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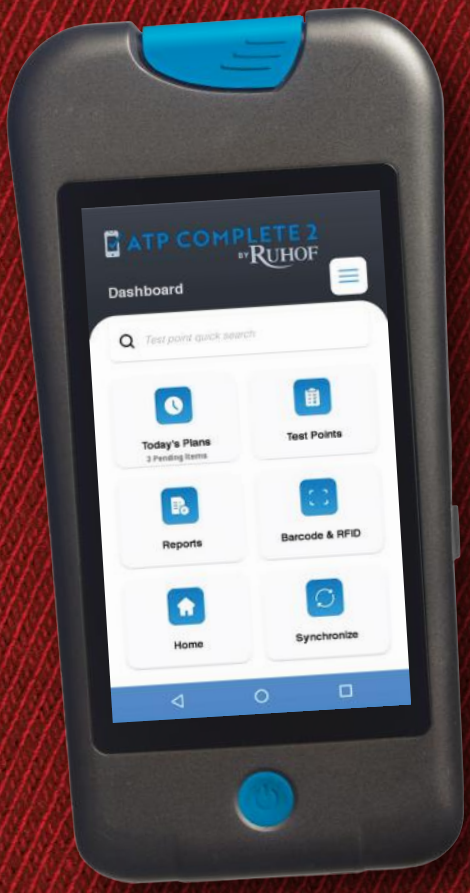

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Editor's Letter

FOD-What?

My Strange Experience With a Strange Digestive Term

I've suffered from irritable bowel syndrome all my life. It's become "normal" for me. I've tried a great many approaches, such as eating more fiber, fruits and vegetables, exercising more, and eating less junk food. I made big progress when I reduced my gluten intake. My mom has Celiac disease, so the idea that I would be gluten sensitive isn't a stretch. However, even after making progress, my gastrointestinal tract was still a source of frustration. I'm usually ready to try anything that will help, but one approach I wasn't ready for was a Low-FODMAP diet.

My experience with FODMAPs started 11 years ago when I was ghostwriting a digestive health book. The publishing team hired a registered dietitian to design the diet. I was familiar with everything she prescribed and had tried most of it—until, that is, she introduced me to an odd term: FODMAPs.

As you'll see in our cover story (if you don't know already): "FODMAPs are fermentable carbohydrates (sugars) that are found naturally in foods, and people with IBS who consume these carbohydrates can suffer from digestive symptoms. One in seven people are affected by IBS, and 70% to 75% find symptom relief by following a low-FODMAP diet." When I learned about this theory from the registered dietitian with whom I was working, I was immediately intrigued. At that time, hardly anyone had heard of FODMAPs. I was excited for a solution, but that enthusiasm ground to a halt when I read the list of foods that people with IBS should avoid if they're on a low-FODMAP diet.

Avocadoes, cashews, cherries, nectarines, etc. Many of my favorite foods! And they're so healthy! As a vegetarian, and with gluten sensitivity, I couldn't face the idea of more food restrictions. Even as I literally wrote a book about following a low-FODMAP diet, I couldn't bring myself to try one. I couldn't bring myself to even think of trying.

Then, a decade later, a helpful and lovely person brought FODMAPs into my world again. Our cover-story author, Amy Laura, sent an email about covering the topic of FODMAPs and I just had to laugh that these darned FODMAPs had caught up with me despite me sticking my head in the sand. Amy calls herself an IBS survivor and is the author of "Calm Tummy Happy Heart," with recipes from the American Southwest. Her cover story offers a great overview of the FODMAP diet and some of the barriers of following it, including that it has a less-than-catchy name. Amy has inspired me to take a new look at this diet and to see that I don't have to completely omit some of my favorite foods that are on the "avoid" list. The diet is indeed easier than I had imagined a decade ago. I hope this article will be a help to those of you who suffer from IBS, and to your patients as well. The article starts on page 18.

Michelle Beaver

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Anchorage Endoscopy Center

Forming Bonds in the Last Frontier

By Madison Knutson

Founded in 1998, the Anchorage Endoscopy Center serves residents of the largest city in Alaska. The department features two admission bays, three recovery bays and two procedure rooms, and treats conditions like esophageal varices, esophageal strictures, celiac disease, achalasia, GERD, Barrett's esophagus, irritable bowel syndrome, inflammatory bowel disease, diverticulosis and polyp detection and removal.

Anchorage Endoscopy has a team of 19 employees to support the needs of the community. The center has four full-time nurses, two part-time nurses, five PRN nurses, one nurse administrator/manager, four full-time endoscopy technicians, one part-time endoscopy technician, a receptionist and an administrative assistant. The center also has six gastroenterologists.

Challenges

Anchorage Endoscopy is a physician-owned clinic, and according to nurse administrator Dorene Mulcahy, it has been difficult to compete with benefits Anchorage hospitals offer, especially during COVID-19.

"The hospitals have started offering large sign-on bonuses and wages that are difficult for us to compete with," Mulcahy said. "It has been tough with the rise in the cost of medical supplies as well. We have had to be very creative in recruitment and retention."

Mulcahy said the center has attempted to increase retention through strong team bonds. Team members are trained to handle many different roles. According to Mulcahy, this practice increases cohesiveness and allows staff members to have regular breaks and a better work/life balance. Registered nurse Liliys Salinas says that short staffing is a barrier the center has the tools to overcome.

"Like all places, we can be short staffed if somebody is unable to make it to work," Salinas said. "For a smaller procedure center this can be a challenge, but not enough to make it an unsafe environment for patients or staff."

Bonding

The team bonds in many ways outside of work. Alaska provides a unique environment for team retreats, which includes a lot of outdoor activities in the summer and in the winter. According to Mulcahy, the team's medical director, Dr. Steven Ingle, provides an annual day at a ski lodge. Additionally, registered nurse Amy Fredenhagen takes the team out to her cabin each year for a retreat. Mulcahy said this retreat allows the team to disconnect from technology and get to know each other.

At the end of each day at Anchorage Endoscopy, the team walks out together. Mulcahy said this helps staff members get home safely, especially during the winter, when it can be difficult to get cars ready to drive home in the freezing weather.

