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Special Report: Technological Advances in Healthcare

New technique could "revolutionize" trauma care

BY DR. LILLIAN KAO, Chief, Division of Acute Care Surgery, McGovern Medical School, UTHealth, Director, Memorial Hermann Red Duke Trauma Institute

Technology and innovation are no strangers to the Memorial Hermann Red Duke Trauma Institute. As the busiest Level I trauma center in the country, we're constantly faced with a high volume of complex cases. In our capacity as a leading research center, we work to explore new frontiers in trauma care through innovative new techniques. One such technique some believe will revolutionize trauma care is only being used with frequency in a handful of trauma centers across the country, including the Red Duke Trauma Institute.

As many already know, uncontrolled bleeding is the number one cause of preventable death from trauma. Being able to get bleeding under control quickly is a top priority in trauma cases and critical to getting the patient from where the trauma has occurred and into the operating room. Direct pressure and tourniquets can be very effective in stopping excessive bleeding in arms and legs. However, excessive bleeding in the abdomen or pelvis, or what is called a "non-compressible hemorrhage" is more of a challenge because a tourniquet is ineffective in these cases.

Resuscitative Endovascular Balloon Occlusion of the Aorta or REBOA is a technique used to stop excessive bleeding in the abdomen or pelvis. Think of the REBOA as an "internal tourniquet." The REBOA technique involves placing a flexible catheter into the femoral artery, maneuvering it into the aorta and inflating a balloon at the end of the catheter. This stops blood flow beyond the balloon, improves the patient's blood pressure, and minimizes additional trauma for patients.

Prior to using the REBOA technique, the only available alternative for patients who lost signs of life in the emergency center was to perform a resuscitative thoracotomy or to "crack the chest." Resuscitative thoracotomy is a procedure still widely used in trauma centers, including ours, but it is an invasive procedure that requires a large incision to gain exposure to the heart and the aorta in the chest cavity. In many cases, resuscitative thoracotomy is an aggressive maneuver with a low success rate due to the underlying injuries. In contrast, a study from Red Duke Trauma Institute led by Dr. Laura J. Moore, Chief of Surgical Critical Care at McGovern Medical School at UTHealth and Medical Director, Shock Trauma ICU at Red Duke Trauma Institute, reported a return of spontaneous circulation in 60% of patients who had lost signs of life before receiving a REBOA (1).

REBOA is also being increasingly used to provide a bridge to get a severely injured patient from the emergency center and into the operating room or to the interventional radiology suite. The REBOA is not a long-term fix; the technique is simply intended to be a temporary measure that allows us to get the patient to definitive therapy. In a two-center study that included the Red Duke Trauma Institute, more patients who received a REBOA made it out of the emergency center than those who received a resuscitative thoracotomy (2).

The technology behind the REBOA has improved significantly during this past year.

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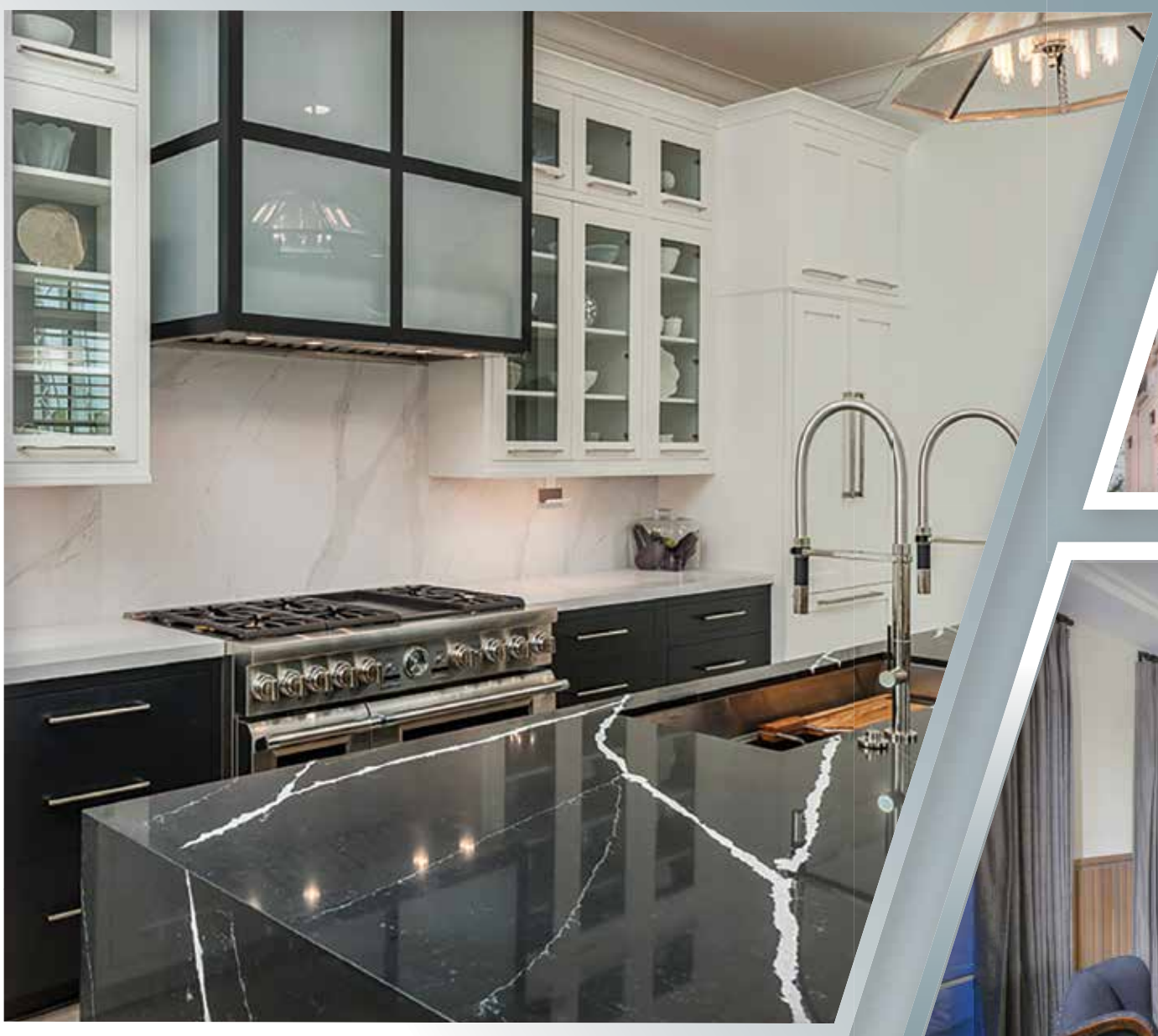

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FINANCIAL PERSPECTIVES

Some ways to boost your medical practice revenue

BY REED TINSLEY, CPA, CVA, CFP, CHBC

As the year comes to a close and with an eye towards 2018, it's important to continuously look for ways to improve your practice's bottom line. As such, I've assembled a quick list of tips to help you pick and choose ideas to increase your medical practice revenue. Hopefully, you are already be doing some of these, but chances are there are at least a few new tactics that could help your practice's financial health.

