Western New York
PHYSICIAN
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Rochester General Hospital System
Reaching New Heights in Robotic Surgical Growth

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Dr. Eigg preparing the patient for the da Vinci robot. Photo: Lynne Tseng, Dept. of Sugery, RGH

Rochester General Hospital System

Reaching New Heights in Robotic Surgical Growth

After completing a milestone 5,000th robotic surgical procedure, RGHS is now ranked in the top 1% of health systems nationwide. This kind of high-volume benchmark speaks volumes about the progressive thinking and expertise behind some of our region's most distinguished surgeons.

Cover Photos:

Top left: Dr. Eigg preparing the patient for the da Vinci robot.
Bottom left: A close up of the EndoWrist instruments that are used by the da Vinci. The instruments are designed with seven degrees of motion and each instrument is designed for specific surgical purposes such as clamping, suturing and tissue manipulation.
Right: Physician Assistant Bettina Trzcinski at the da Vinci robot assisting Dr. Eichel.

Photos: Lynne Tseng, Dept. of Sugery, RGH

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Welcome to Vol #6 of *Western New York Physician* where you will find informative stories and articles about and for physicians in western NY.

"People of all ages will live better lives when we succeed in bringing elders back to the heart of our society."
~ Dr. Bill Thomas, founder of the Eden Alternative

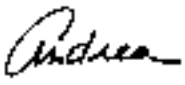
With a focus on Geriatrics, this issue begins to explore how the design of services and care centers in our region are evolving for the fastest growing patient demographic. At the core of this culture shift towards person-centered care is the fundamental belief that our elder patients have a profound right to be active decision makers, as they are able, in how and where they live and receive care. Hear from area experts leading the charge in this care revolution.

Earlier this year, Rochester General Health System (RGHS) completed a milestone 5,000th robotic surgical procedure – elevating RGHS nationally, ranking them among the top 1% of health care systems nationwide; and here in our own region as a leader in the field. Our Cover Story speaks with four RGHS surgeons to get an inside look at what has driven this level of success and where the surgical specialty is headed.

2013 promises to be just the beginning of a major transformation to our health care system – not an event but a process of change. With numerous unknown, immeasurable, and far-reaching implications, making sense of health care reform is a hot topic of discussion and debate. *Western New York Physician's* Health Care Reform series will further the discussion from a local perspective with regional stakeholders as Obama Care unfolds. If you would like to take part in the conversation, please email me: WNYPhysician@gmail.com or call me directly at (585) 721-5238.

Many thanks to each of our advertisers in 2012. Your continued partnership ensures that all physicians in our region benefit from this collaborative sharing of information.

Best wishes for good health in 2013.



Vol 5 Corrections (in bold):

TOC Photo Credit: RIT Biomedical Photographic Communications Surgical Photography **Julie Ducharme** 2009

Page 13 *(Prevention and Targeted Therapies)*: All women with a family history should begin screenings at **40**, they urge, since cancer at this age tends to be far more aggressive.

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PUBLISHER
Andrea Sperry

MANAGING EDITOR
Julie Van Benthuysen

ADVERTISING MANAGER
Jane Frame

CREATIVE DIRECTOR
Lisa Mauro

PHOTOGRAPHY
Lynne Tseng, Department of Surgery
Rochester General Health System

CONTRIBUTORS
Julie Van Benthuysen
James Szalados, MD, MBA, Esq
Nicole Hirt, MSHA
Carol S. Maue, Esq
Jennifer N. Weidner, Esq
Paul S. Fusco, Esq
Stamatia Destounis, MD, FACR
Tarek Sousou, MD
David Gill, MD
Brett W. Phillips, LMT, PDMT
James M. Sperry, PhD, MBA

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WNYPhysician@gmail.com
Phone: 585.721.5238

CLINICAL FEATURE

Anterior Scapular Rotation (ASR): Humeral Formula

By Brett W. Phillips, LMT, PDMT

In my last article, we discussed ASR and the Scapular Formula when dealing with complaints such as neck pain, headaches, front shoulder pain or knots between the shoulder blades.

This time, we'll investigate ASR in relation to what I call the Humeral Formula, which is one of the results of the scapular formula.

When assessing soft tissue pain there are four factors that need to be considered:

1) an instigation or cause
2) a result and
3) the compensation which are both areas of primary pain complaints, and
4) an allowance which is a weak, destabilizing muscle.

The Humerus rolls medially (inward), forcing the Subscapularis to function in a shortened state which makes it contract harder and not release from that contraction.

Instigation: Subscapularis, Teres Major, Latissimus Dorsi hold the humorus in medial rotation This type of instigation may result in Subdeltoid bursitis, rotator cuff tendonitis or biceps tendonitis.

After the instigation comes the compensation. The compensation comes from the Medial and Posterior Deltoid spasm. The Medial and Posterior Deltoids are trying to compensate the medial rotation of the Humerus by constantly contracting which in turn may create subdeltoid bursitis and Deltiod tendonitis .

As a result, the Humerus rolls forward, the Subscapularis over contracts (gets larger in its space than it's supposed to) and now that space is encroaching on the brachial plexus and vascular structures contributing to Thoracic Outlet Syndrome.

The allowance for the Humeral Formula is the weakness in the posterior rotator cuff. There are three muscles allowing the rotation to occur because they are not as strong as they need to be to stabilize the medial rotation of the Humerus. The muscles are: Supraspinatus, Infraspinatus and Teres Minor.

In summary, this Humeral formula engages the Subscapularis so much so that it holds the Humerus in Medial rotation and the three rotator cuff muscles are not strong enough to hold the Humerus. Posterior rotator cuff constantly engages so the muscles become dysfunctional and adhere together. The tendons inflame because they are stressed when a person performs common motions such as putting on a jacket, reaching to the back seat of the car, reaching into the refrigerator. Reaching in front shortens all the muscles in the front which causes all the muscles in the back to work much harder to stabilize that posture.

Brett W.Phillips, LMT, PDMT started his practice in 1994 specializing in Muscle Therapy where the focus is to analyze the dysfunction of muscle tissue and facilitate repair by restoring the original function of an affected muscle and the balance with its antagonist. Currently in practice as Muscle Maintenance at 465 West Commercial St. East Rochester.

Novel Treatments for Metastatic Prostate Cancer

Tarek Sousou, MD

Prostate cancer is the second most common cancer and one of the leading causes of cancer death among men. It is estimated that over 240,000 men will be diagnosed with prostate cancer each year. Androgens, such as testosterone, play an important role in prostate cancer growth. As a result, treatment of metastatic prostate cancer has focused largely on a variety of hormonal maneuvers with goals of reducing testosterone levels. Chemotherapy is reserved for those with metastatic prostate cancer who demonstrate resistance to reduced levels of testosterone. Recently there have been advances in the treatment options available for resistant metastatic prostate cancer which in time may change the landscape for treatment of metastatic prostate cancer.

Prostate cancer is dependent upon androgen stimulation for growth which provides a rationale for androgen deprivation therapy. This is accomplished with the use of gonadotropin releasing hormone (GnRH) agonists such as leuprolide (Lupron) or goserelin (Zoladex) which reduce testosterone to near undetectable levels. As these treatments can be associated with an initial flare in prostate cancer, they are often combined with an antiandrogen such as bicalutamide (Casodex). This combined androgen blockade can either be used for a brief period to blunt this flare phenomenon or for long term therapy.

Androgen deprivation therapy can produce a durable remission spanning the course of years in some cases. Those who develop progression while on androgen deprivation treatment can continue to be treated with additional antihormonal agents. Such treatments include the reintroduction of antiandrogens such as bicalutamide (Casodex) or withdrawal of bicalutamide (Casodex) for patients already on this medication. Ketoconazole, an antifungal medication, can also be used to suppress ongoing production of androgens. However, ketoconazole is not well tolerated and carries several medication interactions.

Chemotherapy is often necessary when hormone manipulations are no longer effective. Docetaxel (Taxotere) is the initial chemotherapeutic for resistant prostate cancer with a significant impact on survival as compared to previously used chemotherapy agents. However, it requires the use of daily low dose prednisone which can be associated with side effects such as elevated blood glucose and bone mineral reduction. Cabazitaxel (Jevtana) is another chemotherapeutic agent that is effective in patients whose cancer advances following docetaxel with significant improvement in survival. Treatment with prednisone is also required. While chemotherapy is associated with an improved survival, it can be associated with a significant reduction in blood counts in some patients. As metastatic prostate cancer is more common in elderly patients, these side effects can limit timely administration of chemotherapy.

Advances in androgen signaling have led to additional therapeutic agents for resistant prostate cancer. Research has demonstrated that despite androgen deprivation therapy, prostate cancer can continue to produce testosterone and stimulate growth. This better understanding has led to two

FDA approved treatments for prostate cancer which include abiraterone (Zytiga) and enzalutamide (Xtandi). Abiraterone is an oral drug that blocks the production of androgens in both the tumor and testes which can further aid in prostate cancer progression. Abiraterone has been shown to improve survival in patients previously treated with docetaxel chemotherapy. Like docetaxel, use of prednisone is necessary. Enzalutamide is an oral medication that acts on the androgen receptor to block the binding of androgen in addition to inhibition of various growth signals that ensue after androgen binding. This inhibition has been demonstrated to increase survival in patients previously treated with docetaxel containing chemotherapy regimens. However, unlike abiraterone, use of prednisone is not required. It is unclear as to whether enzalutamide or abiraterone is more effective as they have not been directly compared.

