

Western New York

VOLUME 4 / 2014

# PHYSICIAN

THE LOCAL VOICE OF PRACTICE MANAGEMENT AND THE BUSINESS OF MEDICINE

2:38

The Golisano Restorative Neurology & Rehabilitation Center

**Celebrating 25 Years  
of Excellence in Brain Injury Care**

**From the Hospital to the Great Outdoors  
Kids' Therapy Shines in Many Forms**

**An Update on Obesity in Kids:  
A Q&A with Dr. Stephen Cook**



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# Contents

WESTERN NEW YORK PHYSICIAN | VOLUME 4 | 2014

## Cover Story



### Special Feature

## Celebrating 25 Years of Excellence in Brain Injury Care **The Golisano Restorative Neurology & Rehabilitation Center**

Fueled by a \$10 million gift from B. Thomas Golisano, the newly named Golisano Restorative Neurology & Rehabilitation Center launches from a new and expanded location at Unity Hospital. This newly designed wing packed with the latest in technology and designed with the patient and family in mind allows this world-class program to deliver best in care to patients throughout the region.

10 From the Hospital to the Great Outdoors Kids' Therapy Shines in Many Forms

### Clinical Features

03 An Update on Obesity in Kids: A Q&A with Dr. Stephen Cook

16 The Ongoing Puzzle of Neurological Diversity:  
*Teenagers and Young Adults Living with ASD*

13 Skin Cancer on the Rise

### Practice Management

17 Identity Theft – Unknowingly Being in Two Places at Once

20 Why Do Physicians Dislike Electronic Health Records?

### Professional Liability

22 Cloning of EMR Notes: *What is My Liability?*

### Regional Resources

15 Bivona Child Advocacy Center  
*Comprehensive and Coordinated Services for Victims of Child Sexual Abuse*

24 From Toddlers to Tweens: *International Kids Yoga Program Comes to Region*

### Medical Research

19 Combination Nicotine Replacement Therapy Boosts Success Rate  
for Smokers Looking to Quit

28 **What's New in Area Healthcare**

27 **Editorial Calendar**

On the Cover From L to R:  
Mary Dombovy, MD, Cecilia Ransom, MD  
Nathan Odom, MD, Nithyanandini Namassivaya

Cover Photo: James Montanus



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**Welcome to the Pediatric Issue of *Western New York Physician* where you will find a variety of informative stories and articles about and from physicians in the Rochester region.**

Our cover story takes a look at the newly relocated and renamed Golisano Restorative Neurology & Rehabilitation Center. With a generous gift from B. Thomas Golisano, this nationally renowned program will continue to deliver world-class care in a brand new wing located on the Unity Hospital campus. While the new location provides for expanded space and the latest technology available, the program's founding mission remains steadily focused on the patient and family, providing compassionate, individualized care with state-of-the-art therapeutics.

Our Special Feature takes a look at the softer side of medicine. We visit both the EquiCenter and the Child Life program at RGHS to learn more their unique therapy approaches to mend the body, mind and spirit of pediatric patients.

Back in the Business and Liability sections you will find timely articles from local experts on identity theft and managing your liability in the cloning of EMR notes.

#### **Participate in the Conversation**

Sharing your expertise is a valuable way to communicate with your medical colleagues and strengthen your position among referring physicians. Looking ahead – our final two issues of the year focus on Oncology and Geriatrics (see the *Editorial Calendar* on page 25 for more detail.) If you specialize in one of these areas, you'll want to be included. Contact me directly to learn how.

Regards –

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# Western New York **PHYSICIAN**

THE LOCAL VOICE OF  
PRACTICE MANAGEMENT AND  
THE BUSINESS OF MEDICINE

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# An Update on Obesity in Kids



Stephen Cook, MD, MPH

*Dr. Stephen Cook, MD, MPH, is dual trained in pediatric and adult-internal medicine. After completing his residency and a chief resident year in Buffalo NY, he joined the Golisano Children's Hospital at URMC in 2001. He completed an academic pediatric fellowship here, during which time he focused on his research and clinical aspects on nutrition, physical activity, obesity and the metabolic complications that arise. He currently sees patients as part of the general pediatric practice at strong, where he also teaches medical student and residents.*

## 1. What is the scope of obesity among kids and teens and how does our region compare nationally?

We have looked at data in for Monroe County in 2007 and found about 15% of kids were overweight and 15% have obesity. When we looked by where they lived, we found 12% of kids in the suburbs have obesity as opposed to 22% of kids in the city. These data are very similar to national data from around the same time. We are in the process of completing a repeat study for Monroe County. The encouraging finding is the overall rates are staying flat. That might not seem exciting but things have to slow down and stop before they can start to decrease. Plus this is a very complex biological, social, behavioral and environmental disease.

## 2. As an impassioned expert in the field what trends are you seeing?

I've been working in this field for the last 13 years and I'm starting to get encouraged by the greater attention to looking at the social and environmental factors related to obesity and how improving built environment and access to healthier food is starting to occur more often. These types of policy and social changes are good for everybody, not sure those affected by obesity. At the same time, these strategies get at prevention and don't really do much for helping treat or manage obesity.

## 3. What makes obesity so difficult to treat and why is it so critical that it is treated?

First, obesity has only recently been recognized as a disease and is probably the most stigmatized disease or condition in our society. To follow this thought, many people feel obesity is only a matter of personal choice. That's not really the case. The data is out - when you gain excess weight your body's metabolism will fight to maintain that higher level of energy storage. In children and teens they are setting up their future health trajectory, but we have to look at the whole family. The child or teen who has

obesity, can't be treated in isolation. Even if parents don't have obesity, they need to participate in a family based approach. The good news is that the parent will gain benefit from being involved and the better research programs show the parents loss weight also.

## What is working and what is not?

First, what is not working, personal choice and stigmatizing people who are obese. Also the supplement industry is not working, despite what Dr. Oz might think.

The evidence of what works starts with behavioral based treatment that focuses on the family, the parent child dyad. And it has to be at a fairly regular level; it's not just nutrition education but involves behavioral change with a family setting being most effective. It all really starts with motivation of the family and really meeting them where they are at. Sticks and carrots are used a lot in our society to try to change behavior, and those can work a little bit at the start, but that approach is tough to maintain because you have to 'keep giving' the reward. If we can help families internalize behavior change, and support their autonomy to make such changes, those will be maintained a lot longer and without nearly as much outside influence.

## 4. Can you describe some of the promising evidence on how to treat and manage?

There are no drugs to prescribe for children or teens. Family based approaches that involve at least 1 parent that is partnered with the child is very promising. The USPSTF guidelines recommend multi-disciplinary approach to behavioral therapy. It needs to be at least 6 months and at least 25 hour of contact time. This is something beyond what primary care providers can do. It will really require services linked to tertiary care centers that serve children and teens. We just completed a large national survey of children's hospital across the US

There has also been promising research looking at using wireless technology to reach teens directly, but also to reach families from far away. Telemedicine is something that is gaining support around the state but I've not seen it used for obesity yet. There are also complex issues with location transmitting the visit, the site receiving the visit and the reimbursement for both.

Rarely, an adolescent needs something like bariatric surgery, but this does come up. The bypass and the band are being used in research but the gastric sleeve seems to be offering the most promise in the very rare and extreme cases that this is considered. There really are no centers in Upstate NY. We had a child that needed bypass for a couple of reasons and we petitioned

NYS Medicaid. They did approve him to have his surgery but it was done in NYC. This is something that might need to be looked at more closely for the comprehensive, pediatric centers like we have in Rochester. Especially one that has the critical adolescent medicine and pediatric mental health providers that are available at the Golisano Children's Hospital at the University of Rochester.

### **5. What resources are available to physicians and their patients in our region?**

There are some resources that can be of assistance to physicians, when the families are motivated to make change. YMCAs are readily available all across the US and they do provide scholarship to families, as long as they fill out their application process. Every county in NY should also have a cooperative Extension office, and these locations have nutrition education specialist that can also be of assistance to motivated families. Also, because they help administer food assistance programs like SNAP, they can also provide information where to use their benefits to get more access to fresh produce at regional farmers markets.

### **6. Insurance coverage is a big issue for patients. Last June the AMA recognized Obesity as a disease rather than a condition. Has this had impact on accessibility of treatment and access to supplemental resources?**

It is really important to acknowledge that obesity is a disease. There is overwhelming evidence that, at some point, excess body

fat is a disease state, just like excess blood pressure is the disease state of hypertension. Despite the fact that BMI is not the best measure for everyone, we should start to measure waist circumference for adults, and consider it in teens also. We also have to ask about social and psychological toll obesity is having on our patients, especially the teasing and bully kids experience and the damage that inflicts on their emotional state. The impact hasn't been realized in NY yet probably for a few reasons. NYS Medicaid and the Exchange system is still new at delivering care, so they are really dragging their feet when it comes to describing what care they will cover. The reality is that Treatment of Obesity for adults and children both care a Grade B level of evidence from the US Preventive Services Task Force. According to the ACA, everything with a grade A or B from the USPFTF has to be covered without co-pay. Medicare has started to put together more specific language for covering Medicare beneficiaries. The only language I've heard from Medicaid is about covering the preventive services for children, which is really important for things like vaccinations and routine screening at annual check-ups, but that is not the same as covering Moderate to high intensity, multi-disciplinary behavioral services for children 6 yrs or older with obesity. While obesity is a disease, it is not one that has the dignity of other chronic diseases. While there is a national group known as the Obesity Action Coalition, it is fighting very hard to be an advocacy voice for coverage of effective treatments for adults. They are just starting to talk about advocating for children and families.

# *Congratulations on 25 years of exceptional care!*

25 years have passed since we began as a small, inpatient brain injury rehabilitation unit at St. Mary's Hospital. What began as a small, 14-bed inpatient brain injury rehabilitation unit has evolved into a comprehensive program including neurological, neurosurgical, rehabilitation, stroke and spine services. The key to this growth has been staying true to the vision and mission of the program by providing services that the community needs, designing these services around the needs of the patient and family and ensuring access to all at a reasonable cost.

visit us at [unityhealth.org](http://unityhealth.org)

 **Unity Hospital**  
Golisano Restorative Neurology &  
Rehabilitation Center

**The Golisano Restorative Neurology & Rehabilitation Center**

# Celebrating 25 Years of Excellence in Brain Injury Care

By Julie Van Benthuyzen

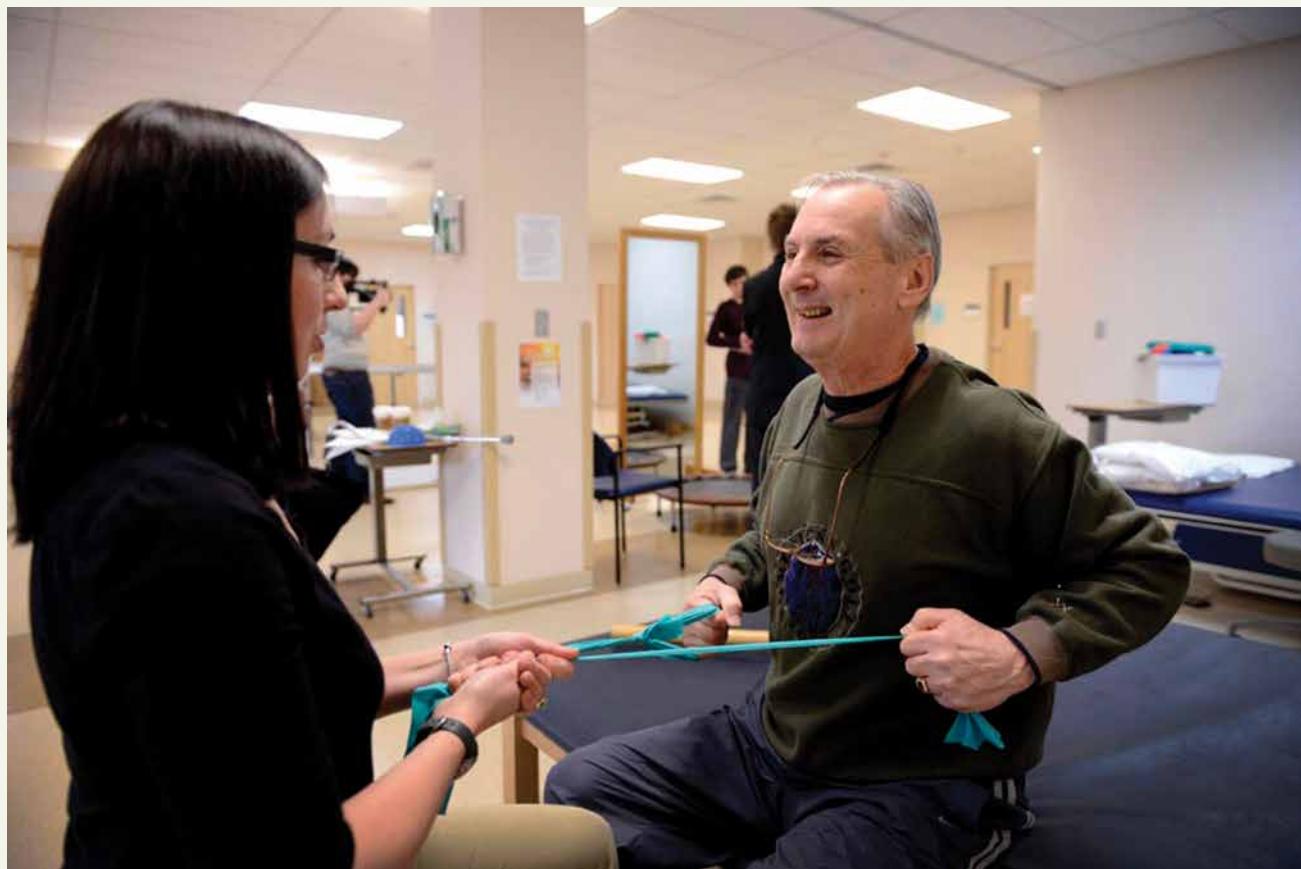


Photo: James Montanus

Maria Heeg, Occupational Therapist works with patient Marc Germain to increase upper body strength, function and stability.