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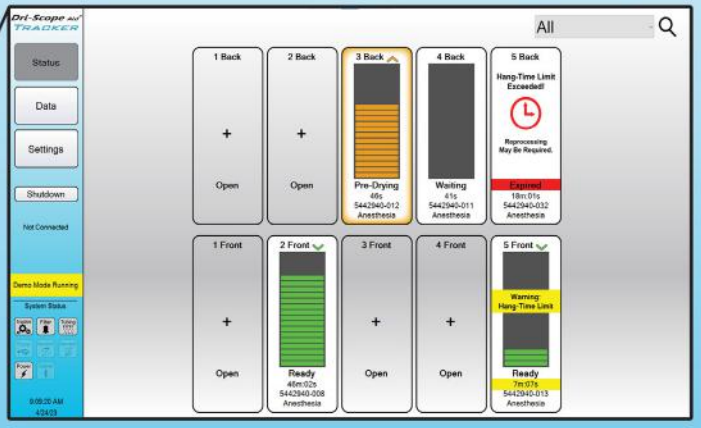

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All these team bonding activities are meant to facilitate a high morale within the center. Mulcahy said that Anchorage Endoscopy's physicians believe that when a team is highly trained, happy and connected, they are more likely to provide patients with great care.

"The patients know when a caregiver is happy to attend to them, resulting in a happy patient," Mulcahy said. "Happy staff, happy patient, happy physician."

Physicians

The physicians are important in facilitating a fun work environment for Anchorage Endoscopy. According to Mulcahy, Dr. Eric Tompkins gets to know employees through music and will ask them icebreaking questions that employees have to answer through song titles.

Dr. Douglas Haghighi bonds with team members through "dad jokes." One of Mulcahy's favorite Haghighi jokes is "We'll be watching CNN today … Colon News Network." Several staff members said their favorite Haghighi quote is, "Everyone has a pink colon. Can't we all just get along?"

Dr. Praveen Roy keeps staff members engaged by quizzing them on various topics such as medicine and geography. Endoscopy technician and graduate nurse Brittany Chappel said that the team even challenges each other online through Wordle. Ingle also likes to answer radio trivia questions with Fredenhagen each morning.

The team is also motivated by food. Roy rewards team members with Oreos, and Dr. Geronimo Sahgun often brings in breakfast for the team.

Dr. Kimberly Houghton, the only female gastroenterologist in Alaska, brings a lot of expertise to the team. Mulcahy said staff members are always learning and growing from her techniques.

Support from leaders and physicians is especially important, not just for the growth of Anchorage Endoscopy staff's skills, but also for the growth of the center as well, according to Fredenhagen.

"As a worker bee and not management, I feel valued when my leaders have kindly intervened and reminded patients to be kind to staff," Fredenhagen said. "Also, when a staff [member] has not been 'a good fit' by not pulling their weight of tasks or stirring up conflict, management lets them go. This takes courage and it also helps our team feel cared about and appreciated."

Madison Knutson is a student at Arizona State University pursuing a bachelor's degree in journalism and mass communication. She works as a producer for the Alaska Teen Media Institute and is a deejay for Blaze Radio at ASU.

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Endoscope Point-of-Use Treatment

How Important Is It?

By Nancy Chobin, RN, AAS, ACSP, CSPM, CFER

Point-of-use (POU) treatment is the first step in endoscope reprocessing and is performed by nurses, endoscopy technicians, or other designated personnel at the point of use, immediately following the patient procedure. POU treatment should begin as soon as possible after the physician removes the endoscope from the patient and before the endoscope is detached from the light source or video processor. This process helps prevent buildup of bioburden, formation of biofilm, and drying of secretions. It is essential that personnel performing the POU treatment carefully follow the instructions for use (IFU) from the endoscope manufacturers and pretreatment cleaning solution manufacturers. This includes any materials, chemicals and methods recommended.

When performing POU treatment, personnel must wear appropriate PPE. A single-use, non-linting cloth or a sponge should be soaked in a freshly prepared cleaning solution and used to wipe the endoscope from the control section to the insertion tube and the distal end. A variety of POU cleaning products are currently available, including pre-measured, diluted detergent in single-use packets.

During the POU treatment process, the endoscope controls should be positioned in the free and unlocked position. Unless otherwise directed by the endoscope manufacturer's IFU, the distal end of the endoscope should be placed in the water or detergent solution and all suction/biopsy channels should be flushed according to the endoscope manufacturer's IFU, using the prescribed volume of water or detergent solution. This helps remove gross debris and verify that the channels are not obstructed. Next, the water or detergent solution should be alternately suctioned with air through the biopsy/suction channel until the solution is visibly clean. Solution should be flushed or aspirated through any additional channels, including (if applicable) the air/water, elevator wire, and auxiliary water channels, according to the endoscope manufacturer's IFU.

After all channels are flushed and aspirated and all external surfaces of the endoscope are wiped, the endoscope should be disconnected from the light source and suction pump. For a video endoscope, the protective video cap should be attached. The same water-resistant cap should be used throughout the cleaning and disinfection process.

While this is another step for processing endoscopes, it is an important one and should not be overlooked. When soil is allowed to dry, it becomes more difficult to remove. Considering the numerous small channels in flexible and semi-rigid scopes, POU treatment can have a dramatic effect on cleaning the endoscope. According to the Multi-Society Guideline on Reprocessing Flexible Endoscopes and Accessories, "technicians should perform precleaning/point of use treatment immediately after a procedure is completed, before bioburden has an opportunity to dry, and before comprehensive decontamination."

Depending on the design of the endoscope, the manufacturer's IFU can vary with the make and model of endoscope. Compliance with the specific IFU is essential to enhance the cleaning process.

Just as important as the POU treatment is the quick transfer of the treated endoscope to the scope processing area. There is a critical time frame between the time the POU treatment was performed and cleaning initiated. The scope manufacturer should provide this information. However, if there is a delay between the POU treatment and the cleaning as recommended by the scope manufacturer, then the recommended delayed processing protocols recommended by the endoscope manufacturer should be followed, according to the Association of PeriOperative Registered Nurses' (AORN) Guideline for Processing Flexible Endoscopes.

To ensure compliance, documentation should be sent with the POU-treated endoscope indicating the time POU treatment was performed so that the processing technician can determine if delayed processing protocols need to be implemented.

Personnel processing flexible and semi-rigid endoscopes have a moral and ethical responsibility to ensure all steps are taken to provide a safe and effective device to the end user. Failure to perform just one step, and perform it correctly, can have severe consequences. Sometimes we "catch" a mistake and have a chance to correct it. However, mistakes are often overlooked, and that is when patient care can suffer.