1. Boost Curb Appeal – Make sure that the outside of your business is inviting to patients.

2. Create a Welcoming Environment – Make your office user-friendly with services like free Wi-Fi, clean and comfortable waiting areas, and good reading materials.

3. Encourage Online Reviews – Positive reviews drive new patients to your door. Encourage patients to leave comments on review sites like Yelp!

4. Become a Social Media Master – Start conversations and engage your clientele on social media.

5. Create YouTube Videos – Videos help people understand topics like women's health, dieting, and medication.

6. Become an Authority Through Content – Publish articles in journals or write a book. Or just start small with a few blog posts on your practice website or another medical site. Being an authority drives new patients to you.

7. Compete Using Your Strong Points – Use quality service as a weapon against lower prices.

8. Encourage Wearable Products and Brush up on eHealth – Wearable technology is a driving force in healthcare. Patients are interested in using technology to better manage their health. Showing you're up on the trends will get you happier, healthier patients who are impressed with your level of service.

9. Update your Practice Website – create a custom page that highlights your strengths. Avoid the cookie cutter templates and fill your site with helpful links to articles you've written, social media, and YouTube.

10. Use Technology to Attract Younger Patients – Millenials want more convenient, tech-integrated healthcare. Try offering online appointment booking, virtual visits, text reminders, and optimizing your patient

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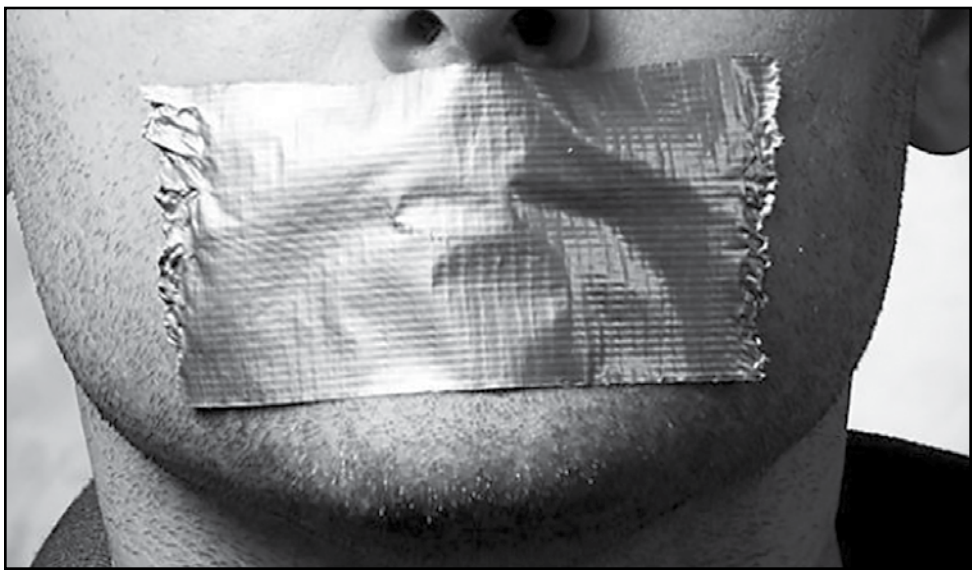
LEGAL AFFAIRS

Physician's suit dismissed because reports to TMB and NPDB are protected free speech

BY MARY M. BEARDEN and ALLISON SHELTON, Brown & Fortunato, P.C.

On October 5, 2017, the Texas Court of Appeals for the Thirteenth District, which serves the Corpus Christi and Edinburg area, granted a hospital's motion to dismiss a physician's lawsuit that concerned one report filed with the National Practitioner Data Bank (NPDB) and two reports filed with the Texas Medical Board. In Columbia Valley Healthcare System, L.P. v. Pisharodi, Dr. Madhavan Pisharodi claimed that Valley Regional Medical Center breached a contract by failing to follow the Medical Staff Bylaws during peer review proceedings. Further, Dr. Pisharodi claimed that Valley Regional was negligent in filing the reports with the NPDB and TMB. In a Memorandum Opinion, the appeals court dismissed Dr. Pisharodi's claims because they related to the hospital's exercise of protected free speech.



Dr. Pisharodi is a neurosurgeon who was a member of the medical staff and had clinical privileges at Valley Regional. According to Dr. Pisharodi, when an issue arose concerning a colleague, the Chief of Staff asked Dr. Pisharodi to write a complaint. After Dr. Pisharodi submitted his complaint, the hospital instigated an investigation into both the colleague and Dr. Pisharodi. Valley Regional suspended Dr. Pisharodi's clinical privileges for a thirty-day period. Further, as a result of the peer review proceedings, Valley Regional filed reports with both the TMB and the NPDB.

Under the Health Care Quality Improvement Act of 1986 (HCQIA), hospitals and other healthcare entities must report to the NPDB certain actions that adversely affect physicians and dentists. Specifically, HCQIA requires health care entities to report the denial, restriction, reduction, suspension, or termination of a dentist or physician's clinical privileges when such actions (i) last more than thirty days; (ii) result from a "professional review action"; and (iii) are based on the practitioner's professional competence or conduct that adversely affects or could affect the health or welfare of a patient. HCQIA also requires health care entities to report the surrender, restriction, or nonrenewal of a dentist or physician's clinical privileges that occurs (i) when the practitioner is under investigation concerning the individual's professional competence or conduct or (ii) in order to avoid an investigation or a professional review action that could be reportable. Further, Texas state law requires such actions to be reported to the TMB.

Dr. Pisharodi claimed that he had been negatively impacted by Valley Regional's reports. Specifically, he claimed that the adverse action reports resulted from improper peer review proceedings which breached his contractual rights and that the reports were negligently made with false statements. In reviewing Dr. Pisharodi's claims, the appeals court looked at whether his claims were based on or related to Valley Regional's exercise of free speech. The Texas Citizens Participation Act (TCPA) requires courts to dismiss claims if they are

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INTEGRATIVE MEDICINE

An integrative approach to upper respiratory infections

BY VICTOR S. SIERPINA, MD, ABFM, ABIHM, Director, Medical Student Education Program, WD and Laura Nell Nicholson Family Professor of Integrative Medicine, Professor, Family Medicine University of Texas Distinguished Teaching Professor

It is that time of the year when those of us in healthcare see a lot of folks suffering from cold and flu symptoms. Sneezing, coughing,

sore throats, body aches, low-grade fevers, headaches, the whole catastrophe.

They come to the clinic in misery seeking relief, any relief, often hoping for an antibiotic. Since over 90% of upper respiratory infections are viral in origin, antibiotics are not helpful and may even be harmful.

So in addition to grandma's chicken soup, lots of liquids, saltwater nasal washes and gargles, and something like ibuprofen or acetaminophen for aches and pains, is there evidence of benefit from other kinds of therapies?