This month, our region's nationally-recognized Acute Rehabilitation and Brain Injury Program will celebrate its 25-year anniversary of providing exceptional care to patients across the country. What began as a small, acute brain injury unit at St. Mary's Hospital decades ago, has evolved into the region's largest, serving patients with brain injury, stroke, spinal cord, orthopaedic and other neurological, musculoskeletal and medical conditions. Formerly operated by Unity Health System, the Program is now part of Rochester Regional Health System.



The Golisano Restorative Neurology & Rehabilitation Center offers 25 private rooms, each with a private bathroom and shower, computer and space to accommodate a family member overnight.

The brand new Unit represents the final cornerstone of a vast four-year modernization and expansion project that called for a full revitalization of Unity Hospital. The relocated Program has been up and running since May, and was renamed the Golisano Restorative Neurology & Rehabilitation Center, in recognition of a \$10 million grant received from Mr. B. Thomas Golisano. “This generous donation is really a testament to how comprehensive our offerings have become,” says Dr. Mary Dombovy, who was recruited to lead the Program in 1989.

The Program is the only one of its kind in the area accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) for acute brain injury rehabilitation and stroke rehabilitation, including pediatrics. “We have created a healing environment where patients can achieve their maximum level of ability,” adds Dr. Dombovy.

### Humble Beginnings

The move to Unity Hospital was actually a long time coming. Back in 1989, fresh from her residency program, Dr. Dombovy identified a critical need to build a local brain injury program. She and colleague Sue Vogl shared the same philosophy for getting the program off the ground. “It was just an idea at the beginning,” explains Dr. Dombovy, “but we both believed that success would be attributable to two ideals: always putting the patient and family first, and always providing the best possible service to make the experience better and more like home — which is ultimately where we want our patients to be even after an often catastrophic injury.”

inviting environment with safety and comfort in mind – down to ensuring extra beds or recliners are in the rooms for family members. “Because we learned to work together when we were much smaller, we’re able to maintain strong communications with our team now that we’re within a larger hospital setting.”

### New Facility Highlights

One of the most noticeable benefits of the new location is the larger and updated space designed to handle new equipment and technology for the Program’s unique patient base. The floor includes 25 single patient private rooms. “We have so many added advantages of being within the Hospital,” says Dr. Dombovy. “Our move now affords us technologically- and aesthetically-enhanced facilities, as well as proximity to all of the hospital’s services. This just further supports our ability to move patients into the restorative phase sooner — which research has consistently shown provides better outcomes,” she explains.

The Golisano Restorative Neurology & Rehabilitation Center offers 25 private rooms, each with a private bathroom and shower, computer and space to accommodate a family member overnight. Also on the Unit is an expansive therapy space that includes state-of-the-art treatment technologies, private treatment rooms for cognitive and speech therapy, pediatric treatment and play space, full kitchen and laundry, dining room and common areas with extensive natural light. “The new unit creates an atmosphere that facilitates treatment focused on restoring function of body and mind, as well as welcoming to

She notes that in order to survive and succeed, staff needed to be exceedingly efficient. As the department eventually grew and additional services were offered including neurology, the priority remained accessibility to patients and family at all times. “If you were a patient, we got you in. You weren’t put on a waiting list if you were having seizures.” While staff was able to make the best of the Unit on the St. Mary’s campus, limitations of space and technology in recent years grew increasingly problematic.

Staying true to where the Program began, the new Center has expanded its space and



peutic strategies, says Dr. Dombovy.

The primary focus, say these program leaders, is rehabilitating the “total person” through a team approach of physicians, nurses and therapists who maintain special certification and training in brain injury, stroke, spinal cord injury and musculoskeletal conditions. Many members of the nursing and therapy staff have earned advanced certification in the rehabilitation and neuroscience field, an attribute unique to Unity’s program. Additional staff includes occupational therapists, physical therapists, speech-language pathologists, recreation and leisure personnel, case managers and dieticians. Educational tutors, counselors and pastors are also available on an as-needed basis. Since family involvement is vital to the recovery process, staff encourages participation in therapies and program activities, and attending evaluations and conferences throughout recovery.

#### **Addressing Stroke, Spinal Cord and Orthopaedic Issues**

As a designated Stroke Center, the stroke rehabilitation program at the Golisano Center helps more than 130 patients recover from stroke every year. Stroke patients are referred for a rehabilitation needs assessment as part of their continuum of care. Optimal stroke care including stroke risk factor management and close follow up by the same neurology team during a rehabilitation stay and after a patient’s return home optimizes best health outcomes.

The goal of caring for patients with a spinal cord injury is to help each patient achieve the highest level of independence possible following spinal cord injury or disease, explains Dr. Dombovy. The program serves pediatrics through elderly patients with diagnoses such as traumatic spinal cord injury, spinal cord hemorrhage and infarction, transverse myelitis, spinal neuropathy and tumors. The program provides an individual-

families and visitors” said Dombovy.

From a Physical Therapy perspective, more options exist. “Patients can move around more extensively, but within an enclosed, safer environment, with alarmed doors,” she says. “Most patients are initially in wheelchairs. We take that kind of mobility for granted, but it’s very precarious at the beginning for these patients.” For that reason, signage and mirrors are angled at the top of the ceiling and on side walls in order for patients to gain a better perspective as they move.

Assuming a large portion of the Unit is the considerably larger, high-tech gym. “Our gym is really the crux of the program because now, everything is fresher and more diverse – from having more mats to ensuring that providers are available 24/7.” Through a more expanded ceiling tracking system, staff can move patients around farther, and with more ease. “Essentially, we’ve gained new technologies across a bigger space.”

#### **Rehabilitating the Total Person**

The Center’s diagnostic, therapeutic, and rehabilitative services run the gamut. Staff provides expertise in determining the impact of brain or other injuries on a patient’s behavior and intellect, and developing a therapy program that produces optimal results. The Program’s neuropsychologists thoroughly assess each patient’s cognitive and behavioral functions. Based on the results of these assessments, they can provide family members and the entire treatment team with detailed information about the patient’s strengths and weaknesses in areas such as attention and concentration, memory, problem solving, judgment, emotional functioning, and social skills. This information guides physicians and therapists in their selection of thera-



Photo: James Montanus

peutic strategies, says Dr. Dombovy.

As the only pediatric rehabilitation of its kind in Western New York, Dr. Dombovy’s program provides consultation and treatment for children with a wide range of neurological and orthopaedic conditions. Physical Therapist Vanessa Ellsworth seen here works with pediatric patient Dominic Pennesi.

ized rehabilitation plan that consists of a comprehensive, highly integrated and intensive program of medical, nursing and therapy care to address the complex needs of each patient. This goal-directed approach enables patients to improve physical function and mobility, develop the skills and strategies to perform daily activities, utilize adaptive technologies that facilitate activities at home, work and in the community, and overcome the psychological and social problems that often interfere with adjustment to life ahead.

One of the primary goals for the Center's orthopaedic patients is to resume their normal activities as soon as possible after a joint replacement. For patients planning joint replacement surgery, staff coordinates a post-operative rehabilitation plan with their primary care physician or orthopaedic surgeon that ensures a streamlined process of care that's simple and efficient. Through the program, patients undergo three to four hours of combined therapy each day, which amounts to two to three times more than patients would receive within a typical nursing home rehabilitation program, says Dr. Dombovy. "This allows many of our patients to return home sooner — and stronger."

#### **Best in Pediatric Rehabilitation**

As the only pediatric rehabilitation of its kind in Western New York, Dr. Dombovy's program provides consultation and treatment for children with a wide range of neurological and orthopaedic conditions. "Our goal is to provide emotional and physical support young patients need as they face the challenges of rehabilitation," she says, "in a comfortable, friendly environment designed with children in mind."

The entire therapeutic team works closely with the child's family and pediatrician to streamline services efficiently and effectively. Academic tutoring is available onsite, in coordina-



tion with tutors from the patient's home school district. Often, young patients in the program are able to work with their own teacher as they prepare to return full-time to the classroom. "It's our goal to ensure that children have access to and receive the services they need to function to the best of their abilities, both at home and in school. After discharge, our physicians and staff continue to interface with the school."

#### **Helping Patients Reach their Fullest Potential**

Dr. Dombovy notes that a key measure of the program's success is patient outcomes. Recent quality survey results show that 98% of the program's patients achieved their predicted outcomes. The average Functional Improvement Measure

(FIM) score for brain injury patients — a standard measure of the patient's improvement from admission to discharge — is 38, well above the national average of 29. The score for its stroke patients is 31 while the national average is 28. Patient satisfaction is another important benchmark for the Center. "One hundred percent of the patients we've surveyed said they would recommend our rehabilitation program to others."

New approaches such as bodyweight supported treadmill training, constraint-induced therapy, functional electrical assistive devices, and new methods of brain scanning are all enhancing the Program's ability to restore function, such as walking and use of an arm, and to understand how the brain is responding to these therapeutic approaches.

The program's affiliations with the University of Rochester, Rochester Institute of Technology, and Nazareth College continue to foster involvement in the latest clinical research, education, and clinical care.

#### **Beyond the Golisano Restorative Neurology & Rehabilitation Center**

Today, the Neuroscience program employs more than 180 staff members including neurologists, neurosurgeons, rehabilitation physicians, spine center physicians, advanced practice providers (NP and PA), nurse navigators (spine and stroke), and neuropsychologists leading a team of experts in physical, occupational, speech therapies, and rehabilitation/neurosciences certified nurses.

Specialized programs are offered in stroke, spine, memory care, brain injury, and concussion. The stroke program encompasses treatment that begins in the emergency room through rehabilitation and home. Patients are seen in a specialized stroke clinic within a week of hospital discharge to prevent complications or a return to the hospital. The Memory Center

# HISTORICAL SNAPS HOT

**August 1989**

Opened 14 inpatient brain injury rehabilitation beds

**1994**

Program achieves CARF Accreditation

**1995**

Added pediatric rehabilitation beds, bed total at 33

**1997-2008**

Expanded outpatient neurology physician and rehabilitation therapy practices to seven locations

**2009**

Established Unity's Spine Center

**2010**

Relocation and expansion of physician and therapy services to Unity at Ridgeway

B. Thomas Golisano provides a 10 Million dollar gift to Unity Hospital for the future Golisano Restorative Neurology & Rehabilitation Center

**2011**

Neurology, Neurosurgery, Physical Medicine and Rehabilitation, and Spine combined to form Neuroscience Service Line

**2012**

Opening of Unity at Brockport Unity Physical Therapy and Rehabilitation location

Established Unity Stroke Center

**2013**

Establishment of Stroke and TIA Clinic, with grant funds supported by the Greater Rochester Health Foundation

Unity Memory Center established

Gold Plus Quality Achievement Award for stroke care

**2014**

Opening (and program relocation) to the Golisano Restorative Neurology & Rehabilitation Center

providers work closely with geriatricians to provide continuity of care. Annually, almost 3,000 new patients with neck and back pain seek care at the Unity Spine Center.