Nancy Chobin, RN, AAS, ACSP, CSPM, CFER, is the president and CEO of Sterile Processing University, LLC, of Lebanon, New Jersey. Her company was founded in 1996 and provides SPD and GI consultations, competency assessments, design of sterile processing areas (in hospitals, surgery centers and endoscopy processing areas), on-site training, and online training courses for ambulatory surgery, SPD and endoscopy processing personnel.

Chobin consults for dental and medical offices where sterilization is performed. She has authored three textbooks and two workbooks, and has provided chapters and served as an editor for other textbooks on sterile processing. Chobin has lectured extensively in the United States; Latin, Central and South America; Mexico; and in Asia and Europe. Chobin has published numerous articles in a variety of professional magazines.

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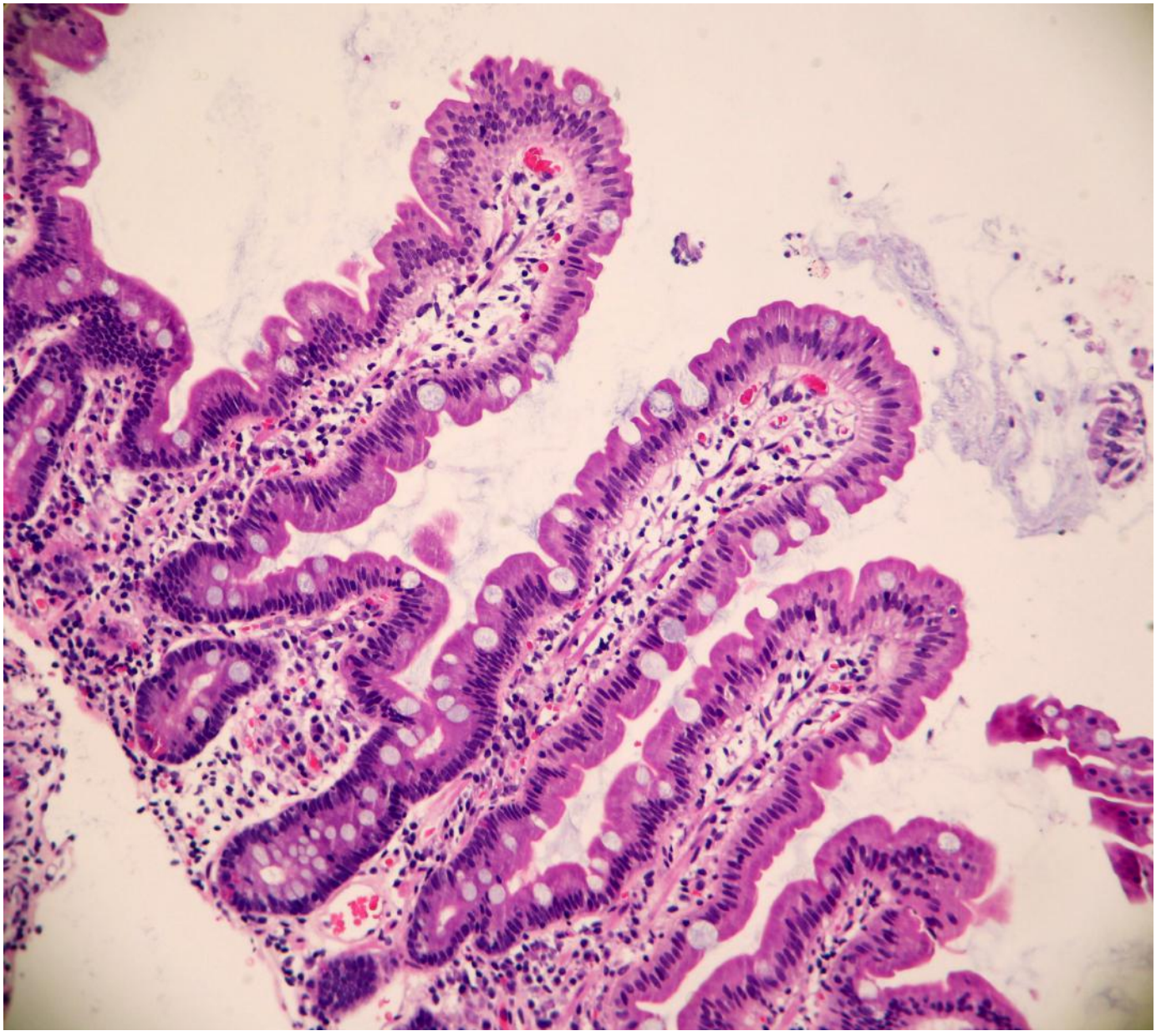
Rewriting the Script on Type 2 Diabetes

The Duodenum as a Therapeutic Target

By Fateh Bazerbachi, M.D.



The duodenum is the initial segment of the small intestine and is now considered an integral player in our body's metabolic regulation, orchestrating a complex interplay between the gut microbiome, various cell types within its mucosa, and the gut's immune and enteric nervous systems. It not only facilitates the efficient breakdown and absorption of nutrients, but also plays a crucial role in maintaining glucose balance and modulating immune responses, both locally and systemically.

This makes the duodenum a promising, yet previously underutilized, target for therapeutic interventions, particularly in the context of metabolic disorders such as Type 2 diabetes mellitus (T2DM).

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body's resistance to insulin and a compromised ability to manage glucose levels. Treatments have traditionally revolved around lifestyle changes, medications to lower blood sugar, and insulin supplementation.

However, the duodenum's central role in digestion and nutrient absorption—where it serves as a critical juncture for the intermingling of stomach contents with digestive enzymes and bile—positions it as a novel focal point for T2DM therapies.

By leveraging the duodenum's natural digestive processes and its influence on metabolic pathways, regenerative medicine is exploring innovative approaches to treat and potentially transform the management of T2DM.

The Duodenum as a Central Player in Metabolic Health and Disease

The duodenum is more than just a pathway for digested food. It acts as a sophisticated control center, integrating signals from the food we eat, the microbes in our gut, our nervous system, and our immune responses. This integration is crucial for managing our body's metabolism effectively. The duodenum achieves this through the release of specific hormones and neurotransmitters like cholecystokinin (CCK), glucagon-like peptide-1 (GLP-1), and others. These substances communicate with the brain and other metabolic organs via nerve receptors in the duodenal wall, influencing various metabolic processes, including insulin production in the pancreas and glucose regulation in the liver and muscles.

However, when we consume excessive calories, especially from processed foods and sugars, the duodenum can become overwhelmed. This overburden can lead to inflammation, an imbalance in gut bacteria, and disrupted metabolic signals. Such duodenal dysfunction not only affects the duodenum itself but also has a systemic impact, worsening metabolic disorders and their associated risks, such as heart and liver diseases.