I had an occasion to look this all up recently when I was trying to figure out a way to manage my own miserable upper respiratory infection that had hung on for a couple of weeks. It had gotten so bad, my staff chased me home from the office and told me not to come back until I was better.

I checked out the American Board of Internal Medicine's Choosing Wisely website. Choosing Wisely is a resource that has a goal of reducing unnecessary tests, procedures, and treatments. It contains over 500 evidence-based recommendations by 70 medical specialty societies. Choosing Wisely partners with community organizations and Consumer Reports to put out a user-friendly version.

In this day and age of self-diagnosis by internet, iatrogenesis, and escalating medical costs, I strongly recommend you familiarize yourself with this important decision-making tool. See their website http://abimfoundation.org/what-we-do/choosing-wisely and download the app.

Their advice was basically the same that I give patients and my own PCP had given me:

"If you have a sore throat, cough, or sinus pain, you might expect to take antibiotics. After all, you feel bad, and you want to get better fast. But antibiotics don't help most respiratory infections, and they can even be harmful. Antibiotics fight infections caused by bacteria. But most respiratory infections are caused by viruses. Antibiotics can't cure a virus."

Well, that was settled but was there anything I could do besides asking my wife to bring home an extra case of tissues? I was building white mountains of them next to my chair

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THA

The best gift for Texas children: continuing CHIP funding

Special to Medical Journal – Houston
BY TED SHAW, President/CEO, Texas Hospital Association

Because the foundation of an individual's health and well-being is laid in early childhood, programs that invest early in a child's development yield lifelong positive results for individuals and communities. Studies show that children who have health coverage through public programs like Medicaid and the Children's Health Insurance Program, for example, achieve long-term positive outcomes not only in health, but also in educational performance, economic well-being, and overall economic productivity.

Nonetheless, the 20-year old Children's Health Insurance Program is on the brink of extinction as the U.S. Congress has not appropriated funds for its continuation.

Nationally, the program provides low-cost health coverage through a state and federal partnership to more than 9 million children nationwide and about 370,000 pregnant women. In Texas, 400,000 children depend on CHIP for preventive, primary and specialty health care services, and 35,000 pregnant women rely on it for a healthy pregnancy.

Federal funding for CHIP expired at the end of September, and so far Congress has not yet renewed the necessary funding for states to continue administering the program. In the meantime, Texas has been relying on carryover funds so that covered children can continue receiving health care services. However, the state anticipates running out of funds by the end of January, although it has sought a special disbursement of short-term federal funding to sustain the program through February.

The state legally is required to send health coverage termination letters to covered children's families 30 days before coverage ends. Depending on whether it receives the short-term bridge funding, those letters could be sent Dec. 22 or at the end of January.

The full U.S. House of Representatives and a U.S. Senate committee have passed similar versions of a bill that would fund CHIP for five years through 2022. Unfortunately, time is running out for the bill to pass the full Congress, as the Senate adjourns for the holidays on Dec. 15, and lawmakers still need to reconcile how they will pay for the program.

In a state that already leads the nation with the most residents without health insurance, Congress risks adding a significant number of children to the uninsured population. More importantly, it risks undermining the long-term health and well-being of our nation's most valuable resource.

Given all that CHIP offers to Texas children, families and health care providers, Congress needs to take quick action to continue CHIP funding. ▼

HOSPITAL HEADLINES

Charif Souki funds neurological research through $10 million gift to the Jan and Dan Duncan Neurological Research Institute at Texas Children's Hospital

Texas Children's Hospital is excited to announce a $10 million commitment from Charif Souki to the Jan and Dan Duncan Neurological Research Institute (NRI) to fund the Huda Y. Zoghbi, M.D. Director's Endowment. In honor of this gift, the NRI atrium will be named in Charif Souki's honor and will now be called the Charif Souki Atrium.

"I am a huge supporter of Dr. Zoghbi and the incredible work she and her team are doing at the NRI," said Charif Souki, co-founder and chairman of the board of Tellurian. "I hope this gift will allow NRI investigators to make advancements in several neurological diseases that children and adults all over the world are battling today."

The Huda Y. Zoghbi Director's Endowment was established to advance research in the neurobiology of diseases by building on the NRI's considerable strengths in genetics, neuroscience and pediatrics, with the goal of developing treatments for neurological and psychiatric diseases.

"I am so honored by the continued generosity of Charif Souki. He continues to be a generous supporter of the institute's research efforts allowing us to make significant contributions to our field and advancing research in many areas including obesity, eating disorders, addiction and bipolar disease," said Dr. Huda Zoghbi, director of the NRI and professor and Howard Hughes Medical Institute Investigator at Baylor College of Medicine.

Collaboration among NRI researchers has already led to several discoveries that have helped individuals with diseases ranging from autism and epilepsy to Parkinson's disease. Approaching disease biology using different disciplines and expertise is revealing potential therapeutic paths that would have been much harder to unearth by any one single laboratory.

"It takes a truly interdisciplinary team of researchers to understand and solve brain disorders our patients are suffering from. Our teams are collaborating and working on dozens of diseases," Zoghbi adds. "With this new round of funding, I am confident the NRI team will be able to make great headway to help more patients, both children and adults, with disorders such as Rett syndrome, Batten disease, addiction, bi-polar, Parkinson's and Alzheimer's."

The institute enhances collaboration between disciplines with the ultimate goal of translating discoveries into effective treatments for these devastating disorders. In existence since December 2010, researchers at the NRI are at the forefront of understanding numerous neurological and developmental disorders and have shared their successes through more than 1,000 publications in high-impact journals.

Souki is a Lebanese-American who is a believer in the value of fundamental research and collaboration, hence his admiration for the NRI. As the second largest donor to the NRI, he has given $16 million in total, including the recent $10 million, to create and support the Huda Y. Zoghbi, M.D. Director's Endowment. Souki is the founder of Tellurian investments, a liquefied natural gas company, and founder and former CEO of Cheniere.

Circulating tumor cells associated with relapse in late-stage melanoma patients

A study revealing a connection between circulating tumor cells (CTCs) and relapse in stage IV melanoma patients points to liquid biopsy as a potential predictor of patients at high risk for disease progression. CTCs, tumor cells shed into the bloodstream or lymphatic system, can lead to additional tumor growth or metastasis to distant sites.

Findings from the study, led by Anthony Lucci, M.D., professor of Breast Surgical Oncology and Surgical Oncology at The University of Texas MD Anderson Center, were presented at the annual meeting of the Western Surgical Association.

Based on earlier studies in which Lucci found significant levels of CTCS in breast cancer, Lucci theorized that CTCs might also be present in melanoma patients.

"Optimal management of stage IV melanoma patients remains a challenge, since in spite of promising emerging therapies, many patients develop disease resistance," said Lucci. "This study, designed to determine if CTCs are associated with relapse, detected CTCs in approximately 40 percent of advanced stage melanoma patients."