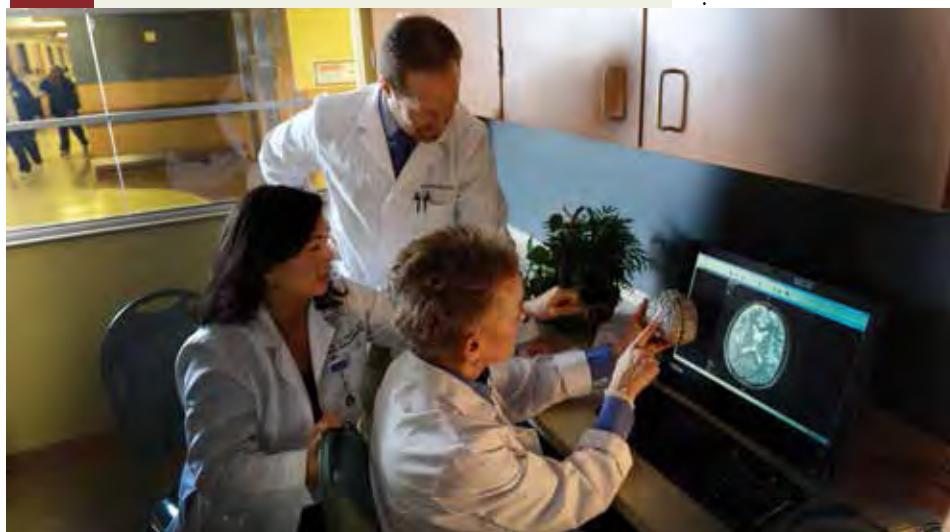
"Building the Neuroscience Service Line and carrying forward the concept of interdisciplinary team care has created a level of collaboration among professionals focused on the patient that is rarely seen elsewhere," says Dr. Dombovy. "My medical school and residency training at the Mayo Clinic, where the entire institution is dedicated to patient care, completely underlies our approach."

## Looking Ahead

Dr. Dombovy sees encouraging signs for an even stronger Program moving forward. "The recent partnership of Unity and Rochester General Health systems means more patients will be exposed to the offerings of the Golisano Restorative Neurology & Rehabilitation Center. This merger is an asset to an already patient-focused program."

As it has from the beginning, she says, the focus will remain on the patient and family, providing compassionate, individualized care with state-of-the-art therapeutics through an often long and difficult journey.

"This journey often requires re-learning basic things such as walking, talking, dressing, and eating. Still after all these years, there is nothing more gratifying than seeing someone take their first step, say their first word, or send a picture of their graduation or wedding," she says. "It is a privilege to have been a part of so many people's lives, helping them to return to the activities and family and friends they cherish. Our entire team wishes to extend our sincere thanks to Mr. Golisano. His generous gift helped create this beautiful new space, enhancing the care and services we bring to our community."



***“Building the Neuroscience Service Line and carrying forward the concept of interdisciplinary team care has created a level of collaboration among professionals focused on the patient that is rarely seen elsewhere.”***

# From the Hospital to the Great Outdoors Kids' Therapy Shines in Many Forms

By Julie Van Benthuyzen

**C**hildren are being exposed to more non-traditional therapies to aid in healing from illness and injury, or in dealing with any range of health or neurological issues. From yoga to horseback riding, kids of all ages are benefiting from unique opportunities to mend body, mind and spirit through indoor and outdoor activity and play.

For nearly a decade, EquiCenter has provided special programs for children and adults in need. The nonprofit facility, located at the spectacular 178-acre William and Mildred Levine Ranch in Mendon, offers a wide range of therapeutic equestrian activities for people with disabilities, veterans and at-risk youth. Children, especially, seem to thrive in this bucolic setting surrounded by pastures, farmland and woods, where horseback riding and related activities serve as a progressive forms of therapy.

Horseback riding helps improve muscle stimulation, strength, coordination, flexibility, posture and balance for people with physical, mental/emotional, neurological and cognitive challenges. These range from Autism, ADD and ADHD, Cerebral Palsy, Developmental Delay, Friedreich's Ataxia, Hypotonia and Intellectual Challenges to Post Traumatic Stress, Traumatic Brain Injury, Tourette's Syndrome, Visual Impairment, Spina Bifida, Down Syndrome, Multiple Sclerosis, Epilepsy, Stroke, and even Spinal Cord Injuries. Beyond the physical benefits, equestrian activities increase communication, social and organizational skills, and enhance self-confidence, relationship building, teamwork and independence.

"The multi-dimensional movement of the horse recreates the human gait more effectively than any other means of physical therapy," says longtime EquiCenter volunteer Ruth Meyers. Horses are dynamic, sensitive animals that communicate through the subtle use of body language. They respond to situations giving immediate, honest feedback without judgment. Horses are large and powerful animals, which naturally create an opportunity for people to overcome fear and develop greater self-confidence. With their own unique personalities, attitudes, moods and backgrounds, horses provide endless experiences and situations for growth, healing, learning and relationship building, she adds.

"Not all of our participants ride, but for those who don't, there are great benefits derived from grooming, enjoying a therapy dog, gardening and harvesting crops, and even helping grow the hay for our horses." For many families, she says, the EquiCenter has been the one form of therapy that really made the



Photo: courtesy Equicenter

Children, especially, seem to thrive in this bucolic setting surrounded by pastures, farmland and woods, where horseback riding and related activities serve as a progressive forms of therapy.

difference for a child with complex problems. "Participation at the EquiCenter provides a unique healing experience for children and adults with physical and emotional challenges in a way that doesn't feel like going to therapy."

EquiCenter participants perceive therapeutic horseback riding as a more positive experience than traditional therapy, serving as a strong motivator in achieving their therapeutic goals, she adds. As a member of PATH (Professional Association of Therapeutic Horsemanship), EquiCenter offers a variety of equine-related activities – from therapeutic horseback riding and hippotherapy, to interactive vaulting (like gymnastics on horseback), as well as equine-facilitated learning and mental health programs, using the horse as a partner in cognitive and behavioral therapy. Participants can also participate in grounds work and stable management. Equicenter's instructors are internationally-certified, and the facility's volunteers and horses have been carefully selected and trained for their vital roles.

Equicenter was recognized early on as one of only two programs in the state achieving both Premier Accreditation from the North American Riding for the Handicapped Association (NARHA) and certification by the New York State Horse Health Assurance Program. Equicenter works with numerous community agencies, including the Al Sigl Community of Agencies, Autism UP, Hillside Children's Center, Golisano Children's Hospital, Association for the Blind and Visually Impaired (ABVI), Lifetime Assistance, Ontario ARC, St. Joseph's Villa, The Norman Howard School and the Veterans Outreach Center.

## **Healing Body, Mind and Spirit**

At the start of a riding lesson — when the rider is securely mounted and the horse leader and side walkers are in place — all are ready for the words that tell the horse it's time to move. At the instructor's signal, the team begins the countdown: "one, two, three" ...and then pauses for the rider to give the final command to "Walk On." Some participants shout it enthusiastically, says Meyers; while others, challenged by disabilities that compromise their understanding or speech, say or signal it as best they can. "Regardless, the joy is universal as the team — both human and equine — moves forward, taking new steps on the student's life-changing path."

Since the program's inception in 2004, Meyers credits EquiCenter's success to its team approach to therapy — between staff, volunteers, Board, Advisory Board and Health Advisory Board members, and numerous community partners. "Our reputation for changing lives every day has spread ... and so our programs have grown." In 2010, Equicenter received visionary funding from the William and Mildred Levine Foundation, which enabled the move to its new, larger home from its original location at Mendon's 23-acre ABC Farm.

With a waiting list and more interested organizations, need for continued expansion has become acute, she adds. "Our goal is to build on what we currently offer to provide a comprehensive therapeutic community for individuals with disabilities and their families, including military veterans." Additional plans include expansion of its canine therapy and horticultural therapy programs, and exploring a job development skills program based on all its current therapeutic offerings. "Our fondest hope is to provide expanded programming across a person's lifespan." From children born with a health condition to seniors with Alzheimer's or other dementias, all can benefit from broader offerings.

"It's difficult to fully understand the power of the EquiCenter without seeing it," says Myers. "I've been volunteering here in many capacities for years and I can honestly say that every day there's something beautiful that brings a tear to my eye: a child who can sit up without support; a soldier who feels peace and connection for the first time since returning from war; a volunteer whose work with these wonderful students and horses helps to heal her own grief."

## **In-Hospital Comprehensive Therapy**

When enjoying the therapy of the great outdoors is not an option, inside therapy programs can offer a successful alternative. Particularly within the hospital setting, children dealing with illness and injury are benefiting from integrated therapy programs. Through generous regional and local grant support, Rochester General Health System has been offering Child Life, designed to address a myriad of childrens' therapeutic needs.

Child Life represents the psychosocial side of pediatric care, says Director Teresa Schoell, Rochester General Hospital's Certified Child Life Specialist, by helping children understand why they're hospitalized, and what's happening while they are. A Child Life specialist brings training in child development to the hospital setting and uses various types of education and play to help promote positive coping skills. Child Life services

can be consulted for all ages of pediatric patients, from birth to age 21. Additionally, Child Life services provide support for children of adult patients facing an end-of-life, or life-limiting condition.

Schoell explains that play is a child's first tool for coping with new, and sometimes overwhelming experiences — like coming to the hospital. Essentially, a Child Life specialist's job is to play all day, with the play always having a specific purpose depending on the situation and need.

"While most children's hospitals have expansive Child Life programs, community hospitals like Rochester General rarely do, so I feel privileged and honored to help blaze this trail five years ago." Schoell divides her time between educating and supporting medical staff in Child Life techniques, and within the in-patient unit, providing therapeutic play to children who stay overnight, as well as in the pediatric emergency department, with play-based support to children with medical emergencies requiring stitches, IV fluids or CT scans.



Photo: Lynne Tseng

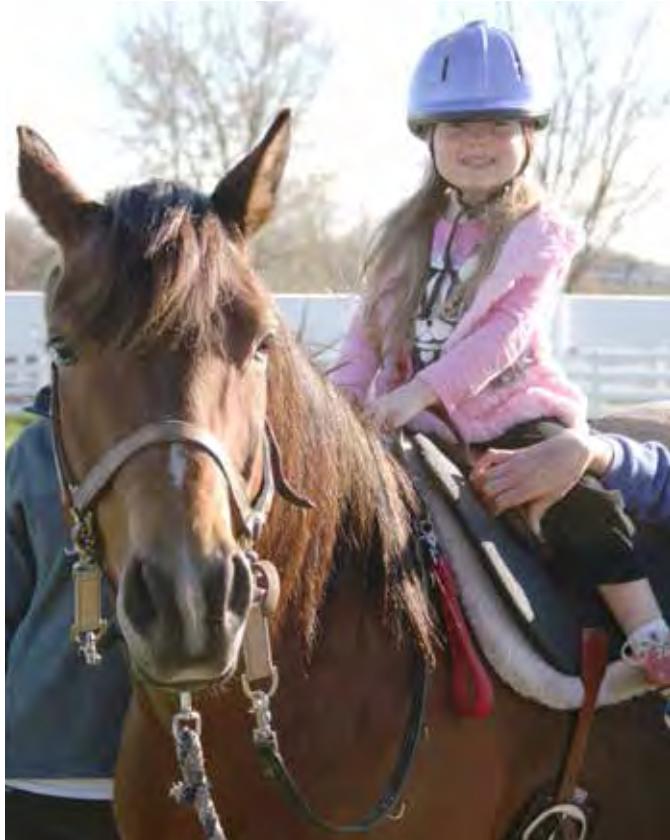
Therapy dogs also play an important role in therapy.

## **Play Therapy**

Schoell identifies different forms of play and how each can provide therapeutic opportunities. 'Normalization Play' helps children feel more comfortable and less frightened. This type of play shows kids that being in the hospital is just one more place where they can play -- just like at home or school. 'Developmental Play' helps them work towards and maintain their developmental milestones, despite hospitalization.