By focusing on correcting the dysfunctions within the duodenum, we could potentially correct this abnormal signaling, offering a new therapeutic target that serves as an adjunct to medical therapies for Type 2 diabetes. This approach may help optimize blood sugar control and potentially reduce the risk of complications associated with this chronic disease.

The accessibility of the duodenum through upper endoscopy (EGD) not only allows for a detailed evaluation of this critical digestive segment but also paves the way for the delivery of targeted therapies. This approach is bolstered by advancements in endoscopic technology, which provide unprecedented visual clarity of the duodenal anatomy, particularly the crypts and villi, offering profound insights into the intestinal changes associated with metabolic diseases.

Diabatic Duodenopathy: A New Concept

The term "diabatic duodenopathy" describes alterations in the duodenal mucosa potentially linked to T2DM. This entity is characterized by several changes that suggest a compromised duodenal environment in diabetic patients. Research using both human subjects and animal models has shown that the lining of the duodenum undergoes excessive growth and multiplication of cells when exposed to contemporary dietary patterns. This response in the duodenal mucosa triggers a signal that promotes insulin resistance, which may contribute to the development of metabolic disorders[1].

Artificial intelligence algorithms can analyze histological changes in the duodenal lining, further supporting the association between these alterations and T2DM.[2] This highlights the role of inflammation and the presence of inflammatory cells in the submucosal layer, which is crucial for signaling to the enteric nervous system, potentially disrupted in T2DM.

Regenerative Therapies: A Brave New World

Addressing the disruptions in the duodenal mucosa and submucosa offers a promising avenue for treating metabolic and inflammatory conditions. Electroporation or pulsed electric field (PEF) therapy represents a significant advancement in this area. PEF uses ultrashort electric bursts to increase cell membrane permeability, leading to cellular regeneration with minimal damage to surrounding structures as it does not generate heat. This approach preserves the tissue scaffold, essential for new cell growth, and offers a uniform, non-thermal ablation method with depth control and minimal inflammatory response.

The detailed imaging capabilities of modern endoscopes, combined with innovative treatments like PEF, offer hope for patients with Type II diabetes. Although procedures like PEF and other adjacent techniques such as duodenal mucosal resurfacing are still under investigation, they hold promise as potential interventions. As research progresses, these approaches could offer additional value in the management of metabolic diseases.

ReCETting the Clock on Diabetes Control

Endoscopic re-cellularization via electroporation therapy (ReCET) represents a new promising approach in the treatment of T2DM, leveraging the regenerative potential of PEF to induce cellular regeneration in the duodenum[3]. This innovative method leads to regeneration of healthier cells in the duodenum that can potentially improved outcome in Type 2 diabetes[4]. The procedure involves treating multiple segments of the duodenum, each 2 centimeters in length, avoiding the area of the major papilla, where the liver and pancreas drains, and with minimal temperature increases, highlighting its non-thermal nature.

The ReCET procedure begins with the endoscopic identification of the major papilla, followed by the insertion of a guidewire and catheter into the duodenum. A flexible circular plate is then expanded to make contact with all duodenal walls, and pulsed electric field therapy is applied. This process is repeated for subsequent segments of the duodenum. The regenerative effects of this therapy can potentially improve some of the changes in the duodenum associated with Type II diabetes.[3]

Looking ahead, the future of diabetes management may parallel the concept of open-access colonoscopy for colorectal cancer screening and surveillance. Just as colonoscopy has become a widely accessible procedure for early detection and prevention of colorectal cancer, endoscopy could play a role in the management of metabolic diseases, particularly diabetes.

The ReCET procedure represents a promising endoscopic intervention for improving Type 2 diabetes outcomes.

Dr. Bazerbachi is director of interventional endoscopy at CentraCare, St. Cloud Hospital in Minnesota. *Dr. Bazerbachi thanks and acknowledges Dr. Barham K. Abu Dayyeh, co-inventor of ReCET, for several helpful and informative discussions regarding these evolving technologies.*

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How Low-

-FODMAP Foods Can Help IBS Patients

By Amy Laura

Irritable bowel syndrome (IBS) is one of the most common gastrointestinal disorders in the world. One in seven people are affected by IBS globally. Following a Low-FODMAP Diet has been found to offer relief for 70%–75% of those dealing with IBS. FODMAPs are fermentable carbohydrates (sugars) that are found naturally in foods. In patients with IBS, consuming these carbohydrates can result in symptoms during digestion.

The Low-FODMAP Diet was developed by researchers from Monash University of Australia, inventors of a scientifically proven food plan for improving the symptoms of IBS and world leaders in FODMAP research. A team on the management of IBS conducted by the American College of Gastroenterology suggested that the Low-FODMAP Diet can be used for overall symptom improvement in IBS.

As an IBS survivor of 30 years who experienced life-changing relief from this chronic condition, this topic is near and dear to me. And I feel a responsibility to educate and encourage other IBS sufferers to try low FODMAP so they can improve their quality of life. When it comes to investing one's time, effort, and hopes on the Low-FODMAP Diet, IBS patients will naturally have questions about the plan, and some are hesitant to give it a try. This article addresses five ways in which the low-FODMAP plan for IBS symptom relief can seem off-putting to some patients, and busts a few myths.

So, why would a medically proven plan that is helping millions of people around the world be unappealing to some people suffering from IBS?

Problem #1: The Weird Name

Like many people who have experienced life-changing relief from a chronic condition, I feel a responsibility to educate other sufferers and to encourage them to try low FODMAP so they can improve their quality of life.

However, early on I noticed that sometimes I'd get "that look" when explaining what I do for a living. Something similar to the skeptical smile when one suspects they're in for a pyramid scheme pitch. In the past, when someone in casual conversation asked about my work, my response was, "I develop recipes for people on the Low-FODMAP Diet." Right then, I'd get that look.

I realize that most people have heard of paleo, keto, intermittent fasting, Whole30, Atkins, juicing, Zone, macrobiotic—a massive number of health diets and programs. And now I'm introducing something that sounds like a GPS system from "Guardians of the Galaxy." "Activate the FODMAP!" That's exactly what came to mind when I first learned of it from an online search.

FODMAPs remain a relative unknown in the United States. And acronyms can be intimidating. So I made an effort to change my wording.