The team conducted a CTC assessment through blood, which was drawn from 93 melanoma patients at the time of stage IV diagnosis. Median follow-up was 17 months, and average patient age was 55 years. CTCs were detected in 42 percent of patients at the time of blood draw. Fifty-seven of the 93 patients (61 percent) experienced disease relapse. The study showed that, within six months, 51 percent of patients who had tested positive for CTCs experienced relapse, while disease recurred in 15 percent of patients without CTCs. Over the five-year follow-up period, 82 percent of those patients who had tested positive for CTCs experienced relapse, while 46 percent of

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MOVING ON UP

Longtime family physician with Memorial Hermann Medical Group Needville honored as Family Physician of the Year

Longtime family physician Dr. Art Klawitter, M.D., of Memorial Hermann Medical Group Needville has been honored by the Harris County Academy of Family Physicians (HCAFP) as the 2017 Physician of the Year.

Dr. Klawitter, a Needville native who has dedicated his career to serving his hometown, was selected based on his enduring commitment to advancing the health and well-being of patients, as well as his lifetime involvement in organizations that promote the healthcare industry at local, state and national levels.

Dr. Klawitter has enjoyed a distinguished career in the Needville community, caring for several generations of patients starting from the time they were babies through adulthood. In addition to his service as a board-certified family physician, Dr. Klawitter served as secretary/treasurer of the Texas Medical Association and also served as a state delegate to the American Medical Association House of Delegates. He has served on multiple committees and commissions in the Texas Academy of Family Physicians.

"I have had the privilege of working with Dr. Klawitter for many years," said Leon Rochen, Executive Director of Harris County Academy of Family Physicians. "He is a tireless advocate in his efforts to improve patient care in Texas and has truly earned the honor as HCAFP's Physician of The Year."

The largest chapter of family physicians in the state, HCAFP bestows its annual Physician of the Year recognition on an individual in the medical community who spends at least 50 percent of his or her time in active practice or family practice education.

The nominee must be able to show that he or she has provided compassionate and caring medical service on a continuing basis, demonstrated direct and effective involvement in community activities that enhance the quality of life where he or she lives, and serves as a credible and invaluable role model to the community, colleagues and other health professionals, especially medical students and physicians in training.

"I'm humbled to have received such a prestigious recognition from my peers," Dr. Klawitter said. "Devoting my professional life to being a family physician has been a tremendously rewarding experience, and it's even more special to be able to care for families in the same community where I grew up. I cherish the relationships I've built with my patients and their families over the years, and I'm honored that they have entrusted me with their care."

Dr. Klawitter earned his medical degree at The University of Texas Southwest Medical School at Dallas in 1978 and earned his board certification from the American Board of Family Medicine in 1981. He has been practicing medicine 36 years in Needville, the last five at Memorial Hermann Medical Group Needville. He lives in Needville with his wife, Pamela, and they have three adult children and four grandchildren.

Peter WT Pisters, M.D., begins tenure as president of MD Anderson

The University of Texas MD Anderson Cancer Center today welcomes Peter WT Pisters, M.D., as its fifth full-time president in the institution's 76-year history. Officially named president in September after being unanimously selected as the sole finalist by the UT System Board of Regents, Pisters previously served MD Anderson in faculty and leadership roles for more than 20 years. Most recently, he was president and chief executive officer of the University Health Network (UHN) in Toronto, Canada.

"I am beyond thrilled to return to MD Anderson to serve as its new president, which is an honor of a lifetime," said Pisters. "Driven by recent achievements, great optimism and a renewed spirit of unity, I'm confident we will continue building upon our successes in cancer treatment, research, education, and prevention while also forging a new path forward in the fight to end cancer."

Pisters oversaw more than 14,000 employees and a $400 million research enterprise at UHN, Canada's largest hospital-based research program, beginning in January 2015. Prior to his appointment at UHN, he was vice president for MD Anderson's regional care system, comprising multiple Houston-area locations.

Pisters initially joined MD Anderson's faculty in 1994 as assistant professor of Surgery, rising to full professor with tenure in 2004. His specialties are sarcoma and gastrointestinal cancer, and he remains a board-certified surgeon. He also holds a master's degree in health care management from Harvard University.

"Dr. Pisters has devoted most of his

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FINANCIAL PERSPECTIVES

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portal.

11. Give Back – Donate some time or sponsor community groups that are improving healthcare. The goal is to get your name out there.

12. Expand Your Medical Services – Consider adding alternative medicine and therapy to your office's list of services. Medical massage, chiropractic services, or even a nutritionist helps differentiate you from your competition.

13. Offer Free or Affordable Patient Education Classes – Target your audience such as diabetics, dieters, people trying to stop smoking, etc. Some classes may be billable.

14. Expand Appointment Options – Can you offer weekend or evening appointments at your office? Could you supplement in-person visits with virtual care in the off-hours?

15. Consider Wellness Clinics – Group visits and clinics help raise ROI for you and your patients.

16. Encourage Boosters – Flu shots, school vaccines, MMR's are all easy money. Try sending out an email campaign to patients with reminders to get all their vaccines.

17. Embrace Medicare – There are a lot of services that Medicare covers such as DME, diabetic supplies, etc.

18. Partner with other Vendors – Partner with the local gym, so your patients get a discount for getting healthy. That is a marketable service that draws in more patients.

19. Reduce Your Wait Times – Long wait times can be a key reason a patient decides to leave your practice, or go to the retail clinic down the street for quick, minor conditions.

\20. Lease a Classroom – There are plenty of other professionals that would lease a classroom from you. Yoga is a good example.

21. Add a Cash-Pay Side – Cash services are a big business. Try offering additional services that may not be covered by insurance, on a cash-pay basis to patients.

22. Work-Related Services – Physicals, drug screens, health screenings for employers, insurance companies, and government agencies can be a great way to get more business and find new patients.

23. Train your Staff on Top Customer Services – Customer service is key in healthcare. Train your staff to be polite, professional and engaging.

24. Renegotiate Payer Contracts – Review and renegotiate your rates. Add new ones at least annually.

25. Evaluate Scheduling – You want to see as many patients as possible, but you don't want to downplay quality.

26. Refills by Virtual Appointment – Instead of calling in prescription refills, do them via a virtual visit with patients so you can charge for the service!

27. Your Ideal Patient Persona – Learn what your practice's ideal patient is and then focus marketing on that target audience.

28. Buy Rather than Lease – Evaluate your financials and the location and see if you can buy. Rent can be a huge cost and money that's not going towards any future investment in your practice.

29. Bill for Missed Appointments – No-shows cost your practice money. Institute a cancellation policy and charge for these.