Another form is 'Diagnosis Play,' which helps children learn about their illness or injury through age-specific, hands-on play. 'Procedural Support Play' includes both preparatory play before a procedure, and in-the-moment support and coaching while undergoing the procedure. 'Medical Play' helps children become more familiar with medical equipment and staff to build confidence in the medical setting. 'Therapeutic Play' helps children express and cope with the emotional experience of being at the hospital. "Whether frightened, angry, sad, or withdrawn, therapeutic play can definitely help."

"Play is the language of children, so everything I do as a Child Life specialist is rooted in play," says Schoell. "I always invite



Horseback riding helps improve muscle stimulation, strength, co-ordination, flexibility, posture and balance for people with physical, mental/emotional, neurological and cognitive challenges.

parents and siblings to participate when I teach about diagnosis through play. When teaching about sickle cell disease, we make blood cells out of playdough. As we drop the larger, stickier, sickle-shaped cells through the toy vein, and watch them clump up to create a pain crisis, it's not just my young patients who learn. Parents often join in that play-based 'ah ha' moment, gaining a deeper understanding of their child's illness. Parents appreciate the child-centered approach to medical care, and the comfort, insight, and joy that play brings to the hospital experience." Included in Child Life services is 'Sibling Support,' helping the brothers and sisters of pediatric patients understand what's happening at the hospital, and helping them feel included in family-centered care.

Bereavement Support, another component of the program, can help a child through the loss of a loved one. Whether supporting a child patient and family through legacy-making activities, or providing support to the children of an adult patient, a Child Life specialist can help children and their families navigate the emotionally complex reality of a family death. "I also work with the children of our adult patients in the ICU, or on palliative care. Child Life specialists receive extensive training in child development, including techniques to help support young children through a parent's illness or death." Families facing end-of-life, and life-limiting conditions, often turn to Child Life services for assistance in talking with the children, and helping them understand and cope with these sad and difficult transitions.

### Power of Play in Action

Last October, 4-year-old Wallace arrived at Rochester General's ER with a sizable cut under his left eyebrow, having collided with another little boy at preschool. His cheeks were streaked with tears and blood. The nurse placed numbing gel on the cut to ease the pain and stop the bleeding and prepare him for stitches, while Schoell dried his tears. Wallace and his parents remembered his cousin getting stitches the year before, and feared the worst. But Wallace's experience would be nothing like his cousin's. "I blew bubbles and colored with Wallace until he felt comfortable with me," she relates. "Then I brought out one of my teaching toys – a doll with a cut on its head – and together we learned all about stitches. Wallace took the lead as we rehearsed each step of the procedure on the doll. First we numbed the doll's cut, then we cleaned it and put in the strings. Playing the role of the doctor (with a little coaching from me), Wallace instructed the doll when to hold still, which part would hurt, and how to be brave. When it came time for Wallace to get his stitches, I stayed by his side to coach him, and continue the therapeutic play. I repeated to Wallace the same words he used with the doll – 'count to 10 to feel brave' and 'blow on the silly whistle if it hurts.'"

At just four years old, Wallace held still without needing to be held down, and managed to get his six stitches without screaming or crying. "He was brave, if a little tearful, during the initial painful lidocaine injection, but then happily sang songs with me throughout the stitching. His parents were thrilled and relieved. Afterwards, Wallace told me he loved his stitches, and that they would make his Halloween pirate costume 'the bestest costume ever!'

Whether easing the boredom of a toddler on the in-patient unit, singing to an infant in the emergency department, enticing a post-op patient to increase fluid intake, or educating a child about her mother's cancer diagnosis, everything about the Child Life program is based in play. "Having a solid foundation in child development, Child Life helps support positive coping skills, increases compliance, supports family-centered care, and makes hospitals less scary, and more fun, for children of all ages."



Photo: courtesy Equicenter

"Not all of our participants ride, but for those who don't, there are great benefits derived from grooming, enjoying a therapy dog, gardening and harvesting crops, and even helping grow the hay for our horses."

# Skin Cancer on the Rise



Brett C. Shulman, MD

ACCORDING TO THE AMERICAN ACADEMY OF DERMATOLOGY, someone dies from skin cancer in the United States each hour. In addition, half of all new cancers diagnosed this year will be skin cancer with skin cancer being the most common cancer of all. Skin cancer accounts for approximately 2 million cases each year and approximately 20,000 deaths. Despite this frightening fact, nearly all cases of skin cancer are preventable, treatable and curable according to Brett C. Shulman, MD a board certified dermatologist practicing dermatology and skin cancer surgery for the Rochester General Medical Group on Hagen Drive in Penfield.

Dr. Shulman states that the most common warning sign of skin cancer is a change on the skin. This may include changes in existing spots on the skin or the development of new skin lesions. "What a patient needs to look for is any new or old skin growth that changes in size, shape, color, texture or bleeds," says Dr. Shulman. Although not all skin growths that show these changes are cancerous, it is important to have a changing lesion examined by a board certified dermatologist to determine what course of therapy is necessary.

The average age of discovery of the first non-melanoma skin cancer is usually about fifty years of age and for melanoma around age 35. Skin cancer rarely occurs in childhood. However, with increased access to ultraviolet light exposure through winter vacations, summer exposure and exposure to artificial sources from tanning salons, the incidence of skin cancer in younger patients is increasing at an alarming rate.

The most common types of skin cancers are basal cell carcinoma, squamous cell carcinoma and malignant melanoma.

**Basal Cell Carcinoma** is the most common type of skin cancer and accounts for approximately 1.2 million cases each year. Over ninety percent of basal cell carcinoma are thought to occur due to exposure to the sun and basal cell cancers account for seventy five percent of all skin cancer. The tumors usually appear as single small bumps generally on "sun exposed regions of the body." The spots range in color from flesh color to red, brown or purple. In approximately one third of cases, a small ulcer will appear in the center of the growth. As the growths develop they tend to grow in size and often bleed after long periods of growth. This type of skin cancer is generally slow growing and rarely spreads to distant locations in the body, but can extend and tunnel deeply below the skin to the bone and do extensive local damage. Basal cell carcinoma needs to be detected early and treated early to achieve good result. Within five years of

diagnosis of a basal cell carcinoma, 35% of patients will develop a second basal cell carcinoma, so continued monitoring is important.

**Squamous Cell Carcinoma** is the second most common form of skin cancer and accounts for approximately twenty percent of all cases of skin cancer and nearly 350,000 cases per year in the United States. Like basal cell carcinoma, squamous cell carcinoma usually occurs on sun exposed areas of the body such as the face, ear, neck, lip or hands. These tumors are more difficult to detect in their early stages and may present as a non-healing patch of eczema or chronic scaling of the skin. This cancer goes through an orderly progression from a pre-malignant scaling spot on the skin called an actinic keratosis, which in a certain percent of cases progresses to an invasive squamous cell carcinoma. Squamous cell cancers tend to be more aggressive than basal cell cancers. These tumors can invade deep structures and travel rarely to distant parts of the body resulting in death. Squamous cell cancer that arises in burn or x-ray scars are more likely to have adverse outcomes.

**Malignant Melanoma** is the least common and the most feared and deadly of the skin cancers. Melanoma accounts for one percent of all skin cancers but two percent of all cancer deaths. Nearly 20,000 patients die each year from melanoma. This growth represents a malignant change in the pigment cells. Melanoma is commonly pigmented with shades of brown, red and black within the growth. Its other characteristics include an irregular border and color variation. Research has shown that single blistering sunburn doubles a patient's lifetime chance of developing melanoma. Heredity may also play a key role in the development of melanoma and families which appear to be "melanoma prone" with pre-cancerous moles known as dysplastic nevi. Melanoma is much more likely to metastasize or spread to other parts of the body.

## Skin Cancer Risks

The main cause of skin cancer is over-exposure to sunlight or artificial ultraviolet light. Fair skinned people, especially those with red or blonde hair are at increased risk to develop skin cancer. This is because these individuals produce a pigment in their skin that is less likely to protect them from skin cell damage. People who work or play outdoors such as farmers and construction workers, athletes, frequent sunbathers are at increased risk to develop skin cancer.

Today's sunscreens are instrumental in preventing burning while still allowing tanning to occur. Used properly, these

agents can reduce the risk of skin cancer and wrinkling of the skin. Sunscreens can be applied on all everyone over the age of six months and should be reapplied every 2-4 hours. Broad-spectrum sunscreens that are water resistant are the best says Dr. Shulman.

#### Skin Cancer Detection

The early detection and treatment of skin cancer, especially melanoma can be accomplished with monthly self-examination of the skin. Dermatologists estimate that monthly skin self-examination may reduce melanoma's death rate by over sixty percent. According to Dr. Shulman, self-examination of the skin is a simple five minute procedure that should be done by everyone. "Both men and women need to set a fixed time each month to examine their skin looking for new or changing growths. This allows them to develop a visual map to use for monthly comparisons." Early detection has been the single most significant factor in reducing the total number of melanoma deaths in the past two decades.

*The patients who benefit most from self-examination are those that are at highest risk for the development of skin cancer and include:*

- Blonde or Red Hair • Fair Complexions that Burn or Blister Easily
- Blue, Green or Gray eye color • Excessive Sun Exposure as a Young Adult
- Family History of Melanoma • More than 100 Moles, or 50 if under age 20

#### Skin Cancer Treatment

The treatment of skin cancer begins with a careful history and physical examination by your dermatologist who will examine the suspected area as well as look for other possible suspicious growths. If the doctor feels that a lesion may be a skin cancer, a biopsy may be performed in which a small sample of tissue is removed under local anesthesia and examined by a pathologist for diagnosis. In most cases the skin cancers are removed completely surgically.

Dr. Shulman says, "A person who has had one skin cancer is at risk of developing another one. It is essential to do monthly self-examination as well as regularly visit with your dermatologist to prevent the occurrence of a bad outcome. Daily use of broad spectrum sunscreen and monthly self examination may be the difference between life and death"

#### Summary

Your skin is the largest and most visible organ in your body. It is designed to last your entire life and currently the techniques to rejuvenate it such as Botox, Fillers and Laser are not as good as preventing damage to it in the first place. Skin cancer is preventable and curable if caught early enough. If you would like additional information regarding skin cancer, monthly self-examination of the skin, sunscreens, sun safety tips or skin wellness please feel free to contact Dr. Brett Shulman at The Center for Dermatology at (585) 922-9770 or at brett.shulman@rochestergeneral.org

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# SUSPECT ABUSE?

## *Bivona Child Advocacy Center*

### Comprehensive and Coordinated Services for Victims of Child Sexual Abuse

By Jessie Keating, Director of Development

Child abuse is an epidemic. Nearly 5 children die every day from abuse and neglect— more than from Juvenile Diabetes, AIDS or H1N1. Just as shocking, 1 in 10 children will be sexually abused before the age of 18.

Unfortunately, child sexual abuse in particular still carries a stigma that often relegates this topic to the fringes of cultural conversation. Medical professionals understand that its complexities necessitate the work of many hands in many specialized fields to bring healing to the victim and justice to the offender. Bivona Child Advocacy Center understands that collaboration, education and awareness are the only weapons against it.

Bivona is the community resource in Monroe and surrounding Counties for child sexual abuse, severe physical abuse, and child fatalities. The REACH program of Golisano Children's Hospital is one of 21 medical, legal, law enforcement, mental health and child protective agencies collaborating under one roof at Bivona to protect, treat and counsel child victims and their families.

Since opening its doors in 2004, the Team has evaluated 12,000 children - 1,600 last year alone. That's 30 new cases per week! What if children were being diagnosed with a disease at this rate? At Bivona, 42% of children seen are under the age of seven, 35% are boys, and almost one-third reside in the suburbs. From prevention and investigation through prosecution, Bivona provides a compassionate, efficient, cost-effective infrastructure for child abuse intervention.

Bivona's Prevention Education and Outreach Initiatives help educate professionals and the general public about the complexities of child sexual and physical abuse. Bivona curates the Northeast region's largest Child Abuse Summit over two days in April during Child Abuse Prevention Month. Designed for professionals in the fields of medicine, law, mental health, social work, education and law enforcement, the Annual Bivona Summit on Child Abuse features internationally regarded expert speakers on all aspects of child abuse. More information can be found about the upcoming Summit on April 30-May 1, 2015, by visiting [www.Bivonasummit.org](http://www.Bivonasummit.org).