Additional nonchemotherapeutic treatments for resistant prostate cancer include use of immune defenses. Currently, sipuleucel-T (Provenge) is the only vaccine FDA approved for the treatment of prostate cancer. It is a vaccine that is individualized for each patient. Patients treated with sipuleucel undergo leukapheresis, a process by which immune cells can be obtained. These immune cells are then exposed to a stimulant containing prostatic acid phosphatase, a component found on prostate cancer cells. This exposure hones their immune defenses against prostate cancer. Three days later, the activated cells are then infused into the patient and this process is repeated three times over the course of six weeks. Treatment with sipuleucel-T is well tolerated and associated with an improved survival but can only be used on patients with minimally symptomatic disease without organ involvement. Furthermore, it does not impact serum PSA, a key marker of prostate cancer activity, which can make disease monitoring cumbersome.

Treatment options for metastatic prostate cancer continue to change. Advances in prostate cancer signaling have led to a number of novel treatments. These treatments have been associated with improved survival and carry tolerable side effects. However, several questions remain as to which novel approach is best, what is the proper sequencing of agents and what is the role for use of these medications prior to chemotherapy. Future research will undoubtedly attempt to answer these questions.

Dr. Sousou graduated with honors from Syracuse University with a Bachelor of Science degree in Biology. He attended the State University of New York Upstate Medical University and went on to a residency in Internal Medicine at the University of Rochester Medical Center.

He has recently completed a fellowship in Oncology and Hematology at the University of Rochester Medical Center and joins Interlakes in July, 2011.

ROCHESTER GENERAL HOSPITAL SYSTEM

Reaching New Heights in Robotic Surgical Growth

By Julie Van Benthuysen

Dr. Eichel at the da Vinci console performing surgery

This past June, Rochester General Health System (RGHS) received yet another notable distinction for its leading role in robotic surgery. After completing a milestone 5,000th robotic surgical procedure, RGHS is now ranked in the top 1% of health systems nationwide. This kind of high-volume benchmark speaks volumes about the progressive thinking and expertise behind some of our region's most distinguished surgeons.

In less than a decade's time, RGHS has incorporated three state-of-the-art robotic surgical platforms to meet the increasing demand for this technology within the subspecialties of urology, gynecology, colorectal and general surgery. Since the installation of its first daVinci Surgical System in 2004, RGHS has become one of the nation's elite Robotic Surgery programs and one of just four "Global observation centers" in the world, which draws visiting physicians to observe these pioneering techniques. A second daVinci platform was added in 2008 and a third in July of this year, collectively used in more than 1,000 procedures annually – close to three times the national average.

Photo: Lynne Tseng - Surgery Dept. RGHS

A panoramic view of the operating room with the da Vinci robot at RGH. Performing the surgery is Dr. Claudia Hriesik while a medical student observes.

"We're very proud to lead the region in this area," said Mark C. Clement, RGHS President and CEO. "In medicine – and especially in complex clinical procedures such as robotic surgery – high volume equals high experience, which in turn creates a superior level of expertise with tangible benefits to patients."

Using robots for minimally invasive techniques has enabled these surgeons to enter into a new era, further minimizing the physical and emotional impact on patients. Robotically-assisted minimally invasive surgery (MIS) builds upon the advances to open surgery introduced by MIS, taking surgery beyond the limits of the human hand by introducing precise, versatile instrument movement combined with high definition three-dimensional visualization of the operative site. MIS allows physicians to perform surgeries through much smaller incisions, resulting in less patient trauma and pain.

Urology Led the Way

The robotic milestone and elevated leadership status at RGHS only tells part of the story, however. The bigger story centers on the team of collaborators representing different surgical disciplines coming together under the leadership of Urologist Dr. John Valvo, RGHS' Executive Director of Robotic and Minimally Invasive Surgery. "Together, we are building a bridge to the future while standing upon it," summarizes Dr. Valvo.

Within urology, surgical robotics has been utilized for nearly a decade. "It's more established than you think," says Dr. Louis Eichel, Chief of the Division of Urology at RGH, Partner at the Center for Urology and a long-standing colleague of Dr. Valvo's. "Most surgeons perform urological procedures via MIS or robotically-assisted MIS. Only unusual cases are done in an open manner anymore." He also notes that almost all urologic cancer surgeries are handled via MIS these days.

Within RGHS, its success in robotic urology has spawned one of the greatest areas of growth—gynecologic and urogynecological procedures. In fact, over 90% of hysterectomies at RGHS are now performed robotically, and gynecologic case volume has actually surpassed that of urology. "In most instances, after set up the surgeons are not even placing their hands on the patient," adds Dr. Marc Eigg, Director of Urogynecology and Pelvic Reconstructive Surgery at West Ridge Ob/Gyn. "Open hysterectomies are also an unusual case for us these days, even though nationally 70% are still done with large incisions. The da Vinci robot was well suited to pelvic surgery," he says," so it was an easy way to adopt what urology was doing."

Just recently, RGHS was officially designed a "Center of Excellence in Minimally Invasive Gynecology (COEMIG)" by the American Association of Gynecologic Laparoscopists (AGGL). As a leader in the minimally invasive gynecology field, AGGL champions the most effective diagnostic and therapeutic techniques for gynecologic conditions through the integration of clinical practice, research, innovation and dialogue. The COEMIG designation is offered to surgeons and centers around the world that provide minimally invasive gynecologic surgical care on an inpatient and outpatient basis. RGHS with five of their gynecologic surgeons has become the 17th hospital in the world with this designation, the 3rd hospital in New York State, and the only hospital in our region.

Improved Patient Outcomes through Collaboration

The true key to success, say the doctors, is collaboration across disciplines. "It's really different here from anywhere else," says Dr. Eigg. "At most hospitals, you may need a three doctor team, but you likely would be limited by one of them. We're finding that many of our patient cases require different procedures from different specialties to be done robotically at the same time. Thinking creatively and collaboratively with expert trained robotic specialists means we can do that."

"We trust each other and have good chemistry," adds Dr.

Photo: Lynne Tseng - Surgery Dept. RGHS

Dr. Richardson performing surgery.

Eichel. "It's very unusual to have that and a good program too. The big difference here is having the best technology available and being able to use it with a well-trained staff that is always eager and accessible."

In December 2011, at the age of 46, Donna Wollschleger was referred to Dr. Eigg by her primary care physician. Her symptoms had worsened following a hysterectomy performed to prevent a genetic cancer syndrome that had recently taken the life of her brother. "I was suffering from leakage and severe pain when urinating, which my doctor attributed to incontinence," she recalls. Upon Dr. Eigg's review, it was determined that Ms. Wollschleger actually had a hole in her bladder, a direct result of her hysterectomy and stress urinary incontinence.

She developed what is called a vesico-vaginal fistula, says Dr. Eigg. This past May, Drs. Eigg and Eichel, representing both the endo-urologic and urogynecologic disciplines, worked together. "During the same procedure we repaired the fistula and stabilized the bladder neck with a Burch Suspension" shared Dr. Eigg.

Dr. Eigg explained to her that the combined expertise of both doctors would give the best chance for success. "I liked the connection they had." she added. Together, the doctors eliminated the scar tissue and repaired the hole. "… and I'm no longer leaking."

While Ms. Wollschleger has undergone a painful and trying year, she's confident in a full recovery within six months. "Emotionally and physically, it's been awful until now," she says. She underwent the original hysterectomy as a newlywed, having to wear adult undergarments and undergo months of pain, including significant time away from her job. "Both doctors have been wonderful," she says. "When you put the two of them together, they're the best doctors around." She cites their responsiveness and thorough explanations of the procedures involved. "In fact, when Dr. Eigg called me at home to check in on my bladder infection he made sure to give me his cell phone number in case I had any trouble urinating ," she says.

Within Dr. Eigg's practice alone, six out of 11 surgeons have been trained robotically. Two of their doctors are AAGL Center of Excellence COEMIG surgeons. "This isn't a few doctors we're talking about," he says. "It gives us the ability for timely care with more options. We're able to use our advanced training to achieve better results and to match the patient's need to the doctor with the appropriate skill set. We're also fortunate to have the patient volume to justify the extensive and ongoing training that is required."

General and Colon & Rectal Surgeries Weigh

RGHS's Christopher Richardson, DO, represents the first and only general surgeon throughout Monroe County using robotics in general surgery procedures involving the gall bladder, pancreas and spleen. He collaborates with urologists, gynecologists and other specialists to address patients who have multiple issues, like adhesions from hernia repairs when they are having a hysterectomy or prostate surgery. "While Dr. Eichel might be fixing a prostate, I can repair the hernia at the same time," he says. "It's as simple as that." Dr. Richardson, who underwent extensive robotic training last year, recognized the vast potential of doing more closed surgeries with far less pain for his patients. "As a general surgeon, we're just getting started." He already performs cholecystectomy using the single site platform laparoscopically and with the daVinci robotic.

Dr. Steve Ognibene at Rochester Colon & Rectal Surgery has been performing robotic surgeries for the past four years and has benefited as well from this collaboration. "Luckily, robotics has been battle tested by urology and ob/gyn to become a safe, reliable platform," he says. "Once it got approved for colorectal, we jumped right on it. For our practice, it's been a real feather in our cap others don't have, and helps us attract a wider patient base." Six doctors within his practice are trained robotically. "We've really begun to use robotics to its full capacity by working together with other surgical specialties," he adds. "We're simply opening in the same area of the body within a few inches of another part, so it's important that we collaborate.