30. Change with technology – Offer the best services with new equipment.

31. Go Digital – Cloud-based storage saves doctors thousands of dollars each year. Go digital!

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LEGAL AFFAIRS

continued from page 4

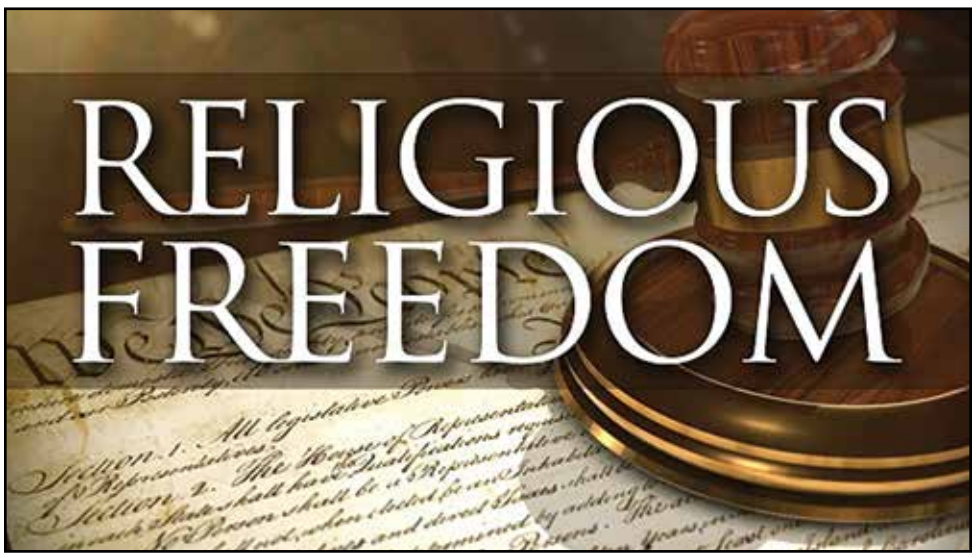
based on the exercise of the right of free speech. TCPA defines free speech as "any communication made in connection with a matter of public concern." When a claim relates to the exercise of free speech, then a court must dismiss the claim unless the claimant can establish clear and specific evidence of each element of the claim.

Dr. Pisharodi claimed that the peer review proceedings were conducted in violation of Valley Regional's Medical Staff Bylaws. As a result, he claimed that Valley Regional breached a contract and improperly filed reports with the TMB and NPDB. In response, Valley Regional contended that statements made during peer review and reports filed with the TMB and NPDB constitute protected free speech. The appeals court agreed because the "provision of medical services by a health care professional constitutes a matter of public concern."

The court found it necessary to dismiss Dr. Pisharodi's breach of contract claim unless Dr. Pisharodi could establish with clear and specific evidence each element of the contract claim. Dr. Pisharodi did not identify a valid contract, however. The court reiterated longstanding common law that medical staff bylaws that do not limit a hospital's governing board "do not create contractual obligations for the hospital." Simply, a set of medical staff bylaws is not a contract. Accordingly, the court dismissed Dr. Pisharodi's breach of contract claim.

In regards to the negligence claim, Dr. Pisharodi stated that Valley Regional breached its duty to him by making false statements to the TMB and NPDB. The court found that Dr. Pisharodi's pleading of "false statements" directly implicated the hospital's exercise of protected free speech. Because Dr. Pisharodi did not present any evidence necessary to establish a negligence claim, and his pleading related to the exercise of free speech, the court dismissed Dr. Pisharodi's claim.

Physicians are often hesitant to engage in robust peer review due to concerns of potential lawsuits. As demonstrated in Columbia Valley Healthcare System, L.P. v. Pisharodi, however, Texas law affords several protections to peer review participants and to peer review proceedings. Such legal protections are designed to enable physicians and hospitals to take necessary steps for the promotion and protection of safe, high-quality health care.



Accommodating employees' religious beliefs: what does the law require?

BY JANET HENDRICK, Partner, Fisher Phillips, Dallas office

With the proliferation of employee requests for accommodations for disabilities under the Americans with Disabilities Act, most employers have become well-versed in their obligations under that federal law to engage in the "interactive process" with employees, and make decisions about whether or not to grant requested accommodations to enable an employee to perform his or her essential job functions. But the ADA is not the only federal statute that imposes accommodation obligations on employers: Title VII of the Civil Rights Act of 1964, the federal law that prohibits discrimination on the basis of sex, race, national origin, color, and religion, also includes an accommodation requirement.

What does the law require?
Title VII requires employers, upon notice by an employee or prospective employee, to reasonably accommodate an employee's religious beliefs or practices, unless doing so would cause more than a minimal burden on the operations of the employer's business. This means an employer may be required to make reasonable adjustments to the work environment that will allow an employee to practice his or her religion.

The United States Equal Employment Opportunity Commissions (EEOC), the federal agency responsible for enforcing Title VII, defines religious practices to include "moral or ethical beliefs as to what is right and wrong which are sincerely held with the strength of traditional religious views." "Religious beliefs" are not limited to commonly known traditional religions, but extends to nontraditional affiliations and

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INTEGRATIVE MEDICINE

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and was seemingly stalled out despite having gotten the flu shot, resting, fluids, my neti pot, vitamin C, and acetaminophen.

I retrieved my copy of the Integrative Medicine textbook by Dr. David Rakel seeking a useful integrative and evidence-based approach. The chapter on Viral Upper Respiratory Infections was written by Bruce Barrett, MD, Ph.D., a family doctor and well-respected researcher at the University of Wisconsin in Madison.

One quote caught my eye: "The common cold is an excellent example of how the mind and body interact. Stress can increase susceptibility while social support can reduce incidence. Perceived empathy of caregivers may also reduce illness severity and duration."

This was in line with well-done research

on the topic and with my own practice experience. Many folks seem to catch a cold after a period of acute or prolonged stress.

For preventing URI's, the advice was not to smoke, to exercise regularly, wash hands frequently, eat a balanced, nutritious diet, including foods containing vitamin C and zinc.

Also, if possible, reduce exposure to those with colds. This latter is just not an option for most of us in healthcare as we are the homing beacons for those with colds and flu seeking relief.

Some evidence suggests the use of andrographis, 400 mg of dried herb or extract containing 5-20 mg of andrographolide up to three times daily for the first few days of illness. It may be useful preventively or for early treatment along with vitamin C 200-500 mg daily, ginseng 100 mg daily, and probiotics.

Echinacea, a long time popular URI botanical also has contradictory evidence but with several positive trials when taken 3-4 times daily at the onset of illness.

Similarly, contradictory evidence with several positive trials was found for early treatment with Vitamin C and zinc. Numerous other remedies are considered unproven but safe and supportive including astragalus, chamomile, garlic, ginger, ginseng, lemon, peppermint, hot baths, hot moist air, nasal saline, and chicken soup.

Pharmaceuticals such as anti-histamines and decongestants offer symptomatic relief but often give side effects as well. Antivirals for true influenza may reduce symptoms and duration but need to be taken within a short window of a couple of days after onset, in my experience often not practical as people tend to suffer awhile longer before they come in.

Staying well hydrated seems to be a consistent theme across multiple systems of care. Teas with peppermint, thyme, eucalyptus, and chamomile may be useful according to naturopathic practice. Add some warming cinnamon or grated ginger root to induce sweating. Aromatherapy and steam inhalations may help loosen mucus. Consider essential oils like eucalyptus, lavender, peppermint, pine, thyme or tea tree oil in a diffuser or by inhalation. Chinese medicine recommends liquid and soft foods like porridge, noodles, and fresh vegetables plus adding ginger and onion for clearing heat. They also advise avoiding greasy food and seafood. Acupressure and acupuncture may help for headaches and congestion, and have been traditionally used to shorten the course of a disease.