Bivona also offers ongoing trainings using a national child abuse prevention curriculum called Darkness to Light (D2L). Designed for parents, youth-serving professionals and organization volunteers, this two-hour workshop teaches participants to identify, prevent and responsibly report child sexual abuse.

The first Child Advocacy Center model was developed in 1985 by Robert E. "Bud" Cramer, a district attorney in Huntsville, Alabama who was distressed by the cumbersome, patch-work, repetitious system for dealing with child sexual abuse.

With the responsibility placed on the child and family to make their way through a maze of services—from the police station to the hospital to social services and back again, with each incidence often requiring a painful retelling of the abuse—the result was more emotional distress for children and a devastating delay in the start of their recovery.

Besides REACH, Bivona's Multidisciplinary Team includes Catholic Family Center, all 12 jurisdictions of Law Enforcement, Linden Oaks Specialized Assessment and Treatment Services, Monroe County Child Protective Services, Monroe County District Attorney's Office, Monroe County Law Department, RESTORE, and Rochester City School District. The Team collaborates to offer the following comprehensive services in a secure and confidential facility:

#### **Forensic interviews by trained professionals**

#### **Victim advocacy support**

#### **Mental health services**

#### **Complete, private medical evaluation with minimal stress to the child**

#### **Joint child protection and law enforcement investigations conducted without multiple victim interviews (to minimize trauma)**

#### **Crisis intervention and counseling**

#### **Advocacy, education and awareness**

Today, overseeing more than 800 Child Advocacy Centers across the United States, the National Children's Alliance offers training and support, and confers accreditation on centers, such as Bivona Child Advocacy Center, which meet rigorous standards.

Bivona's Founding Executive Director Mary Whittier envisions a community where all children are safe and free from abuse. "It takes an entire community to make that a reality," she said.

If you suspect abuse, even if you're not sure, call Bivona Child Advocacy Center at (585) 935-7800 to either make a referral or talk with a trained professional.



# The Ongoing Puzzle of Neurological Diversity: Teenagers and Young Adults Living with ASD



Marguerite M. McCarty  
EdD, LMHC

The mother of one of my teenage clients who is living with an Autism Spectrum Disorder (ASD) told me, "There is awareness (of ASDs) but not sensitivity." Her son has experienced this in one of our resource-rich suburban high schools. For young people living with ASD, early interventions and IEPs often allow for partial or full classroom integration. Post high school programming through organizations such as BOCES and ARC help many individuals with ASD transition into work settings. In the past 20 years, the resources for individuals living with ASD have increased significantly. Not only is there awareness, but also varied resources and interventions that are charged with educational and community integration!

But what about sensitivity and understanding when it comes to each unique individual living with ASD? Historically, diagnostic language attempted differentiation through terms like Asperger's Syndrome, High-functioning Autism, and Autism, but the fifth edition of the Diagnostic and Statistical Manual created a spectrum diagnosis that blurs nuances through the creation of the all-enveloping Autism Spectrum Disorder. One individual living with ASD may earn a PhD like Temple Grandin or an ESPY for being a high school basketball sensation like Jason McElwain (J-Mac), while another may not be in a position to earn a high school diploma. There is so much we do not know in relation to the nuances and diversity within the diagnosis, but throughout my research and clinical work there are some themes and commonalities that assist in my pursuit of understanding ASD!

First, the idea that individuals living with ASD do not feel, do not know how to feel, and cannot empathize is a cultural stereotype that has evolved as a result of our pursuit to understand neurological diversity. It is not a lack of emotion, but a difference in the developmental trajectory of emotional expression and intelligence. If eye contact and socializing are a challenge for a child living with ASD, and this child is in a non-integrated classroom, they are not benefitting from observing the more traditional socialization process that their peers are going through. Children learn from watching other children. This is not to suggest that learning social skills and socialization never happens for the ASD population, it just happens in a different way and likely at a different time. Sensory sensitivity is a well-known symptom of ASD, but what about emotional sensitivity? Autism author, consultant, and presenter, William Stillman, describes individuals

living with ASD as "inherently gentle and exquisitely sensitive" ([www.williamstillman.com](http://www.williamstillman.com)). Lending to this hyper-emotional sensitivity, intense connections with animals and spirituality are common.

Second, many of the individuals living with ASD, who I have worked with, seem to struggle with reality versus imagination. Creative writing, video gaming, movies, the Internet, comics, avatars, and novels are often an escape for teenagers. This is a culturally accepted practice. Young people with ASD tend to take this escape to the next level where they "become" a character and immerse themselves into the experience of being this persona. Perhaps since they often do not have an easy time connecting in person with people, this is a chance to feel and experience what it's like to be someone else. If a 6 or 8-year-old child did this we would think it's cute and normal, but when a 17-year-old merges with an avatar they may get ridiculed and the line between reality and imagination blurs. Yet, perhaps this is a necessary step towards socialization.

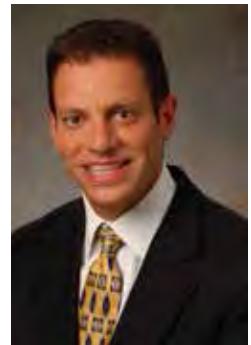
Last, providers and educators seem to dismiss the other kinds of developmental milestones that are being faced by teenagers living with ASD. Adolescence and young adulthood is full of social, emotional, moral, and cognitive development as well as embracing sexuality and racial and cultural uniqueness. In addition, the normal individuation process or identifying oneself outside of the family and separate from parents or simply the rebellion and angst of being a teenager happens for young people living with ASD; it just seems to evolve later. Too often we overlook these common and traditional "rites of passage" that all young people experience!

Neurological diversity has likely always existed. We now call it ASD. In an effort to understand "Aspies" and "Atypicals", we stereotype and categorize their unique and often beautiful minds but let us not forget the individuals, the entirety of the "typical teenager" within.

Dr. Marguerite M. McCarty is a Clinical Assistant Professor in Medaille College's Mental Health Counseling Program. She completed a Master's degree in Counselor Education from SUNY Brockport and a Doctorate in Counseling and Counselor Education from the University of Rochester. After working for a number of years in college student mental health, Dr. McCarty opened a private practice in the Rochester area and works with adolescents and adults on a variety of mental health and career issues. In addition, she is passionate about creating engaging and practical curricula for counselors-in-training. Dr. McCarty is a Licensed Mental Health Counselor in the state of New York and is a member of the American Counseling Association and the New York Mental Health Counseling Association. Visit her practice website at [www.perspectivesandpathwayscounseling.com](http://www.perspectivesandpathwayscounseling.com).

# **IDENTITY THEFT**

## **Unknowingly Being in Two Places at Once**



Steven M. Terrigino, CPA

In today's fast paced world we sometimes wish we could be in two places at once. In some cases we are, at least virtually, and may not even know it. We transmit data every day to confirm our identity. This includes logging onto websites, simply using our credit cards, or even travelling down the thruway with an EZ pass. This is how life works each and every day. However, it is also a daily occurrence to read about the various organizations and the millions of individuals that have been subjected to data breaches where hackers or even disgruntled employees were able to gain access to individual's personal information, in an effort to commit identity theft or to sell the data to identity thieves. Identity theft is when someone steals or obtains your personal information and ultimately uses it to commit fraud or other crimes. In doing so, they may attempt to obtain credit or other benefits in your name.

One type of identity theft that is significantly on the rise is medical identity theft. According to a survey by the Identity Theft Resource Center, medical-related identity theft accounted for 43% of all identity thefts reported in the U.S. in 2013. What is medical identity theft? It is defined as the fraudulent use of identifying information in a health care setting to obtain medical services, goods or for financial gain. With the migration to electronic medical records, these databases of information are yet another resource thieves would be very interested in getting their hands on. Many of these records contain a plethora of information, such as your address, social security number, date of birth, insurance and driver's license information.

This type of information contained in these databases provides the additional ability of the perpetrator, to commit other types of fraud beyond applying for credit cards. This can include using insurance numbers to get medical services, prescription drugs, procedures or other healthcare services. While these EMR's are meant to save time, improve care and centralize data, they are also a real target for identity thieves since the information is all in one place and possibly easily captured. In an era where an identity theft costs hundreds of thousands of dollars in fines, sanctions and lawsuits to the company who loses that data, it is extremely prudent to do what you can to protect the information.

Medical practices have the same responsibility to secure, protect and maintain the privacy of medical records in the same manner as health systems and insurers under HIPAA, HITECH and New York State data privacy laws. HIPAA and the requirements associated with HITECH and Meaningful Use funds (if you have taken advantage of those funds) have many requirements that must be demonstrated. Virtually all of the key items in the HIPAA, HITECH and the NY data privacy laws are in place to direct the actions you must undertake to meet those laws and in an effort to safeguard the data (hard copy and electronic) from improper use or exposure anywhere you store, maintain, process or transmit protected health information (PHI) and personally identifiable information (PII) from identity theft. In fact, you even are required to perform a documented risk assessment to measure your vulnerabilities and see where your and potentially your business associated information security may need to be updated or strengthened to protect the data you possess.

You can help prevent becoming an organization that has been breached or yourself being victim of medical identity theft or other types of identity theft by following basic rules, some of which include:

### **1. Follow the legal requirements for data encryption.**

Make sure ePHI and PII are encrypted. Encryption is one of the best ways to prevent an unintentional breach of data.

### **2. Know your staff.**

People under your employ have access to your patient's information. Thus, it is important to do pre-employment background checks, have employees sign confidentiality agreements, restrict access to only employees that must access certain modules of your EMR and use the audit capabilities within your system to periodically check who is accessing this information. Lastly, don't forget about temporary hires and volunteers. Utilize these safeguards for them as well.

### **3. Know your patients.**

Unfortunately, much of medical identity theft is consensual. This is when people knowingly share their information with others to allow that person to obtain medical goods or services. To mitigate this, require a photo ID and health insurance cards at check-in. Be sure your employees understand the importance of this and do not become complacent. Educate your staff to truly look at the information supplied to ensure the descriptive details match.

### **4. Only provide PHI or PII**

especially your social security number, to those who absolutely must have it. For example, this would include your CPA in order to file your tax returns or banks to open up accounts. Whenever you are asked for that data or for your social security number, inquire the reason why it is needed.

### **5. Open all of your mail**

regardless of if you believe it is simply an advertisement or junk mail. Often times when you are a victim of identity theft, the perpetrator may have opened an account "on line" with your information and the mail you may be throwing out, could be an acknowledgement of the transaction

### **6. Watch out for email scams and email spam.**

These are the most often used ways for an attacker to compromise your computer and then to steal your data and the data you control on all your clients/patients and employees.

### **7. Shred important documents.**

Both at the office and at home, a shredder is a must-have. Documents that contain any private information on them, such as account numbers or social security numbers, should be shredded before discarding. Shredding prevents those that may sift through your garbage from gaining access to your identity.

8. Completely destroy your hard drive when replacing your computer or any of your business computers or systems. Simply deleting the data is not enough as it is very easy to restore deleted files with free software from the internet. Also, if data is stored on a thumb drive, be sure to not misplace it.

### **9. Review your bank statements and credit card statements regularly.**

At a minimum, do this monthly when your statement is available. Ideally, do it even more frequently by looking at the activity

on-line. Look for charges you did not make or bank account transactions you may not have authorized.. Also, review the correspondence from your insurer which lists claims they have paid on, to ensure you actually received those services.

### **10. Consider using a credit monitoring service.**

There are a variety of commercial services that, for a fee, will monitor your credit activity. They will report back to you if there are accounts opened in your name or social security number. There are a variety of services available. Make sure you know what they are providing before you engage them and make sure they are reputable.

### **11. Perform regular risk assessments**

so you know where you may have weaknesses that need to be shored up. While this is a requirement of the HIPAA law and part of Meaningful Attestation, it is also a great way to learn how to best protect your data.

The above are just some basic guidelines that should be adhered to protect your practices data as well as your personal identity. The recommendations are meant to build general awareness within your organization. We have performed several risk assessments and provided many recommendations in order to improve policies & procedures. While sometimes we wish we could be in two places at once, we really may not want to be!