Now when people ask about my profession, I bury naming the diet by saying, "I'm following an IBS diet that relieved my symptoms. It was invented by world leaders in IBS research, and now I write about it and develop recipes for people in the gut-health community." If they're open to discuss, we talk about how it changed my life, I keep it light and judge their interest or lack of to navigate the exchange of information.

When someone in IBS distress asks about my line of work, I'm on it like Cher at a sequin convention. Still, I lead with how the IBS diet helps people, and hold off on the name. We swap stories and talk about symptoms. I ask if they've been diagnosed with IBS, different treatments they've tried, and wait for their lead when they ask, "What is the name of this diet you follow?"

At this point, it's safe to drop names. "FODMAP is named after a specific carbohydrate that's found naturally in foods that cause digestive symptoms for people with IBS. They're called

FERMENTABLE: **Gut bacteria are unable to digest foods that ferment in the gut**
OLIGOSACCHARIDES: **Fructans and GOS found in foods such as wheat, rye, onions, garlic and legumes**
DISACCHARIDES: **Lactose found in dairy products**
MONOSACCHARIDES: **Fructose found in honey, apples, high-fructose corn syrup, etc.**
And
POLYOLS: **Sorbitol and mannitol found in some fruits, vegetables and artificial sweeteners**

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FODMAPs. Sounds like a GPS system from a sci-fi movie—the Low-FODMAP Diet."

I also carry note-card handouts with the FODMAP acronym spelled out.

Can you imagine the look I'd get if I started off with, "It's a food plan about Fermentable Oligosaccharides, Disaccharides …"?

This new approach has made a significant difference in connecting with IBS sufferers, as well as in general conversation.

Problem #2: People Think This is a Forever Diet

This common myth deters many people from investigating and trying the plan. No, low-FODMAP is not a lifelong diet.

Monash designed a three-phase plan that begins with eliminating high-FODMAP content foods to give your digestion a rest, and ends with tailoring menus to your personal taste and tolerances as you add high-FODMAP foods back to your diet. And it's app-friendly. Patients use the Monash FODMAP Smartphone App that contains their entire database of tested foods, with low-, moderate- and high-portion amounts. The plan looks like this:

Phase 1: Elimination—Low-FODMAP

Patients start with two to six weeks of swapping high-FODMAP foods with low-FODMAP, such as replacing high-FODMAP fresh mango with low-FODMAP fresh papaya in portions compliant with this beginning phase.

Elimination also allows for consuming high-FODMAP foods in low-portion sizes. For example, red bell peppers are high FODMAP but have a generous low serving size

While Monash data reports a general timeframe of between two and six weeks for a patient to feel symptom relief, I found my body calming down and adapting to the plan in just three days.

Keep in mind that we all have unique experiences and tolerances, and as a patient feels physical relief and the lightness this brings to their entire being, the plan becomes easier and they'll want to keep at it to manage symptoms.

Phase 2: Reintroduction

Eight to twelve weeks. Patients continue eating low-FODMAP and add back one FODMAP at a time, one food at a time over three days. If they're missing mangoes, they may choose to increase their intake to a moderate serving. If their symptoms are not triggered, each day they can increase the serving amount from moderate to higher FODMAP levels and monitor their tolerance by using a food diary.

Phase 3: Personal Maintenance

Patients continue adding back moderate to high-level FODMAP portions of foods, one at a time, to find personal tolerances and balance. Working with a FODMAP-trained dietitian makes the process much easier.

When I first read about this step and realized that I wouldn't walk through life feeling cranky as my husband ate enchiladas while I was stuck with rice and chicken broth, I felt a happiness like picnicking under Monet's water lilies while listening to Enya and eating tacos. A perfect moment.

Problem #3: The Diet Might Seem Expensive

During the three-plus decades of my tummy drama journey to find answers, I spent a small fortune trying a slew of diets, food eliminations and fad treatments. Nothing offered relief, because all along I was consuming foods containing high-FODMAP content. This is why, when I hear an IBS sufferer balking at trying low-FODMAP with "Oh, gee, another food plan," I get it. Loud and clear.

The cost adds up each time you stock your fridge and pantry with new ingredients, supplements, and specialty products. New items in the Elimination Phase include gluten-free products that are more expensive than regular wheat breads, pastas and so forth, and lactose-free milk, cheeses and dairy that are priced higher than conventional cow's milk dairy.

Monash's website offers budget-friendly advice as you start out, with tips like planning your menus, using leftovers, and stocking up on sale products.

I'm a serious taco-holic. My mantra is, "If I had to live my life over, I'd live over a low-FODMAP taqueria." If you love tacos, using leftovers to fill the shells and extend meals is a cost-cutting tip I've used for years. I also buy in bulk when possible, and make use of sale items that I can freeze or keep in my pantry.

Many FODMAP-trained dietitians offer budget-friendly menus, and this is an important question to bring up as you interview candidates to assist in your journey toward symptom relief.

As for the high-FODMAP foods that are already in your fridge and pantry, don't toss them out. You'll be adding them back into your diet in Phases 2 and 3, so freeze what you can, and save some to serve to family members and friends who can eat "forty-clove garlic Chicken" with no worries.

By the way, if you are vegan or vegetarian, not to worry. There are low-FODMAP menus and recipes for you, and dietitians can help tailor your food plan.

Problem #4: Planning Family Meals

This was an initial concern of mine because my increasingly unpredictable symptom flare-ups were leading toward a home-bound life. The last thing I wanted was to feel even more isolated from my family due to diet restrictions. Particularly

on the rare occasion that my digestion was calm enough to attend special-occasion events.

My worries flew out the window when I found that Monash offers meal plan tips, their app lists certified low-FODMAP recipes, and there are dozens of cookbooks tailored to the Elimination Phase. I'm also lucky in that my family is in full awareness of my "problem child" foods and are supportive of me avoiding those foods.

For family meals, plan ahead: for example, fix a big pot of beef chili prepared with low-FODMAP ingredients. Offer high-FODMAP ingredients separately on the side, such as: a bowl of diced white onion, garlic salt, conventional cow's-milk sour cream, and hot sauces containing onion and garlic. This way, everyone customizes their meal as they like it. FODMAPers at the table may add low-portion toppings of thin-sliced scallion stems (green parts only), lactose-free sour cream, and crushed gluten-free corn tortilla chips to their personal tolerances.

Easy breakfast? Serve scrambled eggs made with no milk or lactose-free milk, low-FODMAP gluten-free toast or pan-

toasted corn tortillas, bacon, air-fryer plain potatoes, and a slice of cantaloupe on the side.