Bottom line: we do not have a cure for the common cold. Supportive therapies can help, including mind-body and various herbs and supplements. In the meantime, lay in a big supply of tissues, plan to get extra rest, fluids, and choose wisely by listening to your body. Oh, and watch your stress level, accept love and empathy, and know you will survive. ▼

LEGAL AFFAIRS

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views, as long as the employee "sincerely" holds the belief. Even if the religious beliefs seem illogical or unreasonable, courts decline "to question the correctness or even the plausibility of the religious understandings." EEOC V. Consol Energy, Inc., 860 F.3d 131 (4th Cir. 2017).

In 2016, the EEOC received and resolved nearly 4,000 charges of discrimination alleging religious discrimination. That number has remained fairly steady for the past five years, indicating employees will likely continue to claim religious discrimination, including failure to accommodate.

Types of Accommodations
Religious accommodations generally can be grouped into three primary categories:

- schedule accommodations to allow employees to observe religious holidays;
- accommodations to dress codes and grooming standards to accommodate religious requirements;
- accommodations to job tasks.

The EEOC provides the following examples of common religious accommodations: flexible scheduling, voluntary shift substitutions or swaps, job reassignments, and modifications to workplace policies or practices. Even where an employer does not ordinarily have a flexible schedule option, the Commission takes the position that the employer should consider creation of a flexible work schedule for employees who request religious accommodation. This could include flexible arrival and departure times, floating or optional holidays, flexible work breaks, working through lunch in exchange for early departure, staggered work hours, and allowing an employee to make up time lost due to observance of religious practices. An example of an accommodation to job tasks is granting a request to a truck driver, whose religious beliefs strictly prohibit alcohol, to allow him to make only deliveries not containing alcohol. That accommodation may or may not be reasonable, however, depending on the company's business.

If an employer cannot accommodate an employee's religious beliefs within the employee's current position, the EEOC's regulations instruct employers to consider reassigning or transferring the employee to a lateral assignment. This echoes the EEOC's position with regard to disability accommodations, as the agency considers reassignment of a disabled employee the "accommodation of last resort," in the event no other reasonable accommodation exists that would allow the employee to perform essential job functions in the current position.

The duty to accommodate religious beliefs and observations extends to job applicants as well. The regulations provide that employers "may not permit an applicant's need for a religious accommodation to affect in any way its decision whether to hire the applicant unless it can demonstrate that it cannot reasonably accommodate the applicant's religious practices without undue hardship."

Are there any exceptions?
The sole exception to the duty to accommodate religious practices is one familiar to those who assess disability accommodations: undue hardship. If an employer can prove—and the burden is on the employer here—that accommodation would result in undue hardship on the conduct of its business, the employer may lawfully refuse to accommodate. But while both the ADA and Title VII use the term "undue hardship," the burden on employers differs under the two statutes. The undue hardship threshold under Title VII religious accommodation claims is lower than the standard for undue hardship under the ADA. Under the ADA, a finding of undue hardship requires significant difficulty or expense, considering (1) the nature and cost of the accommodation, (2) the financial resources of the business, (3) the overall size of the business, including the number and location of the facilities, and (4) the operation of the business, including the composition of its workplace. The undue hardship threshold under Title VII in the context of religious accommodations is lower, requiring only more than de minimis cost.

Unfortunately for employers, there is no "bright-line test" to assess whether an accommodation causes undue hardship, and both the EEOC and courts analyze the inquiry on a case-by-case basis. The regulations instruct that "[a] mere assumption that many more people, with the same religious practices as the person being accommodated, may also need accommodation is not evidence of undue hardship." As further guidance, the regulations list infrequent payment of premium wages to substitute workers and administrative costs incurred in rearranging schedules and recording substitutions for payroll, will not constitute more than de minimis cost to the employer and, thus, will not evidence "undue hardship." The regular payment of premium wages to substitutes, on the other hand, would constitute undue hardship under Title VII. Similarly, an accommodation that would result in a variance from a bona fide seniority system, to deny another employee his or her job or shift preference under that system, would also result in undue hardship, according to the EEOC. Another example of undue hardship is when accommodation creates a safety, security, or health risk to the employee, co-workers, or the public at large.

Interestingly, the United States Supreme Court held, in a 1986 decision, that if an employer makes an offer of a reasonable accommodation and the employee who requested religious accommodation rejects that offer, the employer has met its obligations under Title VII and does not have to even demonstrate a greater-than de minimus cost. In practice then, the undue hardship issue is only an issue where the employer claims it is unable to offer any reasonable accommodation with undue hardship.

Recent Cases
As more courts address religious accommodation claims, their decisions provide some guidance for employers in approaching religious accommodation requests. One recent case that garnered a great deal of attention is Kaite v. Altoona Student Transportation. In that case, the employer required a bus driver to submit to a background check as a condition of employment. She refused, claiming it was her sincere religious belief that fingerprinting is the "mark of the devil," and that providing a fingerprint would keep her from entering heaven. The employer checked into alternatives, since state law required fingerprinting of its employees, and failure to comply with the law could subject the employer to criminal liability. When no authority could provide an alternative under the state law, the bus company terminated the employee, who then sued under Title VII. The court denied the bus company's motion to dismiss, finding the employee had sufficiently described her sincere religious belief about being denied entry to heaven if fingerprinted.

In September 2017, the EEOC filed suit against a healthcare facility, alleging it failed to reasonably accommodate the religious beliefs of four employees. In the suit, the EEOC alleges the employer required employees to attend daily mandatory meetings during which biblical verses were read or studied, fired employees who asked to be excused or contested attending the meetings, expressed disapproval of an employee for being a single mother and another for cohabitating with his girlfriend, and fired an employee who chose not to attend pre-marital counseling as the employer insisted. The EEOC seeks a permanent injunction to keep the employer from engaging in employment practices that discriminate on the basis of religion, including denial of reasonable religious accommodations, and back pay and other damages—including punitive damages—for the four individuals named in the complaint.

In another religious accommodation case the EEOC filed, the agency alleges the employer, Consol Energy, violated Title VII when it required an Evangelical Christian employee, despite his protests, to clock in and out using a hand scanner. The employee believed the scanner would imprint him with the "mark of the beast," and quit rather than scan his hand. A federal jury ruled in the employee's favor, finding the employer failed to accommodate the employee's religious beliefs.

Takeaways
Although there are no "one size fits all" answers to religious accommodation issues, there are some general best practices that will minimize the chance an employer will be on the receiving end of a claim of failure to accommodate religious beliefs:

- Review policies, and, if not already included, add language informing employees that you will make reasonable efforts to accommodate religious practices.