Steven is a Certified Public Accountant and a Partner at The Bonadio Group based in Rochester, NY. He concentrates his practice on physicians and physician practice groups with respect to accounting, tax and consulting related matters. He may be contacted at [sterrigino@bonadio.com](mailto:sterrigino@bonadio.com) or at 585-381-1000.

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## Combination Nicotine Replacement Therapy Boosts Success Rate for Smokers Looking to Quit

Collaborative study of uninsured smokers finds benefit from pairing nicotine patches with quitline support

Uninsured smokers who used nicotine replacement therapy (NRT) patches in combination with NRT lozenges nearly doubled their quit rates when using the support of a quitline, according to a study published online ahead of print in the *Journal of Smoking Cessation*.

A team of scientists from Roswell Park Cancer Institute (RPCI), the Medical University of South Carolina, Yale University School of Medicine and the University at Buffalo (UB) evaluated the smoking quit rates of more than 3,000 daily tobacco users who contacted the New York State Smokers' Quitline. One group of heavy smokers was given a free two-week supply of nicotine patches. A second group of heavy smokers was provided a free two-week supply of both nicotine patches and lozenges. Supportive counseling and follow-up calls were provided by trained Quitline specialists.

The results indicated that combination NRT was no more effective in a single-type therapy overall. However, subgroup analyses provided useful insights into reaching and assisting heavy and uninsured smokers. For example, the use of combination therapy can result in higher quit rates among groups reporting a lower socioeconomic status (SES) and lower nicotine dependence.

"We know that people with lower socioeconomic status are more likely to start smoking, more likely to smoke more heavily and less likely to quit. This study found that the group of heavy smokers benefited more from combination NRT coupled with Quitline counseling, and therefore were more successful in their quit attempts," said senior author Shannon Carlin-Menter, PhD, now a Research Assistant Professor in the Department of Family Medicine at UB, who conducted the research as director of evaluation for the Quitline.

"This study offers significant public health implications for the delivery of evidence-based cessation treatment," added Andrew Hyland, PhD, Director of the New York State Smokers' Quitline, Chair of the Department Health Behavior at RPCI and a co-author of the study. "Quitlines reach underserved populations that often have limited access to in-person cessation treatments. The combination of nicotine replacement when offered in context of a quitline may offer real advantages to smokers from lower socioeconomic strata," continued Dr. Hyland, who also holds a faculty appointment at UB.

### **Findings of note:**

Quit rates were higher for those given combination therapy compared to those given a single therapy, although they were not significantly different overall.

Specific subgroups, including uninsured smokers, using combination therapy compared with uninsured smokers using a single therapy had significantly higher quit rates.

The offer of a free supply of nicotine medication was rated as "very important" by smokers in both groups.

NRT usage was higher among those who received combination therapy compared to those who received a single type of therapy.

Reported relief from cravings was significantly greater among those who received the combination therapy.

The estimated cost of providing NRT was lower among the uninsured participants receiving combination therapy versus those receiving a single therapy, due to the difference in the quit rates.

"In an analysis of subgroups of smokers, researchers found that the smoking quit rates of uninsured participants who received combination NRT were significantly higher than the smoking quit rates of uninsured participants who received a single type of NRT. These data provide insights on the ability of quitlines to reach and assist disadvantaged groups with quitting," added co-author Laure Krupski, PhD, a Training and Development Content Manager at RPCI.

"This study provides valuable insights for quitline managers who are coping with declining budgets and increased demand for services," continued Martin Mahoney, MD, PhD, a Professor of Oncology in the Departments of Medicine and Health Behavior at RPCI who also holds a faculty title at UB and is a co-author on the paper. "These findings and future research provide quitlines with the ability to make targeted and informed decisions regarding providing nicotine replacement therapy to callers."

Smokers who participated in the study were callers to the New York State Smokers' Quitline, which is part of Roswell Park Tobacco Cessation Services. The Quitline offers evidence-based and innovative tobacco cessation services that help tobacco users break their addiction to nicotine. Telephone and technology-based services are provided and include quit coaching, stop-smoking medications and information or referrals to additional resources. For more information, call 1-866-NY-Quits or visit [www.nysmokefree.com](http://www.nysmokefree.com).

The study is "Cost and Effectiveness of Combination Nicotine Replacement Therapy Among Heavy Smokers Contacting a Quitline." The research was funded, in part, by the New York State Smokers' Quitline and by National Cancer Institute (NCI) grant P30CA016056, RPCI's Cancer Center Support Grant from the NCI.



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# Why Do Physicians Dislike Electronic Health Records?

By Colin Rhodes  
Chief Technology Officer eHealth Technologies



plans to make use of any form of EHR.

On the surface, an aggregate of over ninety percent of physicians either using or working towards using an EMR would seem to be a major milestone in modern medicine. However, when we start to drill deeper into the data some disquieting themes emerge. A staggering 70% of respondents felt that EMR's decreased their face-to-face time with patients, 57% felt their ability to see more patients was effected, 27% felt their ability to respond to patient issues was compromised, and 26% felt their ability to effectively manage treatment plans was effected.

So why are physicians unhappy with their EHRs?

One often posited answer is that we are at an early stage of technological development for electronic medical records. Although the first documented medical record, an Egyptian surgery record on papyrus, can be traced to 1600 BC, the concept of the Problem Oriented Medical Record, as introduced by Larry Weed, is barely forty-five years old.

An interesting comparison point in terms of technological age is the cell phone. Invented in 1973 by Martin Cooper of Motorola, the DynaTAC 8000x weighed 2.5 pounds and sported a single-line, text only LED screen and a price tag of \$3,995. Forty years later we have the iPhone 5s, a cell phone with a finger print sensor, a 64-bit chip, a video capable camera that produces extraordinary shots, a beautiful high resolution screen, ultra-fast LTE wireless, every app imaginable, and a price tag of \$199 under plan or \$649 at cost. A cell phone so simple that my two-year-old daughter was found playing games on it one sunny afternoon.

In 2014 Medscape conducted a survey of more than 18,000 physicians and posed a deceptively simple question – “Are you using an EHR?” Eighty three percent of respondents answered with an outright “yes,” four percent were in the process of implementing an EHR, six percent planned to buy or start using one within the next 1-2 years, and seven percent had no

At some level the cell phone analogy may appear flawed. Many would argue that the comparison is invalid because cell phones are not safety critical systems and are thus inherently less complex. However, the apple iPhone has a large code base that would rival any Epic or Cerner implementation and is most likely tested to about the same level. It is when we consider the hospital system as a whole, including connections from diagnostic devices and other information systems such that the complexity grows out of control.

From an end-user perspective, the complexity of the surrounding system is largely irrelevant. Their world is based on screens inside modules of the EHR that are far removed from the HL7 feeds and medical device integrations. A physician’s dissatisfaction with EMR systems is concerned with the fact that the system disrupts flow with the patient and “gets in the way.”

How then does the EMR disrupt work? Most often the disruption comes in the form of workflow or data entry issues. Here’s a common example: There is literally no information that cannot be stored in a traditional paper-based folder. In fact, the author has seen folders containing photographs, micro-cassettes, carefully folded radiology films, and many other strange contrivances. The effort to move this data into the folder is minimal and the administrative controls are simple. Retrieval is even easier; the folder is placed in a cheap plastic carrier outside the exam room for each patient. Try doing that in an EMR.

Of course, this system of the patient folder evolved at a time when a patient was likely to see few specialists and was paired with a family Doctor who treated across generations. Fast-forward to today’s medical system where specialist treatment accounts for upwards of 50% of patient care. A chronically ill patient with diabetes mellitus can reasonably expect to see more than twenty providers in their lifetime, many of whom will want to see and edit the medical record. Clearly the chart of old is no longer a viable option.

For some percentage of physicians the chart of old remains the gold standard and EMRs are just harder to use. Certainly, the 7% of physicians who simply refuse to install EMR’s regardless of the financial benefits/risks of Meaningful Use are likely to correlate highly with this category. Even gold standard systems such as those at the VA have been reported as

having “poor usability, time-consuming data entry, inability to exchange health information, and degradation of clinical documentation (Friedberg et al, RAND\_RR439).”

In our view, usability is perhaps the most important barrier to acceptance of the EHR. Returning to our comparison with the cell phone, nobody would ever have called the DynaTAC 8000x or the next twenty years of its evolution “usable.” It is only in recent years that cell phones would be considered to have reached a usable form factor, and only then after many years of flops and miss-starts. The work of Ives and Jobs set a standard for usability based on years of product testing and an unrelenting quest for perfection at a point when the market had largely stabilized on the flip phone.

In 2013, a KLAS report on Acute Care usability found that none of the six EHRs the report examined scored above a 4. Epic took that high score, followed by Cerner (3.7), Siemens (3.7), AllScripts (3.5), McKesson Paragon (3.4) and Meditech v.6 (3.0). The report stated that Epic: “Wins over physicians during demos. A prescriptive approach to implementation ensures go-live success. Overall adoption of, and highest usability ratings for meaningful use functionality.”

Usability arises from careful work with the users of the system to understand, focus, and arrive at their true needs. This has not historically occurred within EMR design. In fact, a 2012 blog post on KevinMD described the approach to design as follows: “Rather than working with physicians to design the technologies and drive adoption, the experience (and almost universally the perception) is that the technology has been thrust upon physicians by administrators.”

So, where to from here?

It is clear that the current messy user experience in most EHR products is not a short-term problem. Vendors are so consumed with execution and delivery that they have no time, much less the inclination, to change their products to improve user experiences. Practices that use web-based solutions (not imposed on them by a health net-

work) can switch vendors and as such are best positioned for adopting new technology as it arises. Enterprises and health networks face large conversion costs and should expect the current problems with physician experience to continue for at least five years.

In summary, why is EHR so disliked by physicians? In part, because of poorly planned user interfaces not designed for physicians by physicians. Only when the focus returns to medicine and clinical workflow becomes a carefully designed, thoroughly “user experience tested” part of the commercial EHR products will we see this change for the better.

## Working Capital Financing for Healthcare Providers Transitioning to ICD-10

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As we approach the 2015 implementation deadline for the new ICD-10 medical codes, healthcare providers should prepare themselves for the direct impact this transition will have on their reimbursements.

The ICD-10 implementation is expected to delay providers’ revenue collections anywhere from three to six months, with Medicare and Medicaid reimbursements experiencing the longest delays. Providers are also likely to experience delays due to slowed or inaccurate reimbursement submissions as their administrators adjust to the new coding structure. This situation is a recipe for depleted working capital and difficulty in meeting overhead.

Fortunately, help is available. For providers who would find it difficult to keep their practices fully operational through lengthy reimbursement delays, working capital financing can help them cover their costs, conserve their cash, and direct more of their resources toward investments and other strategic purposes.

If your organization requires financing to help manage the ICD-10 transition — or for any other reason — Key’s specialized healthcare finance team can help. Our experienced professionals will take the time to understand your needs and ensure that we structure the best financial package for you.

To learn more about how we can help, visit [key.com/healthcare](http://key.com/healthcare).



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# What is My Liability?

## Cloning of EMR Notes

### Issue

Controversial legal issues seldom have clear-cut answers; from an attorney's perspective I can, at best, offer opinions regarding degrees of defensibility and recommendations which may help address risk management. The way that providers approach the issue of EMR cloning has risk management implications to the individual provider, the practice group, and the hospital. On this particular issue, as one who is also a physician, I must confess to bias. Nonetheless, this column addresses a subject which is increasingly controversial and relevant, and I am reluctant to simply clone the points of view previously expressed on this topic and proceed with a wholesale condemnation of EMR cloning. The cutting and pasting (aka 'save as macro' or 'carry forward') of elements within a previously filed EMR document forward into present documentation is referred to as "cloning". Cloning is not a new phenomenon and is certainly not unique to the EMR – re-copying yesterday's progress note was also prevalent in the era of the handwritten medical record. The EMR has simply made cloning easier and less time-consuming. A discussion of cloning cannot be separated from a discussion regarding medical record documentation: preservation of the history of care provided, facilitation of communication among providers, documentation of the level of care provided as a basis for reimbursement, and setting a platform for quality assurance, peer review, and legal review.

The Centers for Medicare and Medicare Services (CMS) suggests that at least 75% of physicians presently clone at least 20% of their EMR documentation; some suspect that this number underestimates the prevalence of the practice. CMS and the DHHS have firmly condemned cloning. CMS/DHHS expect good documentation to reflect collaboration between provider and patient using technology as a tool with which to communicate and share the individualized and specific (as required by



James E. Szalados, MD, MBA, Esq.