Photo: Lynne Tseng - Surgery Dept. RGHS

Dr. Eichel performing nephrectomy with laparoscopic assistance after using the da Vinci robot to free the surrounding tissues of the kidney. Assisting him are physician assistant Bettina Trzcinski and operating room surgical tech Rosa Ortega.

It's very common to look for assistance, and to always have available expertise. It's just as a natural evolvement, sharing patients for a continuum of care."

In colon and rectal surgeries, it took a lot more self-motivation to pick up on MIS, he says, because it's been done less frequently than other specialties. "In fact, there is still a huge population operating the old way, largely because the colon and rectum are very different from other organs in that there's a lot to be concerned with, different factors involved, like the right side of the colon looking different from the left side." Nationally, only 30 percent of colorectal surgeries are performed laparoscopically. "The old way, patients spend up to a week in the hospital experiencing major discomfort," he says. "Now, with a small port site, pain is so much less and better tolerated. I'm actually more comfortable robotically than laparoscopically. There's more dexterity involved, and I can see better."

Considering Effectiveness and Cost Savings

Robotics has transformed "macro" surgery to a "micro" level," say the doctors, using advanced precision in specific areas, to see on a more magnified level. "You can avoid delicate issues, see the bleeding and where it's coming from," says Dr. Eichel. Across the board, say the surgeons, they have the ability to do a better job with faster recovery, less blood loss, a quicker return to work, and better outcomes overall.

At RGHS, urologists have markedly increased their ability to cure prostate cancer by switching from open to robot-assisted radical prostatectomy. "When we looked at the surgical margin results from four different surgeons who converted from open to robotic prostate removal, there was a significant decrease in the overall and pT2 positive margin rates for all of them." Treatment for advanced prostate cancer with radiation and hormonal therapy can cost well over $100,000 per patient, he adds. "This means that by using surgical robotics we are curing more cancer, saving lives, and saving the healthcare system millions in the long run. "

Looking Ahead

"We're very proud of our robotics capability and thankful that RGHS has been so visionary in creating an environment that makes this kind of program work," says Dr. Eichel. "In the near future, surgical robots will become even more specialized and versatile. We will see an increasing movement toward "LESS" surgery (Lapo Endoscopic Single Site) in which the instruments all enter the patient's abdomen via a single small incision near the belly button. As technology advances this type of surgery may offer better cosmesis and less pain for our patients."

Looking forward, the doctors also see enhanced collaboration and patient access to advanced procedures via internet-based systems that will allow remote telepresence surgery, where a surgeon at one institution can operate remotely on a patient at another institution. "This concept is similar to how unmanned aircraft are used today in the military." For example, within RGHS, patients at Newark Wayne Hospital could have their surgery done locally and recover in their home town while the surgeon actually operated on them remotely from RGH. "It'll be done locally, but from a distance," he says. "This way patients in remote areas will be have access to regional experts without the stress and burden of having to travel away from home. This is one more way that health care providers will collaborate in the future and we're proud to be on the forefront of combining traditional medical therapies with the latest technology for the benefit of our patients."

Photo: Lynne Tseng - Surgery Dept. RGHS

Physician Assistant Bettina Trzcinski at the da Vinci robot assisting Dr. Eichel.

"Art Takes Flight for Your Health" Stairwell Project Underway at Highland

Artist Sarah Rutherford working on painting for the stairwell.

- Local artists painting murals on seven flights of hospital stairwell
- Goal is to encourage employees, physicians and visitors to take stairs for exercise
- Project inspired by Highland physicians, Ashish Boghani, M.D., and Ian Wilson, M.D.

Highland Hospital has launched a project that combines art with exercise. Two local artists are painting murals in a seven-flight stairwell as part of a hospital wellness project, "Art Takes Flight for Your Health." The goal is to make one of the most-used stairwells more inviting for walkers, including employees, physicians and visitors.

"This stairwell is becoming a vertical art gallery," said Ashish Boghani, M.D., Chief Hospitalist at Highland, who came up with the idea for the project. Dr. Boghani has climbed the stairs at the hospital for the past eight years to get exercise while rounding on patients.

"Incorporating exercise into daily life keeps you healthy, and it saves time – you don't necessarily have to go to the gym when you get home from work if you are climbing stairs throughout the day," he said.

Interventional Radiologist Ian Wilson, M.D., who leads a public art program called Wall Therapy, recruited two local artists – Lea Rizzo and Sarah Rutherford – to design and paint the stairwell murals. Once complete, the murals will depict a story centered on the circle of life, incorporating elements seen around the hospital and the city.

Artist Lea Rizzo at work on one of her own designs.

"Art enhances everyday life," Dr. Wilson said. "For employees in particular, I hope the stairwell will be a place they can go on break to ponder or be inspired. It's a way of being well at work."

The project is being funded by donations made through the Highland Foundation. Several physicians have made contributions. The project is expected to be complete by December.

The Lovejoy Transitional Care Center

Back to Health, Back to Home

Julie Van Benthuysen

For most patients recovering from illness, injury or elective surgery, the days of long-term hospital stays have passed. Back in the 1990s, when our regional healthcare environment changed significantly, hospitals endeavored to more quickly discharge patients not in need of acute care in an effort to maintain needed hospital beds and to lower costs. Consequently, transitional care facilities emerged to ensure that more patients could recover successfully and more cost-effectively outside of the hospital setting. Today, many patients are benefiting from a far more interdisciplinary approach to rehabilitation—regaining their strength, independence and capability so critically needed for their long-term well-being.

Since 1999, The Lovejoy Transitional Care Center (TCC) at The Friendly Home has adopted an interdisciplinary approach to rehabilitation that balances personalized care with the unparalleled comforts of a dedicated, state-of-the-art facility. This guiding philosophy ensures that patients get back to health and home faster.

Attention to Total Wellness

In 2010, a major building renovation and addition at The Friendly Home in Brighton enabled the Lovejoy TCC to relocate to a convenient private wing. TCC professionals there provide personalized services to patients ranging from physical and occupational therapies, stroke and cardiac rehabilitation and IV therapy to social work, nutritional services, speech services, and recreation. Lovejoy TCC features its own gym/therapy area, as well as private rooms and a deluxe bath spa. Well-balanced meals may be enjoyed in the formal dining area or in the comfort of the patient's own private room. Individuals are free to socialize in the dedicated lounge area complete with fireplace and comfortable furnishings, and benefit from all

Photo:HuthPhoto

The Friendly Home in-house services, like pastoral care/worship services, recreational opportunities, gift shop, café, and art gallery.

"We have always been committed to delivering the highest quality care and services," says John Gagnon, The Friendly Home's Administrator. "We recognize that consumers have a choice of where to go for their short-term rehabilitative needs. Our goal is for TCC patients to successfully get back to health and back to home, building on a positive experience at The Friendly Home."

Since 2009, Lovejoy TCC has contracted with Freedom Therapy, one of the area's leaders in providing adult and older adult rehabilitation services throughout Monroe and surrounding counties. Freedom Therapy partners with TCC to provide exceptional rehabilitation to individuals who require both short and long term care. "We've always been committed to delivering a quality rehabilitation program that places great emphasis on meeting individual needs," says Sam Burge, President.

More than 33% of Medicare patients over 65 actually return to the hospital within 30 days of returning home from a skilled nursing facility stay, notes Burge. The Friendly Home's re-hospitalization rate is significantly lower, thus reflecting the importance of choosing a quality rehabilitation provider.

Tuned Into Patients

Recent patient Elaine Maginness, 77, chose Lovejoy TCC after deciding to undergo a hip replacement in October. She and her husband attended an optional class where physical and occupational therapists demonstrated therapy procedures with various rehabilitation equipment. "We were both definite afterwards that The Friendly Home was the way to go because we knew it would be easier and safer for me there," says Maginness. As a former nurse who worked summers at The Friendly Home back in the early 1980s, she was familiar with its operating philosophy and appreciated its well-established reputation. "Even as a nurse, I can be kind of critical of medical care, and I didn't know rehab very well – but the staff there took very good care of me." She spent close to two weeks undergoing four rounds of therapy each day, followed by several more weeks at home visited each week by a dedicated PT. Six weeks post-surgery, she's walking 30-40 minutes a day.

"It was a wise decision," she adds. "The staff pushes you a little bit more, but at the same time makes you feel good about it. I'm not sure I would have been as motivated at home." The atmosphere surpassed her expectations as well. "My husband could come and go throughout the day. We shared dinners together on several occasions and even my daughter and husband could visit and bring their dog." She also happened to know some other patients there undergoing rehab, sharing meals with them as well. She also enjoyed additional amenities, like being wheeled down to the salon to have her hair done. "It was pleasant and reasonable," she says. "The Friendly Home really seems to be tuned into what you need."

Keeping Patients Safe

At Lovejoy TCC, staff knows that the best location of service depends on the needs of the patient. "Home care is great when the client is ready for this level of care," says Burge. "However, patients returning home before they're ready can lead to less than desirable outcomes, a worsening condition, re-hospitalizations, or in some cases even death." Services provided by certified home health agencies, he says, typically only provide therapy services one to three days per week and cannot provide aggressive or extensive amounts of therapy. Within the TCC setting, however, it is not uncommon for therapists to provide care for up to 18 hours a week, often seeing patients multiple times a day to better meet their needs. In-patient transitional care allows a safe transition from hospital to home."