- Train managers and supervisors on how to recognize religious accommodation requests, and how to respond. The best practice is to designate a single person or group of people within the company who are responsible for considering accommodation requests and responding to the requesting employee, rather than leaving it to myriad members of the frontline.

- Train your workforce to be sensitive to the beliefs of others and encourage them to embrace a diverse workforce. Anti-harassment training is also important.

- Make sure managers and supervisors are aware of your non-retaliation policy, and understand this includes not taking any adverse action against employees because they requested religious accommodations at work.

- Individually assess each accommodation request, avoiding stereotypes and assumptions. This is important and exactly what the EEOC is requiring of employers.

- Make efforts to accommodate an employee's desire to wear a yarmulke, hijab, or other religious garb.

- The law does not require employers to allow employees to proselytize at work. In fact, in its guidance, the EEOC cautions employees to "cease doing so with respect to any individual who indicates that the communications are unwelcome."

- Ask for and consider a proposed accommodation from the requesting employee, but keep in mind the employer is not required to provide an employee's preferred accommodation if there is another effective accommodation that is less burdensome or less expensive to the employer.

- Once an accommodation is agreed upon by employer and employee, check back in with the employee and his or her supervisor periodically to see how the accommodation is working. Make modifications as needed, after conferring with all involved.

- Make sure the employee knows where to go with any further concerns. This is an opportune time to emphasize your open door policy with multiple avenues to raise concerns.

- Consider reassignment of the employee to another job, if no other accommodation that is reasonable is available. The EEOC considers reassignment, under both the ADA and Title VII, the accommodation of "last resort."

Document all efforts to accommodate an employee's religious beliefs.

The EEOC provides further guidance for employers on its website (EEOC.gov), including rights and responsibilities relating to religious garb and grooming, and questions and answers concerning employment of Muslim and Middle Eastern individuals. ▼

HOSPITAL HEADLINES

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those who did not have CTCs had disease recurrence.

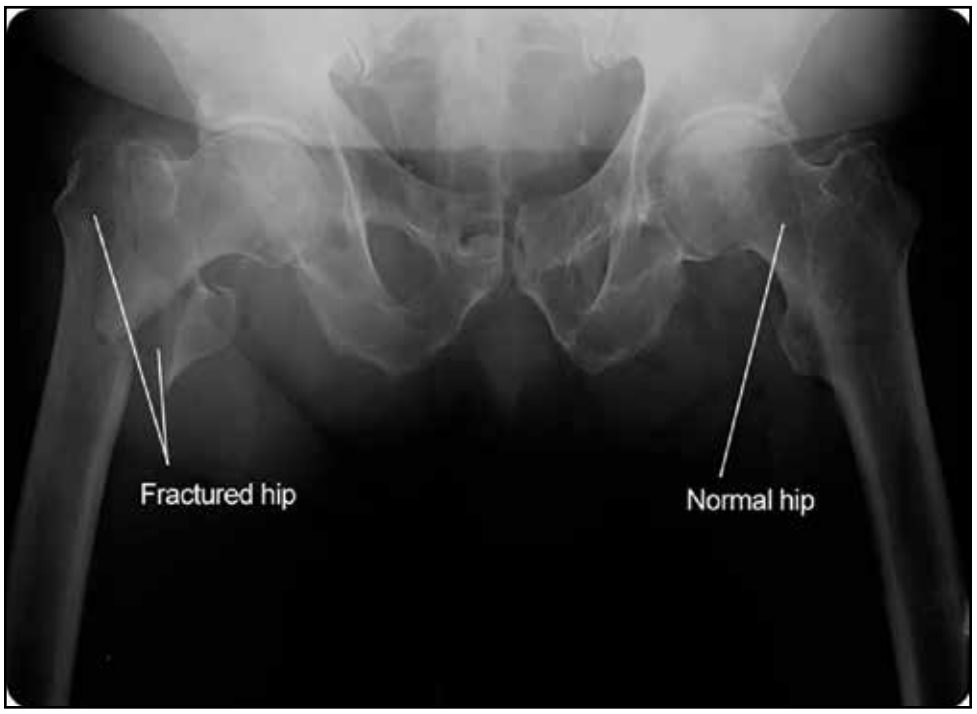
"Based on our findings, it is clear that stage IV melanoma cancer patients with CTCs have a significantly higher chance of relapsing or progressing as compared to those without CTCs," said Lucci. "Hopefully, in the future, this information could be used to guide treatment, or select patients for treatment – or maybe stop a treatment and switch to another – when it appears it is not working."

Lucci previously led the first study of CTCs in early-stage breast cancer, which followed 302 non-metastatic breast cancer patients. Lucci's team discovered that CTCs were present in 24 percent of stage 1-3 breast cancer patients, demonstrating CTCs as an independent predictor of worse, disease free, and overall survival.

MD Anderson team members in the melanoma study included Merrick Ross, M.D., Richard Royal, M.D., Mandar Karhade, Ph.D. and Jessica Bauldry, Surgical Oncology; Carolyn Hall, Ph.D., Breast Surgery; Joshua Upshaw, Breast Surgical Oncology; and Sapna Patel, M.D., Melanoma Medical Oncology.
Cutline: Anthony Lucci, M.D.

UTMB to study new approach for hip fracture recovery

A multimillion-dollar grant could help researchers develop a novel therapeutic for women recovering from hip fractures.



The University of Texas Medical Branch at Galveston is part of a consortium of seven universities that has received $15.6 million from the National Institute on Aging for a multisite clinical trial to study the use of testosterone therapy and exercise in post-menopausal women recovering from hip fracture. Dr. Elena Volpi, director of UTMB's Sealy Center on Aging, is one of the seven principal investigators.

The project will evaluate hip fractures in elderly women and the benefits of short-term testosterone therapy combined with supervised exercise during the recovery process.

Results of the study may help reduce the significant burden of hip fracture now faced by many older women.

"Hip fracture is a major contributor to loss of independence in older women. With this study, we hope to find a novel therapeutic approach to accelerate recovery of physical function and independence in these patients," Volpi says.

More than 260,000 hip fractures occur annually in the U.S. Many of those experiencing a fracture also incur a significant functional decline. Many patients also end up dealing with persistent strength and mobility issues that can impair their ability to live independently.

A primary goal of the research funded by the National Institute on Aging is to develop the fundamental knowledge to improve health and reduce the burden of disability.

UTMB's Sealy Center on Aging focuses on improving the health and well-being of elderly through research, education, and community service.

The other participating institutions are Washington University, Harvard University, University of Maryland, Johns Hopkins University, University of Colorado Denver, and University of Connecticut. ▼

TRAUMA

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This past February, the Food and Drug Administration approved a smaller version of the catheter that reduces the risk of injury to the blood vessels where the REBOA is inserted. While REBOA holds significant promise, there are potential pitfalls and complications to its use. Thus, in order to better assess the benefits and risks, McGovern Medical School at UTHealth is leading a prospective, multi-center study comparing outcomes with REBOA versus resuscitative thoracotomy.