ICD-10) record of each patient's total health. Therefore, inaccuracies within the medical record are perceived to violate the collaborative trust of the healthcare encounter. The Institute of Medicine estimates that the cost of healthcare fraud to the government was \$750 billion in 2009, corresponding to a 75% increase in Office of the Inspector General (OIG) prosecutions for 2011 as compared to 2008. The OIG has targeted cloning as one of its top program integrity (False Claims) challenges claiming an increase in improper billing and insufficient documentation specifically stemming from the practice of cloning. Independent Medicare Administrative Contractors (MACs) who reviews medical records for appropriateness of service has been directed by CMS to identify "suspected fraud, including inappropriate copying of health information" under the Benefit Integrity/Medical Review Determinations mandate. The Center for Government Services (CGS) states that "for Medicare, the medical necessity of a service is the overarching criterion for payment," but necessity is considered fraudulent if cloning of past medical services, lab and x-ray results, and medical notes from previous days, are simply reinserted into a new day's progress note to justify need." The impression that providers are intentionally using EMR functions to manipulate reimbursement also undermines confidence in the meaningful use initiative. Documentation practices which create a potential for violations in patient safety, quality of care, and compliance may leave an organization vulnerable to liability.

Healthcare fraud is defined as the "intentional deception or misrepresentation that the individual or entity makes knowing that the misrepresentation could result in some unauthorized benefit to the individual, to the entity or to some other party." The intentional fabrication of medical records to improve reimbursement may be considered fraudulent and could certainly result from misuse of "copy and paste" functionalities or the overuse or misuse of templates originally designed to increase documentation efficiency. Nonetheless, there remain questions of intent and of unauthorized benefit for which the burden of proof rests with regulatory agencies. Still, it is important to note that systematic repetitive errors can suggest intent.

On the one hand, critics of cloning argue that cloning (1) perpetuates erroneous entries and can increase the risk that the note does not accurately (medical error) reflect the patient's contemporaneous (specific) medical condition; (2) creates a

false impression regarding the complexity of the provider's work product and thereby improperly inflate (upcode) claims; (3) creates an overly burdensome document (waste) that is difficult to read and digest in the clinical setting. Obviously cloned medical records which contain carelessly perpetuated errors are very difficult to defend in medical malpractice or DOH / OPMC cases, since they may create or foster an appearance of widespread carelessness in medical care.

On the other hand, proponents of cloning argue that the practice of cloning (1) saves valuable time, time perhaps redistributed to patients and families; (2) decreases the risk of introducing new errors; (3) can be used to create a comprehensive stand-alone note reflecting the course of care (the history of present illness or HPI); (4) can simultaneously reflect resolved, dormant, and new problems; (5) effectively leverages the technological efficiencies inherent to the EMR; and (6) potentially offsets the additional time requirements of EMR documentation. Hand-typed or dictated de novo EMR entries may be no less likely to contain errors than are handwritten record entries – as was long-evident in the era of the handwritten charts. Truly contemporaneous charting may represent a mythical ideal since the patient's condition may be changing as the note is being written – is it correct to chart what was seen at the time of the initial encounter or document what has already occurred, thereby detracting from the clinical decision-making process? In addition, aside from cloning, the EMR has fostered an industry of manufactured documentation which specifically aims to enhance coding and reimbursement through point-and-click smart menus which may be no less insidious than cloning. Invalid auto-population of data fields and the use of point-and-click templates may very well introduce at least as much inaccuracy into the medical record as does indiscriminate cloning. Templates designed to meet reimbursement criteria may miss relevant clinical information and may arguably foster at least as much over-documentation as does cloning.

Therefore, with respect to impact of cloning on the propriety and integrity of the medical record and its ability to properly reflect the provider-patient encounter, each argument has merit. Therefore, rather than a blanket examination of cloning, it is probably more reasonable to look at cloning as a matter of degree. Certainly, cloning material from the note of another provider increases both the risk or error and the appearance of impropriety and must be avoided. Information erroneously "copied and pasted" from a different patient's record is both wrong and embarrassing; however, it occurred on occasion within written records, honest mistakes cannot be completely avoided. In academic hospitals, where the emphasis is on a full clinical assessment and a derivative plan of care, cloning in residents' charting detracts not only from patient safety and good clinical care, but also from CMS investment in Graduate Medical Education. On the other hand, the perpetuation of the long-established and well-accepted clinical documentation style wherein a patient's hospital course is presented as a chronological narrative which addresses major diagnoses, interventions, and ongoing plans of care can be appropriately facilitated and even strengthened by discriminate cloning; in such

cases it is important to separate the chronology from the acute issues and plans so as to avoid a confusing deluge of information. Overly extensive notes may detract from communication because they detract one from fully reading all the cloned text; however, experienced clinicians should be able to identify the updated assessment and plan if it is organized and separate from the bulk narrative. Easy availability of the HPI within the bulk narrative may help efficiency of case review by incoming providers as an element of signout, or continuity of care.

Regulators have yet to formally address the extent of EMR documentation which represents the minimally acceptable standard. Presently, such determinations are largely being dealt with on a case-by-case basis. However, what may be correct or convenient in the eyes of regulators may not be best for optimal clinical care. Ideally, physicians should proactively define these standards before regulators do so. AHIMA defines information governance as "the accountability framework and decision rights to achieve EIM (which) is defined as the infrastructure and processes that ensure information is trustworthy and actionable." Hospital committees, in consultation with legal counsel, are best positioned to define standards for the appropriate use of cloning, limit and review its inappropriate or indiscriminate use, and argue the merits and pitfalls of various types of EMR entries. An accurate information governance program will best ensure accountability over the optimal clinical management of medical record information and its integrity. Staff education on best practices for documentation should then focus on the consensus as it is defined in policies and procedures in a credible compliance plan.

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## Advertiser Index

- Medical Liability Mutual Insurance Co. - 26
- St. Ann's Community - Back Cover
- Re/MaxPlus - 14
- Rochester General Health System - Inside Front Cover
- Plastic Surgery Group of Rochester - 19
- Key Bank - 21
- Golisano Restorative Neurology & Rehabilitation Center - 4
- The Bonadio Group - 18
- Bivona Child Advocacy Center - 24
- Manning & Napier - Inside back Cover

# From TODDLERS to TWEENS

## *International Kids Yoga Program Comes to Region*

By Julie Van Benthuyzen

While yoga continues to gain in popularity for people of all ages, children are being exposed to this ancient practice at a much younger age these days. Children today live in a very fast-paced world. Between pressures from school, extracurricular activities, their peers, parents, and society, the hustle and bustle of everyday life can quickly wear down on a child's inner peace and joy – even at a remarkably young age. All of these pressures and expectations can lead to a whole lot of stress, and while most kids are not familiar with the concept of stress, they can still experience what it feels like without giving it a label or name.

Schools, community centers and fitness studios have recognized this need for reaching out to children, and have begun incorporating yoga into their offerings. Here in the Rochester region, the Southeast Family YMCA in Pittsford has recognized the unique opportunities and benefits that yoga can bring to all aspects of body, mind and spirit. Recently, the Southeast Y became the first YMCA branch in the nation to embrace an internationally-known, fast-growing yoga program specially-designed for kids ages 2-12.

Kidding Around Yoga (KAY) is designed to help children be active, learn to relax, improve focus, and have fun in a non-competitive environment. Based in St. Petersburg, Florida, Kidding Around Yoga has been teaching transformational yoga to teachers all over the world, from New York to Paris and South America, and now recently, here in Rochester.

"Kidding Around Yoga, at its very essence, is stress management for kids," says Debbie Masters, Executive Director of the Southeast Family YMCA, who has been instrumental in incorporating KAY into the branch's many programs and services for children and their families over the past year. "Our staff has received creative instruction in meditation, breathing practices, relaxation, poses, games and activities, using a series of original music created by a tight-knit family of teachers and trainers."

Starting this fall, The Southeast Y will be expanding its school-aged KAY classes to include kids ages 6-12, as well as a weekly class for preschool age children, and a Family Kay class for parents and their children. But the offerings go far beyond the formal class setting. "We've trained several staff members who manage the pre-school and after-school programs, and already our younger members are benefiting from KAY within these alternative locations," she adds. Additional trainings will be held this coming fall for YMCA employees across its Rochester-area network, in hopes of bringing KAY programs to a broader membership base. "This is an opportunity that goes well beyond the fitness component of our Y, because yoga has no boundaries."

Kidding Around Yoga can benefit kids in countless capacities. Standing poses improve posture and strength, and also reduce symptoms of scoliosis. Balancing poses improve focus, concentration, strength, coordination and poise. Backbends stimulate the sympathetic nervous

system and are invigorating. They also open and strengthen the heart and chest. Forward bends stimulate the parasympathetic nervous system and are relaxing.

They also help to massage the digestive system. Inversions and more difficult poses encourage practice and build strength and self-esteem.



The "Secret Garden," incorporated into all the KAY classes, is a version of deep relaxation that allows the body to assimilate all of the benefits of the Yoga practice. "In this still and quiet portion of class, kids are able to create a special place in their minds where they feel peaceful, happy, and safe," says Masters. Regular meditation, even at a young age, enhances calmness and clarity of the mind.

Yogic breathing practices, or "pranayama," are a great way to reduce stress and help with focus and concentration. They also help reduce allergy and asthmatic symptoms. The cardiovascular activity included in KAY classes allows kids to expend their energy in a healthy way and strengthens the cardiovascular system. The sense of play incorporated into KAY classes allows kids to let loose, be silly, and have fun. Music and dancing have therapeutic properties and teach rhythm, tempo, and coordination. Kids enjoy using the many props to make the experience more fun – from toy microphones to maracas and drums.

During the summer months, the branch's nearby Camp Arrowhead incorporates yoga into its summer camp offerings – from creating peaceful and inspiring crafts and artwork, to nature walks and yoga-focused games. In addition, the Southeast Y offers Kidding Around Yoga Birthday parties and KAY special events for area Girl Scout/Brownie Troops, where girls can earn their fun patch through a program customized just for them. "The principles of Yoga teach kids kindness, sharing, compassion, mindfulness, awareness, and much more," says Masters. "These tools will serve them well for the rest of their lives."



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Diabetes  
Gastroenterology  
Infectious Disease

### **Vol 3: Women's Health**

Orthopaedic Discussion: *Hips & Knees*  
Top Issues in Women's Health  
Heart Disease & Stroke

### **Vol 4: Pediatrics**

Concussion  
Derma Disorders  
Rural Health Specialist Care

### **Vol 5: Oncology**

Palliative Care  
Imaging Advances  
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### **Vol 6: Senior Medicine**

Dementia & Alzheimer's  
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# in Area Healthcare

**RGH****Rochester General Performs First Procedure with Advanced Robotic Surgery System**

*Colon & Rectal Surgical Group at RGH Named National Advanced Observation Site to Teach Surgeons Latest Techniques & Best Practices*

Rochester General Hospital, ranked among the top one percent of hospitals nationally for robotic surgery volume, is one of the first 20 hospitals in the U.S. to acquire the world's newest and most advanced robotic surgical technology for minimally invasive surgery.

John Valvo, MD, director of robotic surgery for Rochester General who performed the first procedure on the new da Vinci Xi System said "Robotic surgery delivers many benefits to patients requiring surgery for a range of complex issues. These procedures are minimally invasive and reduce blood loss and post-operative pain. That frequently translates into shorter hospital stays and faster recovery periods."

"As a national leader in robotic surgery for more than a decade, innovation has been integral to our success," added Valvo. "This new surgical system marks another important step in our ongoing ability to provide the most advanced surgical care to our patients."

Rochester General Hospital, one of the nation's top sites for robotic colon and rectal surgery, in collaboration with board certified colorectal surgeons Stephen Rauh, MD, and Steven Ognibene, MD will be designated a national Advanced Observation Site for the new da Vinci Xi System. Rochester General will host surgeons and their staffs from across the country who will come to learn the advanced techniques and best practices that can improve outcomes.

Stephen Rauh, MD, partner with Rochester Colon and Rectal Surgeons, PC, who operates at Rochester General, spoke to colorectal surgeons in May at the American Society of Colon and Rectal Surgeons meeting about this new technology and their designation as an Advanced Observation Site. "The da Vinci Xi technology is the game changer in colorectal surgery, enabling more surgeons to expertly perform multi quadrant robotic intestinal procedures."