Patients coming from the hospital typically have acute conditions that require additional therapy than what homecare can provide, adds Burge. "Their acute status requires greater comprehensive care by a multi-disciplinary team. The setting here allows greater communication between disciplines to enhance the coordination and quality of care."

Inpatient rehab also allows greater access to needed equipment that therapists cannot provide in the home setting. Often, the home environment presents significant challenges that place the patient at risk for injury while their condition remains in the acute status. Issues range from stairs and upper level bedroom and baths, dim lighting, uneven surfaces and lack of assistance from family members.

Satisfied patient Elaine Maginness agrees. "My husband and I were both adamant that we be in the safest place to prevent my falling, especially after a hip replacement," she says. "Even after I left Lovejoy TCC and a physical therapist began coming to the house, he made sure everything was safe and that I knew how to handle the 17 steps leading up to my bedroom." Need clarification here: we are assuming that a Friendly Home therapist came to the house to ensure safety for the discharged patient, but that the physical therapist visiting on a regular basis at her home was not from The Friendly Home. Perhaps it could be rewritten along the lines of: "Even after I left the Lovejoy TCC, the therapist from The Friendly Home visited to make sure everything was safe and that I knew how to handle the 17 steps leading up to my bedroom." (If in fact this was the case – may need a quick follow up phone call to Elaine to clarify.)

"The Lovejoy Transitional Care Center stands out in this community because of our people and our team approach to rehabilitation," says Gagnon. The environment here is beautiful, which allows patients to rehab in one of the best places in town to recover."

The Friendly Senior Living Continuum

Cloverwood Senior Living
An independent retirement community in Pittsford for people 62 and older seeking an active lifestyle. Visit cloverwood.org or contact Karen Sullivan at (585) 248-1131 or ksullivan@cloverwood.org.

Glenmere at Cloverwood
Glenmere features assisted living, enhanced assisted living and memory care. Visit glenmere.org or contact Tamara Stout at (585) 248-1135 or tstout@glenmere.org.

Linden Knoll
An apartment community located adjacent to The Friendly Home in Brighton which offers independent senior living and a wide array of available support services. Visit lindenknoll.org or contact Sharon Peterson at (585) 385-0223 or speterson@lindenknoll.org.

Lovejoy Transitional Care Center
Located within The Friendly Home, the Lovejoy Transitional Care Center provides short-term rehabilitative care that helps patients regain their independence. Visit lovejoytcc.org or contact Shireen Haynes at (585) 385-0271 or shaynes@friendlyhome.org.

The Friendly Home
Serving seniors in our community since 1849, The Friendly Home provides 24-hour skilled nursing care, rehabilitation, memory care and hospice care. Visit friendlyhome.org or contact Shireen Haynes at (585) 385-0271 or shaynes@friendlyhome.org.

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SILVER TSUNAMI

Financial Implications of Losing One's Ability to Live Independently

James Sperry, PhD, MBA

The Lake Wobegon Effect in LTC

In his popular show *A Prairie Home Companion,* radio personality Garrison Keillor speaks of the fictional town of Lake Wobegon where "…all the women are strong, all the men are good looking, and all the children are above average." While it is amusing to reflect on how we all view our own children as above average, this superiority bias or leniency error is real. You may recall the study in which 87% of Stanford University MBA students rated their own academic performance above the median.[1] Not only is it real, but this bias can have tragic consequences, especially when it comes to confronting various risks in your personal financial, retirement, and estate planning.

Many find it impossible to envision themselves ever needing hands-on assistance with basic living activities such as eating, bathing or dressing. Losing one's ability to live independently can be devastating emotionally, physically, and financially to one's family. In your professional capacity, you have surely witnessed the emotional and physical toll suffered by a family when it is thrust into a long-term care giving role. But how can one quantify the financial impact? It is easy to compile average costs of care in each region (in Rochester, the average annual nursing home cost is over $110,000), but that is only the beginning of the analysis. What about the indirect costs such as one's own lost wages and those of their family as their time was redirected to care giving away from their career? So, estimates of the financial impact have historically not been as readily available and they have been largely anecdotal. However, one study was able to document that 41% of women who have been care takers had been forced to quit their jobs or take a leave of absence, amounting on average to over $240,000 in lost earnings over their careers?[2] Another study demonstrated the increased risk of depression for women who took on significant care giving duties.

All of this is to say that the direct and indirect costs of losing one's ability to live independently and needing long term care can significantly undermine even an otherwise healthy retirement plan, but what is the chance that it will happen to me? Were you aware that 70% of those ages 65 and older will require LTC services in their lives?[3] Obviously, the joint probability for a couple is even higher, closer to 85%. Yet, the majority of overachieving professionals like you are convinced that you and your significant other will never put each other or your children in this position. Like the Stanford MBA students, do you really believe that you and your spouse will be among the fortunate 15% or so who will die before needing assistance with any activities of daily living or developing a cognitive impairment? If you need a reality check, speak with my family's friend. He was an avid runner and a health food enthusiast who is now working hard to learn to walk independently again after suffering a massive stroke in his mid-40's. Most people are very surprised to learn that 40% of the LTC population is under 65 years old.

1 "It's Academic." 2000. *Stanford GSB Reporter*, April 24, pp.14–5. via Zuckerman, Ezra W.; John T. Jost (2001). "What Makes You Think You're So Popular? Self Evaluation Maintenance and the Subjective Side of the "Friendship Paradox"". *Social Psychology Quarterly* (American Sociological Association) **64** (3): 207–223. doi:10.2307/3090112. JSTOR 3090112. http://www.psych.nyu.edu/jost/Zuckerman%20&%20Jost%20(2001)%20What%20Makes%20You%20Think%20You're%20So%20Popular1.pdf. Retrieved 2009-08-29.

2 MetLife Mature Market Institute, National Alliance for Caregiving (NAC) and National Center on Women and Aging. "The MetLife Juggling Act Study: Balancing Caregiving and Work and the Costs Involved." (1999).

3 DHHS, 2008. Most recent statistic available on www.longtermcare.gov. Administration on Aging: 202 619-072

Solutions

There are several approaches to managing the LTC risk: self insurance, stand-alone LTC insurance and so-called hybrid or linked-benefit insurance. Historically, the motivation for self insuring had been either superiority bias (i.e., "it won't happen to me") and the concern that therefore any premiums paid would be an unnecessary and possibly significant sunk cost if no benefits were ever received or a personal net worth so great that no type of insurance (homeowners, auto, life, LTC, etc.) was deemed necessary. Fortunately, the rapid advancement and evolution of the insurance industry as it relates to LTC has rendered self insurance altogether unnecessary and in most cases financially unjustified and imprudent.

Consider the hypothetical example of a 60-yr old female who has a $100,000 CD that is up for renewal. She has been diligent in saving for retirement and she has no expectation of ever needing the assets in this CD during her lifetime. She can roll the balance over into another CD, where rates remain unattractive for most investors (national average APY on 5-yr CD as of 12/15/2012 was 0.91%, www.bankrate.com). If instead she were to deposit the $100,000 into a linked-benefit insurance product, like Genworth's Total Living Coverage, she would have accomplished several things. First, she will have immediately established over $669,000 in nursing home and home care coverage (equal to $9,300/month for 6 years). Second, she will have immediately established over $223,000 in death benefit (less whatever she uses for LTC, if any). Finally, if her plans change within 15 years and she decides not to keep the policy, she can get back her initial premium of $100,000 (less any benefits paid). With the linked-benefit insurance, she has leveraged her money over 6x for LTC and over 2x for life insurance, and preserved the option of cashing back out of the policy. Products like these can make self-insuring less prudent, even for the ultra-affluent who believe their resources are so vast as to be able to withstand any scenario, including extreme LTC events. Further, there are ways of positioning such products in various trusts, like Medicaid Asset Protect Trusts (MAPTs) or Special Needs Irrevocable Life Insurance Trusts, to generate additional tax advantages.

With the aging of our population and the impending "silver tsunami," the number of families in a long term care giving situation is clearly rising. The insurance industry has long recognized this trend and has innovated, especially over the past 5 years, in response to this growing need. In our practice, we have seen more physicians seeking our advice on alternatives for managing the LTC risk in the overall context of their estate and retirement planning. Of all the risks we help our clients manage (e.g., market volatility, taxes, interest rate risk, inflation, etc), the risk of LTC is the one that simultaneously threatens to undermine a retired couple's financial well-being, sense of independence, concern for good health and adequate care, and family relationships. Sound planning is all about creating options that enable you to succeed under any circumstance. Now there are strategies and products available to create these options in managing the LTC risk. So, in your personal life, have you honestly confronted the possibility of needing assistance in living independently and have you taken informed, active steps to manage that risk so your significant other and family do not suffer the same consequences?

James M. Sperry, Vice President, Tompkins Financial Advisors (JSperry@TompkinsFinancialAdvisors.com) **585-419-8384**

Jim develops customized protection, growth and transfer strategies for physicians and owners of diverse lines of business. He earned his MBA from the Simon Business School at the University of Rochester (2002), his Ph.D. in engineering from Duke University (1997), and his BA from Williams College (1987). Through M Financial Group™, Jim's clients enjoy the most advanced wealth protection, growth, and transfer strategies and products available anywhere.