Who doesn't love a taco bar? You know I do! Everyone gets to build their own meal with low-FODMAP seasoned taco meat and a separate bowl of high-FODMAP onion and garlic-laden meat for the family. Toppings are simple: shredded iceberg lettuce, black olives, diced common tomato, lactose-free sour cream and a sprinkling of minced chives.

Obviously, mind your unique tolerances as you cook.

Problem #5: The Title Implies That Sugar is Off-Limits

This is another myth to bust. FODMAPs are short-chain carbohydrate sugars, but that doesn't mean all sugars are high-FODMAP.

I was elated to learn that granulated white sugar is low-FODMAP, and brown and confectioners' sugars both have ample low-FODMAP amounts. For those of us who believe that where there is cake there is love, with a few ingredient swaps you can make chocolate and "tres leches" (or "three milks")

cakes, as well as vanilla flans, brownies, and countless desserts that will have you building sweet memories of all the low-FODMAP cupcakes available to you.

Conclusion

IBS and digestive distress have been taboo topics in the U.S. for far too long, and FODMAPs are still so new here that misinformed assumptions are widespread. The good news is that open conversation about digestive issues is becoming more common, as are articles about IBS and FODMAPs.

Just last week, my jaw dropped when two high-profile, national talk show hosts were discussing digestive health on their morning show. No talk of symptoms (poop details might put a damper on viewers enjoying their early morning pancakes), and they were a bit hesitant with their wording of this new show segment, but digestive issues were mentioned, with follow-up stories to come. That moment was one small step for national TV hosts, and one giant leap for digestive conditions and IBS mainstream awareness in the United States.

When my symptoms began in the 1980s, IBS and FODMAPs were not on the U.S. radar. Today, we have access to Monash data, recipes, and newly tested foods, with heaps of medically proven advice in learning to manage our symptoms.

Please note that it is important for patients to be medically diagnosed with IBS by their gastroenterologist and work with a registered dietitian and healthcare professional when starting the Low-FODMAP Diet to tailor the plan to their particular sensitivities. It's vital that before you change your diet, you check with your GP and get a proper diagnosis for any gastrointestinal symptoms.

By following the proper steps, before you know it you could be feeling better than you ever imagined.

Amy Laura, IBS patient, is digestive-health author of "Calm Tummy Happy Heart," the first low-FODMAP cookbook from the United States with Monash FODMAP-certified recipes inspired by the American Southwest. The book is available at https://bit.ly/FODMAP-book.

	High-FODMAP foods	Low-FODMAP alternatives
Vegetables	Artichoke, asparagus, cauliflower, garlic, green peas, mushrooms, onion, sugar snap peas	Aubergine/eggplant, beans (green), bok choy, green capsicum (bell pepper), carrot, cucumber, lettuce, potato
Fruits	Apples, apple juice, cherries, dried fruit, mango, nectarines, peaches, pears, plums, watermelon	Cantaloupe, kiwifruit, mandarin, orange, pineapple, blueberry
Dairy & alternatives	Cow's milk, custard, evaporated milk, ice cream, soy milk (made from whole soybeans), sweetened condensed milk, yogurt	Almond milk, brie/camembert cheese, feta cheese, hard cheeses, lactose-free milk, soy milk (made from soy protein)
Protein sources	Most legumes/pulses, some marinated meats/poultry/seafood, some processed meats	Eggs, firm tofu, plain cooked meats/poultry/seafood, tempeh
Breads & cereals	Wheat/rye/barley-based breads, breakfast cereals, biscuits and snack products	Oats, quinoa flakes, quinoa/rice/corn pasta, rice cakes (plain), sourdough spelt bread, wheat/rye/barley-free breads
Sugars, sweeteners & confectionery	High-fructose corn syrup, honey, sugar-free confectionery	Dark chocolate, maple syrup, rice malt syrup, table sugar
Nuts & seeds	Cashews, pistachios	Macadamias, peanuts, pumpkin seeds/pepitas, walnuts

visit

FODMAPs and Low-FODMAP Diet Information: **www.monashfodmap.com**

Monash Meal Tips: **www.monashfodmap.com/blog/low-fodmap-meal-planning**

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To Outsource or Not Outsource?

The Pros and Cons of Physician Practice-Management Companies

By Lisa Hewitt, MA

Many people outside the healthcare industry imagine that doctors who own their own practice have lives of luxury, flush with cash and eased by the convenience of staff members leaping to their command. We may envision that during nights and weekends, this hypothetical doctor enjoys the calm of the good life, their golf practice closer to their thoughts than their medical practice.

However, the reality is quite different. Sure, doctors make an excellent living, but the stress of owning a practice can be extreme, and very few of those business realities are taught in medical school. The human body? Check. The anatomy of a business? Uncheck.

Many practice owners are beleaguered and trying to figure out how to squeeze hours of administrative work into an already overbooked day of seeing patients. Riding to the rescue is the physician practice-management company, or PPMC.

More familiarly known as a management services organization (or MSO), a practice-management company is like having a dedicated team of admins—and so much more. While not everyone favors having a practice-management company involved—and indeed, even when the arrangement works out, the transition can initially cause huge upheaval—the benefits can be numerous.

Depending on the company, services can include: premises and/or equipment leasing and repair, bookkeeping and electronic health records (EHR) management, personnel management, billing and claims submission, financial management, technology support, marketing and public relations, regulatory compliance oversight, staff training and education, and managed-care contracting assistance. Generally speaking, if a doctor needs something done in a non-clinical arena, a practice-management company can get it done.

The Ninety Nine Healthcare Management blog offers the six following reasons to consider partnering with an MSO.

Improved patient care: Farming out clerical tasks means the on-site staff can focus on what's most important: the patients.

Budget trimming: Utilizing an MSO reduces your need for additional staff, as well as freeing up monies earmarked for such things as in-office technology, office space, and even parking.

Strategic support: If someone else is handling the admin tasks, you don't have to worry about creating an administrative strategy to implement those tasks in the most cost-effective fashion.

Practice growth: An MSO can offer effective marketing strategies to expand your patient base and track the ROI.

Experienced management: The experts on an MSO's team can handle problems and deal with issues proactively.

Streamlined administration behind the scenes: New software? Not your problem. Training a new clerical staffer? Let someone else handle it. Reorganizing medical files? Let the MSO do it, so you can actually take a day off.