As one of only a few trauma centers in the country actively teaching the REBOA technique to our trauma residents, we believe the use of this technique will continue to grow across the country. We train all our faculty in the use of this technique, fellows and residents also go through the course. We're already seeing lives saved using the technique. It's not appropriate in every case, but it is another tool we have to potentially save a person's life.

References:

(1) Moore LJ, Martin CD, et al. Resuscitative endovascular balloon occlusion of the aorta for control of noncompressible truncal hemorrhage in the abdomen and pelvis. Am J Surg 2016 Dec; 212(6): 1222-1230. https://www.ncbi.nlm.nih.gov/pubmed/28340927

(2) Moore LJ, Brenner M, et al. Implementation of a resuscitative endovascular balloon occlusion of the aorta as an alternative to resuscitative thoracotomy for noncompressible truncal hemorrhage. J Trauma Acute Care Surg 2015 Oct; 79(4): 523-30. https://www.ncbi.nlm.nih.gov/pubmed/26402524

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MOVING ON UP

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professional life to the care of patients at MD Anderson, and he gained invaluable experience in Toronto leading one of the most respected academic health centers in North America," said Ray Greenberg, M.D. Ph.D., executive vice chancellor for health affairs, UT System. "This combination of his clinical expertise, institutional knowledge, and servant leadership make Dr. Pisters the ideal person to take MD Anderson to the next level."

During the transition to new leadership, Marshall E. Hicks, M.D., served as president ad interim. In those eight months, MD Anderson strengthened its finances, further developed the institution's team-based culture and successfully cared for patients and employees during Hurricane Harvey.

Six researchers from MD Anderson elected as AAAS Fellows

In recognition of their contributions to basic, translational, and clinical research, six faculty members from The University of Texas MD Anderson Cancer Center have been named Fellows of the American Association for the Advancement of Science (AAAS). Election as a Fellow, a tradition that began in 1874, is an honor bestowed upon AAAS members by their peers. MD Anderson's faculty now includes 46 AAAS Fellows.

"Election to AAAS is a prestigious honor that highlights the exceptional achievements of MD Anderson's newest Fellows," said MD Anderson President ad Interim Marshall Hicks, M.D. "We are proud to work alongside these excellent researchers who are working to improve cancer prevention, diagnosis, treatment and education."

MD Anderson's newly elected AAAS Fellows are:

- John Heymach, M.D., Ph.D., chair of Thoracic Head and Neck Medical Oncology, honored for identifying new therapeutic targets, biomarkers, mechanisms of drug resistance and treatment paradigms that have advanced the treatment of lung cancer worldwide.
- Kelly Hunt, M.D., chair of Breast Surgical Oncology, honored for practice-changing breast cancer research involving sentinel lymph node biopsy, breast conservation, novel surgical staging systems, contralateral mastectomy, skin-sparing mastectomy and quality outcome measures.
- Dimitrios Kontoyiannis, M.D., Ph.D., professor of Infectious Diseases, honored for contributions to medical/translational mycology through advances in antifungal pharmacology, study-host defenses against fungi, novel diagnostics, clinical trials, professional service and life-saving patient care.
- Frederick Lang, M.D., professor of Neurosurgery, honored for contributions to the field of cancer biotherapeutics, particularly for developing and translating gene, adenoviral and stem cell therapies in the treatment of brain tumors.
- Zhimin (James) Lu, M.D., Ph.D., professor of Neuro-Oncology, honored for milestone discoveries that elucidated mechanisms of the Warburg effect, demonstrated protein kinase activity of metabolic enzymes and revealed non-metabolic functions of metabolic enzymes in tumorigenesis.
- Shao-Cong Sun, Ph.D., professor of Immunology, honored for his contributions to the understanding of NF-kB signaling pathways and the regulation of immune responses and inflammatory diseases by protein ubiquitination.

Jones new senior vice president and dean of nursing school at UTMB

Deborah J. Jones has been appointed senior vice president and dean of The University of Texas Medical Branch at Galveston School of Nursing.

Jones, currently the associate dean for professional development and faculty affairs at The University of Texas Health Science Center at Houston, School of Nursing, will join UTMB.

"Dr. Jones is a dedicated mentor, passionate researcher and energetic leader, and she is a great addition to an already outstanding team. I'm excited to welcome her to our UTMB family," said Dr. Danny O. Jacobs, executive vice president, provost and dean of UTMB's School of Medicine.

Jones said, "It is an honor and a privilege to be named dean of the school of nursing at UTMB, a school with a long history of excellence that provides an education for future health care professionals that is second to none."

Jones is an expert in oral care, and her research has helped change national health protocols aimed at reducing ventilator-associated pneumonia by improving oral hygiene.

Earlier this year, she was elected to a three-year term to the board of the American Association of Critical Care Nurses. She serves as a peer reviewer for many national and international nursing and interdisciplinary journals including the Journal of Clinical Nursing and American Journal of Critical Care.

Jones holds a doctorate and a master's degree in nursing administration from Virginia Commonwealth University and a bachelor's degree in nursing from Radford University.

Jones appointment comes after the recent retirement of Pamela G. Watson in September who served 16 years as dean. ▼

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FINANCIAL PERSPECTIVES

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32. Review Billing – Submit bills daily, follow up on denied claims, do not let revenue sit out in unpaid claims.

33. Check Insurance Often – Copy insurance cards and verify the insurance is up-to-date at the time the appointment is made, to avoid any billing headaches later on.

34. Let Patients Pay Online – If patients have a way to pay online, there's less likely to be a delay in payment or a case of the bill getting lost in the mail.

35. Hire More Staff – Avoid overtime and offer flexible hours or shifts.

36. Evaluate Your Marketing Strategy – Make sure that your marketing metrics are measurable. Get rid of marketing that does not have a positive ROI.

37. Offer Discounts on Certain Days – If Tuesdays are slow, offer a discount or waive a percentage of the co-pay.

38. Consider Outsourcing – Is it cheaper to outsource some office work?

39. Join a Purchasing Club – Save on office and cleaning supplies.

40. Pre-certification – Make sure you have authorization on all services over a specified dollar amount.

41. Government Contracts – Apply for contracts that bring patients into your practice.

42. Review Your ICD-10 Codes – At least monthly make sure you have the correct codes.

43. Expand Your Online Presence – Many new patients are looking for new doctors by searching online.

44. Create an Online Library – Encourage patients to read care sheets by making them available online.

45. Collect Co-pays – And Out-of-pockets expenses at the time of service.

46. Switch to a Better HER – Is your EHR the right fit? It might be time to consider a switch to boost your practice productivity.

47. Review your practice's financial metrics every month – Are you hitting designated financial benchmarks? How does your accounts receivable aging look?

48. Review your organizational chart – Too many employees? Find and eliminate the inefficient employee(s).

49. Perform detailed review of your internal controls – You don't want your hard earned money walking out the door in someone else's pocket.

50. Conduct a billing review – Undercoding office visits? Not billing all available CPT codes? ▼

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