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Innovative Models for Caring for the Elderly

By Julie Van Benthuysen

As our nation's elderly population continues to grow and live longer, our region's medical community has been seeking far more innovative ways to handle long-term care for those who can no longer live independently – whether it's remaining in the home environment or relocating to a dedicated facility offering a continuum of care. This effort on the part of healthcare professionals reflects the changing mindset of the aging and their loved ones actively involved in the decision-making.

"It's about noticing the importance of quality of life for each and every patient— about being very present. With person-centered care, you know it when you see it." Pictured is Susan Lewish, GNP-BC of St. Ann's Community visiting with a resident.

Demands for Home-Based Care

More elderly people are choosing to remain at home, despite functional impairment and significant medical conditions that require comprehensive healthcare support. The Rochester General Health System (RGHS) has responded through its Independent Living for Seniors (ILS) Program, established more than 20 years ago to provide a matrix of coordinated healthcare services to frail seniors. These patients, whose social identities still include a strong need and commitment to their communities, homes and families, are demanding comprehensive healthcare support that allows them to remain as independent as possible.

"Rather than a nursing home, our program keeps patients at home, which can be both the most cost-effective approach and the one favored by the vast majority of seniors," says Kathryn McGuire, RGHS Senior Vice President for Senior Services and Behavioral Health. As the area's only PACE program (Program of All-Inclusive Care for the Elderly), ILS encompasses medical and personal care, rehabilitation, equipment, medication, transportation to medical appointments, and family caregiver support.

RGHS's ILS Program represents the ninth PACE program to be launched in the U.S. and the only one of its kind in our region. PACE is a form of Managed Long-Term Care modeled after a comprehensive blending of acute and long-term care services developed by On Lok Senior Health Services in San Francisco. "PACE allows service in the way many elderly people want it," she says. "It also makes sense to families, health care providers and the government programs and others that pay for care."

ILS participants must be at least 55, live in the PACE service area (Monroe County, but applying to expand into Wayne and Ontario Counties), need community-based long term care services for a minimum of 120 days, be certified as eligible for nursing home care, and be able to live safely in the community with the support of ILS services. Funding is provided from federal and state governments and is typically covered under Medicare, Medicaid and private insurance.

"We recognized years ago there were opportunities to decrease the need for nursing home and hospital beds, which represents a significant cost for the state," says McGuire, who helped launch and manage the ILS program and has been instrumental in expanding all RGHS senior-care affiliate programs. "We're helping take the waste out of the system. New York State recognizes that these programs really need to grow and grow quickly." Within two decades, approximately 90 PACE programs now exist throughout 29 states, supporting 30,000 patients. Only 8% of PACE patients ultimately move to a nursing home, when there is no longer an emotional benefit to remaining in the larger community. About 90% of PACE patients have advanced care directives in place for when a catastrophic event happens. "They don't want to die in a hospital."

The ILS program, which has grown 30% to roughly 400 participants in the past year alone, focuses on person-centered care. Its team of experienced geriatric professionals across all disciplines manages patients with a wide range of medical conditions. One patient, for example, is a 75-year-old man with diabetes, congestive heart failure and depression, who suffered from unhealed wounds and fleas from his dog while living alone in an unkempt house before enrolling in the program. "In a

traditional health care model, this patient would see his primary care doctor to treat some of his issues, and maybe see a social worker for his depression, while other issues aren't addressed at all," says ILS Executive Director Jill Graziano.

"A continuum of health care professionals ensures a 'whole person" scenario, where we can make full connections to treat his issues most effectively." The team includes a medical doctor, physical therapist, home health care nurse, housekeeper, and even the driver transporting him to a day facility for other services. "This way, we have eyes in different places." She emphasizes that while this comprehensive team is put into place for each patient, opportunities still exist for a patient's regular primary care physician to stay involved once enrolled in PACE. "Our program allows the flexibility for PCs to do that."

Kathryn McGuire, RGHS Senior Vice President for Senior Services and Behavioral Health.

Socialization outside the home plays a key role under this model. Coming regularly to one of ILS Centers for warm meals and recreational therapy, a patient with depression can be on the path to recovery," she adds. "When frail people are isolated, they can even stop eating. When they come here, food becomes more of a social issue, and they regain their strength."

Considering Facility-Based Long-Term Care

For those better served within a nursing home environment requiring round the clock support, RGHS's Hill Haven facility continues to offer that capability, while shifting to broader-based complex care including post-acute rehab services and transitional care. "Caring for seniors is no longer a one-size-fits-all proposition," says McGuire. "Hill Haven will always be a home for seniors with specialized medical needs, but our expert rehab team is equally skilled at handling the needs of a wide range of patients."

St. Ann's Home represents another person-centered medical model that has made great strides in responding to the changing needs of the elderly. While the 139-year-old institution has grown to offer retirement living, short-term rehabilitation and transitional care as well, its commitment to long-term care for patients with debilitating conditions remains a key area of focus – from treating wounds to speech and swallowing disorders.

"When patients come to us in the late stage of their lives, we need to have an open dialogue about the entire medical process to identify whether longevity or quality of life is more important," says Dr. Kim Petrone, St. Ann's Associate Medical Director. "This can make a big difference in our treatment plan."

Because many patients have dementia and can't provide a cogent summary of their medical problems and life history, St. Ann's staff reviews everything with family -- from personal interests to anxieties that might directly affect medical and non-medical treatments. "It's more a need to create a road map to really individualize the care, to look beyond just medicating a behavior or a symptom." The elderly can have dozens of medical problems once they reach their 80s or 90s, she says. "If you followed an algorithm, it would be untenable."

"Reviewing a patient inside and out, from the heart to the skin, can be a lengthy process to evaluate," she says. "We recognize that not all elements are necessary, or reimbursed, so we have to make sure we're doing what makes the most sense and is cost-effective as well."

St. Ann's Special Care Unit for Dementia (SCU) is designed for patients in the middle to late stages of dementia requiring skilled nursing care. The SCU provides a secure, calm environment that reduces anxiety and confusion, supports socialization and communication and fosters independence and engagement.

Recently, a patient was admitted to the SCU with very little memory. "It was evident that we weren't able to talk to him about anything relevant," says Dr. Petrone. Sitting down with his wife, staff discussed his life, his professional accomplishments, personality and pastimes. "When we learned he was a late sleeper and once an avid photographer, we adjusted certain areas of his care with more person-centered elements. "We made sure his routine wasn't interrupted. We even placed a camera and a book of photographs in an accessible place in the event it piqued his interest or might help him reduce anxiety."

Creating Warm Environment

Within St. Ann's, personal touches are seen throughout; even in the colorful casual clothing the staff wears. Its design supports participation in life skills, including a kitchen, family style dining, baking, cooking, and midnight snacks -- enhancing the mission that every patient experiences life fully. "We pay very close attention to our environment," says Nurse Practitioner Susan Lewish. "While there's nothing quite like your own home, everything at St. Ann's circles around a central area to make it more inviting. A kitchen will soon be added to all nine floors because staff have found patients responding with better appetites when they actually smell the meals cooking. At St. Ann's everyone contributes to the care, from serving breakfast

and cleaning the table to actually cooking the meal. "It's about noticing the importance of quality of life for each and every patient — about being very present, she adds. "With person-centered care, you know it when you see it."

When one staff nurse learned that a patient loved to gamble, she took it upon herself to buy his weekly lottery tickets. "He'd had a hard life and was estranged from his family, so those lottery tickets meant a lot to him," says Lewish. Another patient complained about her coffee being served in 'horrible' mugs. "Coming from England, she thought that was barbaric," recalls Lewish, "so one of our nurses brought her in a teacup and saucer. It meant so much her."

"Taking care of their elderly parents, they're seeing how vital person-centered care is and are already securing long-term care insurance for themselves so they know they eventually have more options."

Preparing for What's Ahead

For both healthcare organizations, person-centered care will continue to take center stage. "This really parallels the burgeoning field of palliative care," says Dr. Petrone. "As physicians step back, we need to ask people what they want. We look at the patterns as a whole, and it's really more about quality of life. "Patients don't want to suffer, especially the baby boomer generation more used to having choices and likely to advocate for themselves.

As time goes on, she adds, staff will become more adept at this type of care. "We're moving away from institutional care. We've learned people don't want to live in a hospital-like place. They want to either stay at home, or feel at home." She envisions large nursing home facilities being replaced by more smaller-scale home-like facilities. "It's not about advanced directives anymore, it's about weighing the options," she says. "It doesn't make sense financially and is irresponsible to patients to continue care that really is not beneficial to them in the long run."

For in-home care, the need and demand will continue to grow, particularly in the area of behavioral health needs," says McGuire. "We're already expanding into Wayne County and opening a second Center near the hospital." She also sees more 60-somethings responding well to in-home PACE programs. "Taking care of their elderly parents, they're seeing how vital person-centered care is and are already securing long-term care insurance for themselves so they know they eventually have more options."

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HIPAA Security Rule, *Is your practice compliant?*

Nicole Hirt, MSHA

HIPAA IS NOT A NEW CONCEPT IN THE HEALTH CARE FIELD and many believe their practice to be HIPAA compliant simply because they have posted their privacy notice and patients sign a privacy statement prior to receiving care. However, chances are that if you were to review your HIPAA Privacy Manual, it would be greatly deficient in regards to securities within the practice involving electronic patient health information (ePHI). The good news is that you're not alone; many practices are in the same position. The bad news is that a HIPAA Security Manual has been required for every covered entity since 2005.