A Changing Business Landscape

According to a biennial analysis from the American Medical Association, the past decade has seen a dramatic shift in practice ownership, with doctors eschewing the traditional private-practice model in favor of working in a hospital or for a practice owned by a hospital or health system. From 2012 to 2022, the number of physicians working in private practices dropped from 60.1% to 46.7%—a change of 13%. At the same time, large practices (those with 50 physicians or more) saw a jump from 12.2% to 18.3%.

Rather than embracing self-employment, many doctors—especially younger doctors—now seem content to work as employees. According to the AMA, "Between 2012 and 2022 the share of physicians under the age of 45 who were self-employed fell by 13 percentage points from 44.3% to 31.7%. This suggests that a smaller share of each successive class of physicians has started their post-residency career in an ownership position."

In a land of increasing debt and uncertain viability of the traditional private practice, going to work for a health system has become an increasingly appealing option.

It isn't just doctors who see these changing demographics. Investors are also paying very close attention. Daniel Levin and Nicholas Janiga wrote in HealthCare Appraisers, "Gastroenterology ("GI") practices have been going through a period of consolidation since 2016 when the most recent wave of GI-focused physician practice management ("PPM") companies started acquiring practices. Currently, there are several large private equity-backed PPM companies operating in the space, and we continue to observe interest in a variety of transaction types and structures.

"The GI space is attractive for many reasons, including the presence of ancillary services, favorable demographic trends, and recent changes to colorectal cancer screening recommendations. In addition to these industry tailwinds, operators face challenges related to provider shortages, inflation, and complicated relationships with hospitals."

But the complex side of corporate ownership is a raft of laws in several states that prohibit non-medical entities from owning medical practices.

CPOM Legislation

These Corporate Practice of Medicine (CPOM) laws "preclude hospitals from employing physicians to provide out-patient services," according to the IRS. The 33 states that have implemented these laws—including California, Texas, Ohio, Colorado, Iowa, Illinois, New York and New Jersey—maintain there is a conflict of interest between the "interests of a corporation and the needs of a patient." A corporation, by its very nature, is required to make money and is answerable to shareholders—not patients or their families. (See your state's

laws for more information on how CPOM may affect you and your practice.)

Moustakas Nelson LLC wrote, "In essence, the CPOM doctrine … prohibits a licensed practitioner from providing health care services as an employee of a general business corporation or a business entity in which the shareholders are not all licensed practitioners (with certain specific exceptions).

"The basis for the CPOM doctrine is to create a wall between the practitioner, who must act in [a] patient's best interests, and corporate shareholders, who seek to maximize profits, thereby eliminating any influence in the provision of medical care from a corporate shareholder."

Attorneys Shtern and Lipsky wrote in Physicians Practice, "… the CPOM prohibition prohibits the MSO from impacting or controlling a physician's clinical judgment and independent medical decision-making, which must be reserved solely to the physician and the physician practice.

"Arrangements between physician practices and MSOs must be carefully structured and implemented in a manner that does not run afoul of a state's CPOM prohibition. Most states have some form of a CPOM prohibition, with some states having more stringent rules than others."

And we're not just talking about the family practice. Michael H. Cohen of Cohen Healthcare Law Group said, "If you have a medical spa, a multidisciplinary clinic, a medical group, a telemedicine venture, psychology group, software or an app that involves M.D.s, psychologists, or you're in a situation where the non-medical entrepreneur wants to control the venture, but can't entirely hand it over, due to corporate practice of medicine and fee-splitting concerns, that is where you'll want legal advice on what your MSO can and can't do."

California is one of the most stringent states when it comes to CPOM laws. Nelson Hardiman Healthcare Lawyers stated that if a practice chooses to employ an MSO, it's critical to ensure that a physician or physician-owned medical corporation is the one making medical decisions. And we're not just talking diagnoses, but also hiring, management and termination of employees, oversight of treatment, and selections of medical equipment and supplies. "Physicians and PC's need to remember that they will be held accountable to regulators for the conduct of the MSO," they wrote.

While gross and net revenues may not be shared between PCs and MSOs, physicians may pay an MSO a percentage of gross revenue for services, "provided that the payment is reasonably commensurate with the value of the services and not simply a payment for patient referrals."

On the other end of the CPOM spectrum is Florida, where according to the Florida Healthcare Law Firm, "non-physicians can both own a medical practice on their own or jointly own a medical practice with other physicians. However, Florida requires entities with non-physician owners to register the practice as a health care clinic and a physician must be employed as a medical director to direct and supervise the clinical aspects of the practice. In other words, a physician may be employed by or contracted by non-physician owned entities for the delivery of healthcare services. For this arrangement, the non-physicians must not be engaged in the diagnosis and treatment of patients and cannot exercise any control over the physician's professional judgment or the way he or she renders medical care to patients."

While it's doable to have a stake in—or even own—an MSO if you're a physician, there are certain caveats. According to Cohen, it can be considered a conflict of interest. "Every time the physician provides services, the MSO also makes money," Cohen said, "as the MSO typically charges the physician or the physician's professional medical corporation at fair market value for MSO services. This conflict of interest is an ethical violation, possibly a legal violation in principle, and at a minimum should be disclosed to the patient." Part of the decision-making process is evaluating one's tolerance for risk, Cohen said.

Violations of CPOM laws can have major repercussions. Nelson Hardiman Healthcare Lawyers wrote, "Specifically, if physicians or other clinical personnel work for entities other than professional medical corporations, they may be exposed to disciplinary risks, as well as to forfeiture of revenues from payors for services rendered. For non-physician business partners, violating the CPOM may also bring both civil and, in extreme cases, potential criminal liability for engaging in medical practice without a license."

Before diving in, check with your state's regulatory agency for more information. If you've done your due diligence and you're ready to take the plunge, start by looking at your practice's needs and potential future growth. Will you need assistance with billing? Medical coding? Are you planning to partner with another provider in the future? Want to jump into an ASC? Are you ready to create your own healthcare app?

Vet any agency thoroughly. Ninety Nine Healthcare Management said partnering with any MSO should be a thoughtfully considered decision, supported by substantial research. They recommend looking at any MSO's corporate philosophy and values to ensure they align with yours. Also, be careful to check the company's track record, especially their history with practices similar to your own. Any MSO should not be asking you to sell your practice, join an Independent Practice Association (IPA) or become an employee. Read the fine print. And it's never a bad idea to consult an attorney before making such a big change.

Ready to Make the Leap?

Here is a partial list of companies and organizations that might help get you where you want to go. This list is not exhaustive, and EndoPro Magazine does not endorse hiring any specific MSO.

