations of FIT

- Indication limited to colorectal cancer screening
- Not as good as colonoscopy for detecting colonic neoplasms
- Not useful for gastric or small intestinal bleeding

Ordering Guidance

- *Colorectal cancer screening*
  FIT Test X1 (preferred for rea sons listed above) or
  Guaiac X3 (Note: invalid screen if fewer than 3 cards are received and tested)
- *Evaluation for occult GI bleeding from upper or lower GI tract*
  Guaiac X1

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