So, what is the difference between Privacy and Security? To differentiate, you can think of the HIPAA Privacy Rule as a standard for protecting certain patient health information (PHI) in all contexts and the HIPAA Security Rule as a standard for protecting certain patient health information that is held or transferred in electronic form (ePHI). In short, the Security Rule operationalizes the protections contained in the Privacy Rule by addressing the technical and non-technical safeguard that must be put into place. For example, under the Privacy Rule you may have asked your staff to turn over any patient chart with health information attached to the front so others are unable to see it; whereas in the Security Rule you may address this issue, now using EHR, by informing your staff they must lock their screen anytime they step away from their computer to protect the patient's ePHI.

For practices participating in the Meaningful Use program, one of the Core Measures is to perform a Security Risk Analysis, with the requirement that the findings would be documented and addressed within a Security Manual. If you have not performed a Security Risk Analysis, the process should involve:

- Evaluating the chance of potential risks to ePHI
- Implementing security measures to mitigate the risks identified
- Documenting the security measures you are addressing and rationale for adoption
- Maintaining continuous oversight for appropriate security protections

Once you have performed the Risk Analysis, you essentially have an outline to guide you in addressing your deficits and creating your policies and procedures in response to those findings. The HIPAA Security Rule addresses the three main safeguards below and should be addressed in your Security Manual:

Administrative Safeguards:

- ***Security Management*** - Implementation of security measures that reduce the risk of exposing ePHI
- ***Security Personnel*** - A designated security officer responsible for policies and procedures
- ***Information Access Management*** - Assigning role-based access within the system
- ***Workforce Management*** - Training of employees and appropriate sanctions for those who violate the rule

Physical Safeguards:

- ***Facility Access*** - Assure physical facility is secure
- ***Workstation and Device*** - Policies and procedures regarding appropriate workstation usage

Technical Safeguards:

- ***Access Control*** - Only allowing authorized users access to ePHI
- ***Audit Controls*** - Implement appropriate standards for how, when, and what to audit
- ***Integrity Controls*** - Make sure ePHI is not inappropriately destroyed or altered
- ***Transmission Security*** - Protection of ePHI that is sent or provided electronically

For smaller practices, the Security Rule is flexible and allows you to analyze your own needs by labeling measures "addressable" or "required" within the rule. The rule is vague and only eight pages in length, which leaves you and your practice open to interpretation when operationalizing the standards. The technical standards should be addressed with your IT provider as they can involve extremely technical terms and knowledge. Healthcare IT professionals are a valuable resource and can assist you in developing security standards for your practice. To make certain the Security Rule is as effective as possible, you must continuously review and update your policies based on regulatory compliance and changes made within your practice. Developing a Security Manual for your practice is not only required by law but will help define your internal policies and procedures in all aspects regarding your electronic health information.

Nicole is a Senior Health IT Advisor at Innovative Solutions based in Rochester, NY. She provides strategic and operational consulting to medical organizations related to their use of Health IT.

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What is My Liability?

EMRs and Data Breaches under HIPAA and HITECH Laws

James E. Szalados, MD, MBA, Esq.

Issue

In February 2011, the General Hospital Corporation and Massachusetts General Physicians Organization Inc. (Massachusetts General Hospital) agreed to a fine of $1 million ($5,200 per breach) and a 3-year corrective action plan imposed by HHS for violation of the HIPAA Privacy Rule. The PHI of 192 patients, including names, dates of birth, medical record numbers, health insurers and policy numbers, diagnoses, and names of providers was lost when a department manager in the Infectious Disease practice left the documents on a subway while commuting to work.

In April 2012, Phoenix Cardiac Surgery, P.C., of Phoenix, AZ became the first small medical practice liable under HIPAA and agreed to a $100,000 settlement, a corrective action plan, and agreed to implement policies and procedures to safeguard the protected health information of its patients after it posted clinical appointments for patients on an Internet-based calendar that was publicly accessible.

In March 2012, Blue Cross Blue Shield of Tennessee settled with HHS for $1,500,000 for failing to comply with Section 13402 of the Health Information Technology for Economic and Clinical Health (HITECH) Act (the HIPAA Breach Notification Rule) after 57 unencrypted hard drives containing social security numbers, diagnosis codes, birth dates, and plan identification numbers were stolen and BCBST failed to notify patients that their PHI has been compromised. OCR Director Leon Rodriguez remarked that "this settlement sends an important message that OCR expects health plans and health care providers to have in place a carefully designed, delivered, and monitored HIPAA compliance program."

Privacy of medical records is a fundamental tenet of both medical ethics and health law. 'Privacy' refers to a person's right to be free from unwanted publicity and intrusion without one's consent. Professional respect for each individual's privacy is essential to the physician-patient relationship because only in an atmosphere of confidence will patients completely and trustfully disclose personal health information that is essential to medical diagnosis and treatment. The medical record contains an enormous amount of sensitive personal information ranging from family, lifestyle and social histories, to past and present medical, surgical and psychiatric illnesses, treatments, responses to treatment, medications, and insurance coverage. Physicians are thus charged with a fiduciary duty to protect the privacy and confidentiality of their patients and their intimate medical information. The duty of physicians to uphold the confidentiality of medical information dates from the Hippocratic Oath, and is also within the Principles of Medical Ethics of the American Medical Association (AMA).

The Health Insurance Portability and Accountability Act (HIPAA) was enacted into law by Congress in 1996. HIPAA is divided into three parts: (1) the Administrative Simplification provisions which mandate the adoption of standard data sets; (2) the Privacy Rule provisions which defined security for Electronic data Interchange (EDI); and, (3) the Security Rule which addresses relationships between healthcare business associates. PHI refers to any health information in any form that personally identifies a patient. The HIPAA Security Rule requires three levels of safeguards for PHI: (1) administrative; (2) physical, and (3) technical. Given the technical nature of these EHRs and EDI, and the associated costs, compliance with these standards is becoming especially difficult for individual providers and small medical groups.

The American Recovery and Reinvestment Act of 2009 (ARRA) later established a tiered civil penalty structure for HIPAA violations and also defined the Health Information Technology for Economic and Clinical Health Act (HITECH). The HITECH Act focused primarily on incentivizing the adoption of electronic health records (EHRs) but also made the HIPAA Privacy Rule and the HIPAA Security Rule critical issues for healthcare providers because breach of HIPAA became punishable not only by civil and criminal penalties but also loss of financial incentives associated with

EHR adoption and use. HITECH also specifically mandated that HIPAA-covered entities and their business associates provide notifications following any breach of unsecured protected health information – a provision known as the Breach Notification Rule. HITECH's time-frame requires providers notify those affected by a data breach within 60 days of the event.

The Patient Protection and Affordable Care Act of 2010 (ACA) further broadened liability and increased civil and criminal penalties under HIPAA and HITECH. The civil monetary penalties under HIPAA are based on the level of knowledge that violators are presumed to have had at the time of the breach, ranging from fines for (1) individuals who did not reasonably know they violated HIPAA begin at $100 per violation with an annual maximum of $25,000; ranging to violations by individuals with 'willful neglect' fined at $10,000 - $50,000 per violation with an annual maximum of $1.5 million. The Department of Justice (DOJ) imposes criminal liability for 'knowing' breach or disclosure of PHI ranging from a criminal fine of up to $50,000 with imprisonment up to one year; through fines of $250,000 and imprisonment for up to 10 years in cases of malicious breach associated with personal gain. "Knowingly" for the purposes of criminal liability requires only a general knowledge that a breach could constitute an offense. Furthermore, civil and criminal penalties can extend to any or all business associates.

The Office for Civil Rights (OCR) has been authorized to investigate and enforce HIPAA violations. In addition to federal enforcement of HIPAA by the OCR and the DOJ, individual states are free to enact their own state-specific privacy laws under the jurisdiction of the State Attorney General, potentially resulting in both a federal and a separate state level prosecution.

Common causes for a HIPAA breaches continue to include theft of patient health information, unauthorized access to the data, human error, loss and improper disposal of patient records. OCR investigations reveal that most HIPAA breaches (55%) involve data theft; and are less likely to involve unauthorized access to PHI (20%), data loss (12%); hacks (6%) and disposal errors (6%). The location of the data when it is compromised is most likely to be on a laptop (25%), and less likely to be in paper form (23%), on a personal portable device (14%), a computer (14%), or server (9%). Smart phones, iPads and jump drives represent an important evolving compliance risk and it is vital that practices conduct regular risk assessments, enact policies and procedures, and develop comprehensive data breach notification protocols. The potential for various types of data compromise through cloud computing represents a potential but yet indeterminate risk.

Patients identified through social media represent a unique form of risk because such information can be virally disseminated and can become a permanent element of cyberspace content. In one recent case, resident physicians 'tweeted' information to each other regarding a patient with a relatively rare disorder; although the patient was never identified by name, sufficient data was disclosed to potentially compromise the patient's identity and a prosecution for a HIPAA violation was upheld.

Physicians must realize that civil prosecutions under HIPAA and HITECH may be associated with exclusion from federally-funded payment programs, and such exclusions can rapidly escalate to include state and private funded insurers. In addition, criminal prosecutions must be reported to the Department of Health and consequently result in loss of medical licensure. Finally, depending on the physician's liability insurance policy it is likely that neither prosecution is covered under traditional 'malpractice insurance.'