Offering members a practice-management "toolbox" and a host of other resources, the **American College of Gastroenterology** has expert instruction on Medicare coding, a

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coding forum, and information and updates from the U.S. Food and Drug Administration, the ACG's Prior Authorization Task Force, and Public Policy News. See https://gi.org/practice-management/.

The American Society for Gastrointestinal Endoscopy, or ASGE, offers practice-management products that include a GI operations benchmarking survey (executive summary and databook); a screening colonoscopy performance improvement module, or PIM; a coding primer with webinar support; and other patient-engagement resources.

Founded in 1941, ASGE is a trade association "dedicated to advancing patient care and digestive health by promoting excellence and innovation in gastrointestinal endoscopy." Find out more at asge.org.

ModMed offers "specialty-specific EHR systems and solutions" across multiple disciplines, including gastroenterology. Its gGastro and gGastro Endoscopy Report Writer are "built by and for gastroenterologists," according to the website. The gGastro ERW platform was chosen by Olympus to replace its EndoWorks platform nationwide—no small endorsement.

ModMed's gBoost combines a practice-management platform with comprehensive billing services designed to help you take control of your revenue sources. The company also offers gPortal, an online patient engagement portal, as well as other patient-oriented offerings. Modmed.com.

NextServices offers a "powerful services and software platform," including full-stack revenue cycle management: medical coding, same-day billing, eligibility and benefits, prior authorizations, AR management, daily denial management, patient balances, and analytics. Other offerings include new service lines, data services, and compliance.

Its Digital Health Studio gives clients the opportunity to bring their "healthcare ideas to life" via web and mobile apps, EHR sandbox, data warehousing and consulting. Its technology offerings include product development, cloud management, hardware integration, healthcare interoperability and business analytics. Cloud-based EHR software was created to be "clinician-friendly," and IT and automation services all fit neatly under the umbrella of local, state and HIPAA laws. Find out more at nextservices.com

One GI is a Tennessee-based, "physician-centric" MSO whose website says it is "committed to physician autonomy first." Offering resources for "practices of every size," its menu includes finance and accounting, legal and compliance, HR, revenue enhancement, practice benchmarking, IT, marketing and advertising, development and growth, and ancillary services such as infusion, research, pathology, pharmacy, anesthesia, and outpatient centers.

Its board is composed of medical doctors, and the leadership team offers "healthcare industry experts." The company is at www.onegi.com.

PE GI Solutions says it partners "exclusively with GI specialists and healthcare providers to help their practices, ASCs [ambulatory surgery centers], and ancillary services thrive." Working with single practices and partnerships, the company provides business operations solutions and management services, as well as investment opportunities, "to grow practices while maintaining physician independence."

The company also helps physicians or health systems "build, develop, and optimize a new or existing GI-specific ASC" via a flexible service model that offers differing owner or investor options, whether you want to build an ASC from the ground up, merge with an existing one, or engage in a joint venture. Check out more at pegisolutions.com.

Pinnacle GI Partners says they "take a joint approach to partnership," offering to help physicians modernize so they can grow. The private, equity-backed GI platform has created four programs: Base Camp, Launch, Ascent, and Apex.

Base Camp "supports the journey" through leadership development and business analytics. Launch helps not only support physician recruitment, but also develop clinical, mentorship, educational, research and other opportunities to help physician careers flourish. Ascent defines, plans and executes new avenues for practice growth, while refining workflows and deploying tools for automation. And Apex focuses on patient care by improving care models, supporting patient communication and providing patient access. Pinnacle is at pinnaclegipartners.com.

United Digestive has more than 130 physicians in its portfolio, according to Becker's ASC Review. Atlanta-based and backed by private equity, United Digestive calls itself "a collaborative, progressive organization where clinical voices are heard." Services include operations, marketing, IT, HR, finance and accounting, compliance, revenue cycle management, patient call center, provider recruiting, and growth.

With practices in Georgia, Florida, North Carolina and South Carolina, United Digestive says it strives "to be on the cutting edge of gastroenterological care – we bring the latest advancements in both diagnostic and treatment services to our patients, and offer a wide range of in-office services." Uniteddigestive.com.

U.S. Digestive Health (USDH) calls itself "one of the largest gastroenterology practices in the country," employing more than 250 physicians in 37 offices, 23 ambulatory surgery centers, and four clinical research sites. As a physician-led, professionally managed MSO, USDH offers its clients support in operations, finance and accounting, information technology, human resources, marketing, provider recruitment, revenue cycle management, business development, and compliance.

The MSO's website not only offers information for physicians, but also for patients seeking care. It also provides links and information about the company's clinical trials and research. Check it out at usdigestivehealth.com.

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The website says its award-winning software "focuses on streamlining operational efficiencies and helping recover every dollar earned—and enabling practices to deliver the best care for patients."

The advanced scheduling software may help practices manage the unexpected changes and cancellations. Revenue tracking can keep all your financial data in one place, streamlining your decision process. And automation of scheduling, billing, patient check-in and more, empowers your front and back offices to work together with fewer hiccups. They're at Veradigm.com.

Compliance Risks

As with anything involving your business, prudence and due diligence are always a good idea. Getting up to speed on your state's CPOM regulations before signing on the dotted line should go without saying.

Shtern and Lipsky wrote, "In addition to the CPOM prohibition, physicians and MSOs must be mindful of federal and state laws (including the federal Anti-Kickback Statute and state law equivalents) that prohibit improper compensation and ownership arrangements between health care providers and actual or potential referral sources."

They advise clinicians to keep an eye out for potential regulatory red flags, such as an MSO that offers marketing or referral procurement services; if the MSO arrangement precludes a practice hiring a different MSO; and if "the MSO's compensation is directly or indirectly related to referrals or revenues generated by a physician practice." If you think you might be getting into regulatory hot water, consult an attorney. You don't want your practice to become a test case.

Practice management offers challenges for any hospital, practice or medical center. But as long as you go into it with your eyes open, a partnership with a reputable MSO can be beneficial for you, your office team, your patients—and your bottom line.

Lisa Hewitt, MA, senior editor at EndoPro Magazine, has had a long career as an editor, writer and designer, with an emphasis on medical content.

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Properly dried channels reduce the risk of infection. Studies indicate there is a strong correlation between moisture and microbe colonization within flexible endoscopes. The Airtime Instrument Channel Dryer dries flexible endoscope channels, as well as channels in other cannulated surgical instruments.

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