In conclusion, it is imperative that, in order to avoid severe penalties under HIPAA and HiTECH, physicians, practices, and healthcare facilities must ensure that both they and their staff understand the laws, develop proper policies and procedures to facilitate compliance with the laws, and adhere strictly to the policies and procedures. It is critical that providers have an action plan in place before a data breach occurs. The importance of a comprehensive and up-to-date HIPAA/HITECH compliance plan, which provides for regular risk mapping and assessment, is vital in the event of a PHI data breach, both for rapidly mitigating the impact of the breach, and for minimizing individual, practice, and institutional civil and criminal liability.

Dr. Szalados is a licensed physician engaged in the practice of anesthesiology and critical care; a senior-level hospital administrator, and an attorney admitted to the practice of Law in New York and concentrates his practice in the areas of Health Law. Dr. Szalados is an attorney with healthcare law firm of Kern Augustine Conroy & Schoppmann, P.C.

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Medical Practice Disability Planning

How to Avert a Catastrophe

Carol S. Maue, Jennifer N. Weidner and
Paul S. Fusco, attorneys at Boylan Code, LLP

We return to our fictional case study of the Mensch Medical Group, P.C. (the "Group") to illustrate the importance of planning ahead for the possibility of a member of a medical practice becoming disabled. As you'll recall, the Group consists of three physicians: Henry, the senior physician; Samuel, the middle-aged physician with a progressive disability, and Lucy, the newly-admitted physician to the practice. Samuel was diagnosed with muscular dystrophy several years ago; a degenerative condition that has gradually been getting worse, but suddenly and recently deteriorated to the point that it has now completely hindered his ability to practice medicine. Whether or not the Group appropriately planned for this possibility will determine the extent and severity of its negative impact on the practice and the individual physicians of the Group. While it will no doubt be emotionally difficult for all involved to witness a colleague and friend deal with a degenerative illness, proper planning can significantly reduce the negative and potentially disastrous financial consequences for all concerned.

At the time Samuel's condition rendered him unable to work, the Group's practice was thriving. There was a long waiting list for patients, and as a result Henry, Samuel and Lucy were all working long hours and were at full capacity. If there was no plan in place for the Group to address Samuel's disabling illness, the Group could expect the following to occur:

- First, since the revenue of the Group is dependent on all three partners being able to see patients, the Group will suffer severe adverse economic impacts hit if Samuel (at least 33% of Group's earning power) is unable to work. Henry and Lucy are already at full capacity, so it would be impossible for the two of them to absorb Samuel's workload. It will take time to find someone to replace Samuel, and even if the Group can find a competent physician to perform the work normally performed by Samuel, the Group will still have to figure out a way to pay Samuel at the same time it must incur additional expense to pay the new physician. Assuming Samuel's condition abates after a time such that he can return to work full-time, for some period of time at least, the Group will be in the position of having the double expense of hiring a new physician and continuing to pay Samuel some portion of the income from the practice, all while experiencing a decrease in revenue.
- Second, if Samuel is permanently disabled, the Group or Lucy and Henry will eventually have to buy Samuel's ownership interest in the practice. If there is no Shareholders' Agreement in place with good buy-sell provisions, Lucy and Henry will be negotiating with Samuel (or perhaps with his family) the terms of a buy-out when Samuel is least able, physicially and emotionally, to undertake this task.
- Lastly, since Samuel no longer has the ability to support himself financially, unless there is a good disability policy available, he will necessarily have to tap into his savings, which Samuel expects will be depleted at some point over time.

Without proper planning, Samuel's disability will have disastrous financial consequences to everyone involved – Samuel, the medical practice and his partners, Henry and Lucy.

All of these negative consequences are avoidable with proper planning.

The Group could have purchased business overhead expense insurance (BOE) to provide coverage for the expenses associated with operating the medical practice when one of the partners becomes disabled. In a medical practice this would typically include some portion of staff salaries, rent, utility bills, medical equipment lease payments, and other costs necessary for the practice to operate. Some policies also include the cost of a temporary replacement for a disabled partner. If the Group had a BOE policy in place, the short-term financial strain of Samuel's disability would have been entirely manageable. The BOE policy would help pay the bills so that Henry and Lucy could focus on their patients and finding a replacement for Samuel.

Further, the loss of Samuel's ability to earn income could have been substantially mitigated if Samuel had purchased a long-term disability policy. These policies are complex, and it is important to have a clear understanding of the various op-

tions when purchasing disability insurance. The issues to consider include: (1) the percent of the disabled physician's income payable as a benefit (40%, 50%, 60%); (2) the maximum benefit allowable under the policy (usually no more than $120,000 per year); (3) the length of time the physician must be disabled before he or she can begin receiving benefits (90, 180, 360 days); (4) the length of time benefit is payable (2 years, 5 years, until age 65); (5) the definition of disability ("inability to secure gainful employment" or "inability to perform own occupation" or "inability to perform own specialty"); (6) whether benefit is indexed with inflation; and (7) whether mental illness is covered. As this is just a sampling of options available in a disability insurance policy, it is important to seek professional advice when selecting a policy to best meet the needs of each individual in the practice.

As we discussed in our first article, a well drafted Shareholders' Agreement with well-thought out buy-sell provisions is critical during times of transition because its provisions will serve as the "blueprint" for the manner in which the transition will occur. The buy-sell agreement will provide a definition of disability, the procedure for determining whether an individual is disabled, the terms and conditions of the buy-out of the disabled individual's shares, and the mechanism to determine the price to be paid for such shares. Without the benefit of this blueprint, the parties are left to negotiate in a time of turmoil, a significantly more difficult task that has a high probability of becoming adversarial.

Once the Shareholders' Agreement is in place, it needs to be "funded" with the appropriate insurance policies to provide the funds necessary to effectuate the buyout upon an individual's disability. Without insurance, the funds necessary for a buyout would have to come from the cash flow of the Group, or from Henry and Lucy individually. Whether the buyout is structured as a redemption (i.e., where the Group buys shares from Samuel) or a cross-purchase (where Henry and Lucy buy shares from Samuel, typically pro rata to their existing ownership interests) will determine who will own the policies and how many policies are necessary. There are tax and other important issues that need to be considered when structuring the buy-sell and purchasing the appropriate insurance policies which require consultation with an experienced attorney and a sophisticated insurance broker.

While we can't predict the future, there are steps that can be taken to plan for what could occur. A carefully drafted Shareholders' Agreement, with well developed buy-sell provisions together with appropriate insurance policies can go a long way to averting a catastrophe.

DEMENTIA

While Behavioral Neurology has been an unofficial subspecialty of neurology for many years, it was only officially recognized recently as a subspecialty by the United Council of Neurologic Subspecialties and was combined with Neuropsychiatry as a subspecialty of both neurology and psychiatry.

David Gill, MD

Behavioral neurologists see patients with disorders of cognition and patients who overlap between psychiatry and neurology, although the majority of patients that are seen by behavioral neurologists are those with memory disorders associated with aging. In general, behavioral neurologists are also involved in the education and research about these disorders.

The need for providers to care for patients with dementia is a pressing issue, as the number of people with Alzheimer's disease and other dementias is predicted to increase three to four fold by 2040 making what is already a difficulty situation an epidemic. On a professional level, this means that all of us in medicine will be affected by patients with dementia, whether it be the orthopedic surgeon seeing a patient with a hip fracture and dementia, or the pediatrician seeing a child who is cared for by a grandparent with dementia. On a personal level, it means someone each of know will be affected by one of these disorders.

As a behavioral neurologist, my role in the care of patients with cognitive impairment has several purposes:

First, I provide a resource to the community for accurate diagnosis. At the Unity Memory Center, we have a comprehensive program that incorporates a team approach. This type of care has been shown to diagnose patients with memory disorders earlier and more accurately than non comprehensive programs. The Unity Memory Center includes our three neuropsychologists, Drs. William Schneider, Marc Gaudette, and Krista Damann, as well as allied medical staff. Accurate diagnosis is important because many patients with Alzheimer's disease have more than one cause for their cognitive impairment and as many as 50 percent of patients with dementia do not have Alzheimer's disease, especially those under 65 years of age. In general, the medications used for Alzheimer's disease are not effective in non Alzheimer's disease dementias, so correct diagnosis is critical to guide management.

In addition to isolated Alzheimer's disease, many of those patients with Alzheimer's disease have coexistent vascular changes that are severe enough to cause cognitive impairment. These patients need to have their vascular risk factors addressed and we interface with the Unity Stroke Center to provide care for these patients and those with isolated vascular dementia, which is the next most common cause of dementia in the elderly population. We also see a large number of patients with Lewy body dementias (Parkinson's disease with dementia, Lewy body dementia and multiple system atrophy) and frontotemporal lobar degenerations such as frontotemporal disease, primary progressive aphasia, and corticobasal degeneration. Lastly, we evaluate and follow patients with disorders that cause rapidly progressive dementias such as Creutzfeld-Jakob disease and the paraneoplastic/autoimmune encephalopathies.

Next, this comprehensive approach allows for care that incorporates the most up to date medical care, including non medication techniques such as cognitive training and rehabilitation, caregiver training and support, and lifestyle modification. This multi-dimensional care approach allows patients to maintain a better quality of life than non collaborative care. We also provide longitudinal care for our patients which allow us to help guide our patients through their illness and address issues, such as behavioral changes, as they arise. Our close ties with community organizations, such as the Alzheimer's Association allows us to bridge the gap between what we can do in the clinic and the needs our patients and caregivers have in their daily lives.

There are true success stories for us at the Unity Memory Center. As an example, I had a patient who was diagnosed with vascular dementia after a stroke, but when I stopped his cyclobenzaprine, his cognitive impairment resolved and he was able to return to his usual activities. However, we recognize that the majority of our patients will have an incurable disorder of cognition. We specialize in providing a comprehensive approach to diagnosis and treatment for the patient and caregivers throughout the course of their illness. Our primary goal is to maintain their quality of life in a caring and supporting manner.

A question that we often get is what types of patients should be sent to a behavioral neurologist or the Memory Center. We are here to provide a service to the community and our patients. We would be happy to see any patient who you feel could benefit from our services. This often is a person in whom the diagnosis is in doubt. Sometimes, the question is whether the cognitive changes are part of normal aging, mild cognitive impairment, or dementia. Another question that we are asked to address is whether the person has Alzheimer's disease, another cause of dementia or perhaps a psychiatric illness. We also get referrals to address the behavioral changes that occur with dementia.

David Gill, MD is a behavioral neurologist at Unity Rehabilitation and Neurology in Rochester, NY. He completed his neurology residency and behavioral neurology fellowship at the University of Rochester. He then left to run the Penn State Hershey Memory and Cognitive Disorders Program at the Penn State College of Medicine prior to returning to Rochester this fall to run the Unity Memory Center. He has close ties with the Alzheimer's Association, having served on the Board of Directors of the Greater Pennsylvania Chapter of the Alzheimer's Association and sits on the Medical Science Committee of the Rochester and Finger Lakes Region Chapter of the Alzheimer's Association. He is board certified in Neurology and Behavioral Neurology and Neuropsychiatry.

Breast Density

Stamatia Destounis, MD, FACR

Screening mammography is a well-documented, widely publicized, easily accessible screening test that is beneficial for early breast cancer detection. The evidence to support the recommendation for yearly screening mammography comes from the results of several randomized trials (RCTs) conducted in Europe and North America that included a total of nearly 500,000 women several decades ago. Overall, based on a meta-analysis of these randomized control trials, there was a 26 percent reduction in mortality. The Society of Breast Imaging, the American College of Radiology, the American Cancer Society and the American College of Obstetricians and Gynecologists recommend women of average risk to begin screening at age 40, with high risk patients starting at a younger age.

However, in some women mammography may fall short of early cancer detection. These women may be in the subset of women with denser breasts. Each woman's breast has differing amounts of glandular, fibrous and fatty breast tissue. Breast density is the ratio of the dense (white) tissue on a mammogram divided by the total area of the imaged breast on a mammogram. Limitations in determining breast density include the threshold set to distinguish dense versus non dense breast tissue, how the threshold may change with different mammographic imaging techniques (for eg. with digital mammography breast density visibly appears lower versus with screen film mammography density is visibly higher for the same breast), and the actual area of the breast imaged.

There are four categories of breast density specified by BIRADS (Breast Imaging Reporting and Data System) of the American College of Radiology. The radiologist assigns one of these categories to each mammogram read. A small percentage of women have either fatty breasts, (category 1), or extremely dense breasts (category 4) while most women fall into the two categories in the middle (2-scattered fibroglandular densities and 3-heterogeneously dense). Each woman's primary care physician receives a mammography report from the radiologist which includes the breast density.

Breast density at this time is assigned by the radiologist viewing and interpreting each woman's mammogram. It can be a subjective designation as each radiologist may view the breast pattern for each patient differently. There are breast density measurement computer models that are currently receiving great publicity and measure area or volume based on each mammographic image. These models may help standardize breast density measurements across our community and nationally.

As of January 2013 New York State has mandated each radiologist interpreting mammography studies to inform each patient in lay terms which type of breast density she has.

Why is this important? Breast density is an independent risk factor for breast cancer. In a meta-analysis performed by McCormick, a 4.6x increased risk for breast cancer was identified for the denser breast tissue patient in comparison to a woman with predominantly fatty breast tissue. Several other studies have found similar or higher breast cancer risk. Breast density also impacts breast cancer detection. In the denser breast tissue perceiving a lesion on mammography can be masked. The sensitivity of mammography decreases in the more dense breasts (for eg. BIRADS categories 3 and 4). Dense breast tissue appears white on mammography and breast cancer may hide as it also appears white. So along with a patient being at higher risk for breast cancer by having Category 3 or 4 breast density, the same patient also is at higher risk of the mammogram not identifying a subtle lesion in her dense pattern.

The January 1, 2013 mandate will inform each woman of her breast density and recommend a discussion with her primary care physician to review her breast cancer risk and any additional risk factors. The patient may be a good candidate for additional screening tests that may be recommended such as breast MRI for the woman that has a greater than 20% lifetime risk of breast cancer, or screening breast ultrasound for the woman at intermediate lifetime risk. Screening ultrasound has been identified to increase sensitivity of mammography for breast cancer detection especially in the high risk for breast cancer population, however, studies that involve average risk women have been subjective, have smaller numbers and are non blinded and non randomized. How these screening ultrasound studies could be extrapolated in varied practices, academic or private, and settings, rural or metropolitan, is unknown in women of average breast cancer risk, but with dense breast tissue.

The mandate is meant to inform and educate women regarding the limitations of screening mammography, however, the additional studies that may be the outcome of this mandate may lead to findings requiring additional evaluation and many benign biopsies and other procedures will most likely ensue. Most findings from additional work-ups with ultrasound, especially in women with dense breasts, are benign and false positives. This mandate will undoubtedly lead to additional testing, additional expense and most likely increased anxiety for the patient. At this time reimbursement for these additional studies has not been mandated by the government, creating an out of pocket expense the patient may not be able to afford.

Ref: ACR and SBI position statements and ACR appropriateness criteria at www.acr.org

WHAT'S NEW

in Area Healthcare

NEWARK WAYNE

Newark-Wayne Welcomes 2nd Gastroenterologist to Further Enhance Endoscopy Services

Jeffrey Goldstein, MD, a gastroenterologist, has joined the Newark-Wayne Medical Staff and is now providing diagnostic and treatment services for intestinal/colorectal conditions in Wayne County. Goldstein is the Director of Gastroenterology Outreach at RGHS.

Dr. Goldstein is a graduate of the University of Rochester School of Medicine and Dentistry and completed his residency at Strong Memorial Hospital. In addition, he completed fellowship training at Jackson Memorial Hospital in Miami, FL and is currently an attending physician at RGH.
As part of its major modernization project and to accommodate the increased need for these services, Newark-Wayne opened a new state-of-the-art Endoscopy Suite this past summer.

HIGHLAND HOSPITAL

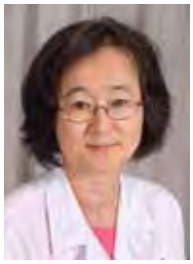
John G. Ginnetti, MD, Joins URMC, Highland Hospital Orthopaedics

Dr. John Ginnetti joins URMC Orthopaedics and Rehabilitation as an Assistant Professor of Orthopaedics. He will be spending the majority of his time at Highland Hospital in the Evarts Joint Center, specializing in adult reconstructive and hip preserving surgery.

Most recently, Dr. Ginnetti completed a fellowship in adult reconstruction and young adult hip preservation at the University of Utah in Salt Lake City. He did his residency in orthopaedic surgery at Allegheny General Hospital in Pittsburgh and earned his MD from the University of Buffalo School of Medicine and Biomedical Sciences.

Rachel Farkas, MD, Joins Department of Surgery at Highland Hospital

Dr. Rachel Farkas specializes in breast surgery and will perform operations at Highland. She received her MD from New York Medical College, completed an internship and an additional year of residency at Saint Barnabas Hospital in Livingston, NJ and recently completed a fellowship in breast surgery at the URMC. She also did her residency at URMC, serving as Chief Resident in general surgery from 2010 to 2011. She is board certified in general surgery and a member of the American College of Surgeons and American Society of Breast Surgeons.



Hong Zhang, MD, PhD, Named Chief of Radiation Oncology for Highland Hospital

Highland Hospital has appointed **Hong Zhang, MD, PhD** as Chief of Radiation Oncology. She will provide clinical and operational leadership for all three sites where Highland provides radiation oncology services: Highland Hospital, Unity Hospital and the Sands Cancer Center at Thompson Hospital.

Dr. Zhang is an associate professor in the Department of Radiation Oncology at URMC. She earned her MD at Yale University School of Medicine and completed her internship in Internal Medicine at RGH and her residency in Radiation Oncology at URMC.

Highland Hospital Appoints Adam Kelly, MD as Chief of Neurology

Adam Kelly, MD has been named Highland Hospital's Chief of Neurology. Dr. Kelly has been involved in neurological care at the hospital since April 2010, serving as the Director of Highland's Stroke Center.

Dr. Kelly received his MD from the University of Rochester School of Medicine and Dentistry, where he also completed his neurology residency and a Vascular Neurology (Stroke) Fellowship.

UNITY HEALTH SYSTEM

Unity Health System is pleased to welcome Michael Foster, MD

Dr. Foster will join Unity as the Clinical Director of Unity's Chemical Dependency programs. He earned his doctor of MD from SUNY Health Science Center at Syracuse and completed his residency and internship at Charles S. Wilson Memorial Hospital in Johnson City, NY. Dr. Foster also served the United States Army Medical Corps as a Major at Fort Bragg. He is a diplomat of the American Board of Addiction Medicine, and is a fellow of the American Academy of Family Physicians.

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