"And what that means for some of our patients is the new robot will enable us to help them with certain severe colon and rectal conditions that we were not able to address as well in the past" said Rauh, "We will be able to perform difficult procedures that will help those patients have an improved quality of life."

The two most common colon and rectal conditions treated with robotic surgery are colon, rectal and anal cancer and diverticulitis. Several colorectal surgeries were successfully performed earlier this week using the Xi system.

More than 7,000 robotic surgical procedures have been performed at Rochester General Hospital since 2008.

The newly formed Rochester Regional Health System, encompassing Unity Health System and Rochester General Health System, offers robotic surgery with four advanced da Vinci Surgery Systems located at Rochester General, Unity and New-

ark Wayne Hospitals. This newest system replaces an existing da Vinci system at RGH.

In addition to its continuous advancements in robotic surgery capabilities, in March RGH introduced a new "OR of the future" surgical suite that integrates numerous state-of-the-art applications including equipment, technology, patient information and to create a safe, data-driven and efficient surgical environment that ensures superior clinical outcomes.

**Rochester General Hospital Recognized for Supporting Families as "Partners in Care"**

*Rochester General Hospital's 24/7 Visitor Policy has been honored by The Institute for Patient- and Family-Centered Care in Bethesda, Maryland. The Institute named RGH a Better Together Exemplar Hospital – one of only 12 hospitals nationwide to receive this honor.*

"These 12 hospitals are also committed to working directly with family members as care partners," said Beverly Johnson, IPFEE president and CEO. "Nurses report greater job satisfaction because they are partnering with patients and families in care, instead of enforcing policies with which many don't agree."

Rochester General Hospital revised its visitation policy in 2001 to allow 24/7 visitation.

Rochester General Hospital has also been consistently proactive in creating a high quality patient experience by forming a Patient and Family Advisory Council made of up current and former patients and their family members, providing free internet access, encouraging 'quiet time' hours, and offering patients' a choice of meal selections based on their dietary needs.

**RRHS****Definitive Agreements Approved for United Memorial Medical Center and Clifton Springs Hospital & Clinic to Join Rochester Regional Health System**

*Q4 2014 Finalized Affiliations Will Create Five Hospital System Serving Region*

Definitive agreements have been finalized by Rochester Regional Health System (RRHS) for previously announced alliances with two hospitals in the greater Rochester and Finger Lakes region. United Memorial Medical Center (UMMC) in Batavia, Genesee County, and Clifton Springs Hospital & Clinic (CSHC) in Ontario County are both expected to join RRHS by the end of 2014.

The formal binding agreement with each hospital, which lays out the terms and conditions for the hospitals becoming a part of Rochester Regional Health System, was developed by the leadership of Rochester General Health System (RGHS) prior to joining with Unity Health System to form RRHS and the leadership of each hospital. The agreements were unanimously approved by the boards of RGHS, CHSC and UMMC late last month, and then assigned and accepted by the newly formed Rochester Regional Health System at its inaugural board meeting in July.

RRHS was officially formed on July 1 as a union of Rochester General and Unity health systems, with a mission to provide a 14-county region with seamless, highly coordinated care. By joining

Rochester Regional Health System, the two hospitals will ensure that the patients in their communities will have the same high quality care they are accustomed to as well as improved access to an integrated network of nationally recognized specialty services when required.

"As health care reform continues to cause the most sweeping changes to the hospital industry in more than a century, rural hospitals in particular are struggling throughout the U.S." said Mark Clement, co-CEO of Rochester Regional Health System, "Through these alliances, the forward-thinking leaders of United Memorial and Clifton Springs will enable the residents of Genesee and Ontario Counties to continue to have access to and receive world-class care, right at home in their communities."

Warren Hern, former CEO of Unity Health System and now Co-CEO of the new system agreed, noting that this growing regional footprint was among the many factors that caused the Unity Board to decide nearly 18 months ago to join forces with Rochester General.

For a number of years Rochester General Health System had maintained clinical collaborations in key service lines with United Memorial and CSHC as well as other area hospitals, to help those providers better meet their communities' needs.

"This is the logical progression of a longstanding relationship between United Memorial and Rochester General which has enhanced our hospital services and benefited our community," said Mark Schoell, CEO of United Memorial Medical Center, "With this permanent, comprehensive alliance, United Memorial will become the western hub of an emerging leader in integrated health services."

"We're excited to finalize our plans to officially join Rochester Regional Health System," said Lewis Zulick, MD, acting CEO of Clifton Springs Hospital & Clinic. "In order for us to sustain the highest standards of community health, our patients must have access to the complete continuum of high-quality care. Working closely with Newark-Wayne Community Hospital, we look forward to serving the Finger Lakes region as the leading provider of comprehensive care."

"We're very pleased to be moving forward with formal plans to join forces with these respected organizations," said Robert Dobies, board chair of Rochester Regional Health System, "and extend our footprint of extraordinary quality, patient satisfaction and value to the west and east."

**UNITY****Unity Health System Announces Appointment of New Chair of Diagnostic Imaging**

Sandeep Naidu, MD has been appointed as Chair of Diagnostic Imaging. Dr. Naidu joined Unity in 2008. He is a board-certified radiologist with fellowship training in nuclear medicine. He was appointed to the Active Staff in the Department of Diagnostic Imaging.

Dr. Naidu earned his doc-

tor of medicine degree from Temple University School of Medicine in Philadelphia, PA. He practiced his residency in diagnostic radiology and his fellowship in nuclear medicine at Upstate Medical University in Syracuse, NY after a transitional year internship at Memorial Medical Center in Johnstown, PA.

#### **ACM Medical Laboratory Opens New Patient Service Center at Ridgeway**

Residents of the Greece area have a new place to go for fast, convenient medical laboratory services. ACM Medical Laboratory opened a new Patient Service Center for collection of samples for medical laboratory testing at 2655 Ridgeway Avenue, located in suite 120.

All aspects of the new center are designed to enhance patients' comfort and convenience. The state-of-the-art facility is easily accessible, has ample parking and will offer extended service hours. The facility will be open weekdays from 6 AM to 5 PM, and Saturdays from 6 AM until noon. The friendly, courteous staff is highly experienced in the collection of blood and other patient samples, and is specially trained for pediatric care. ACM accepts laboratory requisitions from any physicians' office.

#### **Charles J. August Joint Replacement Center at Unity Hospital Awarded Gold Seal of Approval from Joint Commission**

The Charles J. August Joint Replacement Center at Unity Hospital has again earned the Gold Seal of Approval™ for health care quality. The Joint Commission awarded the Joint Replacement Center Disease-Specific Care Certification for knee and hip replacement.

To earn this distinction, the Joint Replacement Center at Unity Hospital voluntarily underwent an on-site evaluation, which included extensive interviews of staff and patients. The Joint Commission determined that the Center meets rigorous quality and safety standards, and awarded full certification to the Joint Replacement Center with no recommendations for improvement.



"We are extremely pleased and proud to have received certification as a Center of Excellence for both hip and knee replacement from The Joint Commission," said Michael Klotz, MD, medical director of the Charles J. August Joint Replacement Center at Unity Hospital.

"This recognition represents the culmination of a great deal of hard work by all of our dedicated and enthusiastic staff, which includes nurses, technicians, therapists, doctors and support staff. It is our commitment to excellence in the service of our patients, continuous assessment and improvement, and evidence based practice which has made the Charles J. August Joint Replacement Center at Unity Hospital the choice for more people in the greater Rochester area than any other hospital."

#### **HIGHLAND HOSPITAL**

#### **Highland Hospital Completes \$3.3 Million Renovation Project/Technology Investments for its Radiation Oncology Unit**

Hospital Becomes First in Rochester Area to Offer Specialized High Dose-Rate Prostate Brachytherapy, Which Dramatically Cuts Cancer

#### **Patients' Treatment Times**

Highland Hospital has completed a 14-month, \$3.3 million renovation of its Radiation Oncology unit including new technology investments to enhance care and bring additional treatment options to cancer patients in the Rochester area.

Highland's Radiation Oncology unit, which delivers more than 30,000 treatments each year, has been reconfigured and completely refurbished. Relocation of its entrance, patient registration and treatment areas offers added convenience and comfort for patients, and a more efficient space for physicians and staff to deliver care.

Radiation therapy uses high-energy radiation to shrink tumors and kill cancer cells; new technology investments at Highland are enhancing care and expanding the unit's treatment options. Highland recently added RapidArc™ Radiotherapy technology from Varian Medical Systems; the technology is much faster than conventional radiotherapy and reduces a patient's treatment time by as much as 50 percent. Cancer patients often undergo daily radiation treatments for several weeks at a time and must lie completely still on a treatment table while radiation therapy is administered. Cutting a treatment session from 20 minutes to 10, for example, improves patient comfort and the quality of care delivered.

Another new technology at Highland is a "4D" CT scanner, which radiation oncologists use to monitor each patient's unique breathing cycle and see how the patient's tumor moves as he or she breathes. This enables radiation oncologists to more precisely define the radiation target and protect healthy tissue from radiation.

Highland recently became the first Radiation Oncology program in the greater Rochester area to offer high dose-rate prostate brachytherapy. Traditional prostate cancer treatments include repeated daily external radiation treatments and/or implantation of radioactive seeds in the prostate to kill cancer cells at the site. High dose-rate brachytherapy uses tiny, hollow catheters, which are temporarily inserted directly into the tumor to kill cancer cells. This approach can shorten a patient's treatment schedule; for many cancer types, the entire brachytherapy treatment takes one to two days, rather than five to seven weeks for external beam radiation therapy.

#### **F.F. THOMPSON HOSPITAL**

#### **Thompson Named Recipient of HANYS Pinnacle Award**

F.F. Thompson Hospital, an affiliate of UR Medicine, was recently named one of only two hospitals in the state to receive the 2014 Pinnacle Award for Quality and Patient Safety, presented by the Healthcare Association of New York State (HANYS).

The Pinnacle Award celebrates significant achievement in improving patient care and reducing unnecessary hospital readmissions.

Thompson was honored for its initiative to eliminate hospital-acquired conditions. This involves using visual tools to track progress and offer reminders of evidence-based best practices. The heightened awareness of these best practices – among staff, patients and families – allows patients and families to actively partner in their care.

The visual management program has resulted in a decrease in falls, pressure ulcers, and central line-associated bloodstream infections, as well as the elimination of ventilator-associated pneumonia.

"This award honors exemplary innovations to improve quality and safety. Patient safety is paramount, and we're proving visual management is an effective means toward achieving our goals," said Thompson Health President/CEO Michael F. Stapleton, Jr.

#### **CLIFTON SPRINGS**

#### **Clifton Springs Primary Care Physician Joins Thompson**

A longtime Clifton Springs physician is integrating his medical practice into the network of primary care practices run by Thompson Health, an affiliate of UR Medicine.

Dr. Zbigniew Lukawski, a native of Poland, completed his internal medicine residency at Wyckoff Heights Hospital in Brooklyn and his anesthesiology residency at Albert Einstein Medical Center in Philadelphia and is board certified by the American Board of Internal Medicine.

The practice is now called Thompson Health Midlakes Medical Care.

In a recent letter to current patients, Dr. Lukawski noted joining Thompson Health will allow him to make enhancements to his practice, including the conversion of all paper records into electronic records.

#### **GENESEE SURGICAL ASSOCIATES**

#### **Genesee Surgical Associates Welcomes Matthew P. Schiralli, MD to the Practice**



Dr. Schiralli joined Genesee Surgical Associates group after completing his surgical training at the University of Rochester Medical Center in 2013. He is a lifelong resident of Western New York who completed his medical school training at SUNY Upstate Medical University in Syracuse.

He is Board Eligible in General Surgery and an associate member of the American College of Surgeons. His interests include advanced laparoscopy, endocrine surgery, gastrointestinal surgery, hernia and abdominal wall reconstruction, melanoma, and breast disease.

#### **Genesee Surgical Associates Moves into New Location**

Genesee Surgical Associates welcomes their valued patients and new referrals to the new medical office conveniently located at 360 Linden Oaks, Suite 300 Rochester, New York 14625.

## **New Doctor in Town?**

If you have recently joined  
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# From Our Hearts To Yours.

## Introducing the HeartMatters Cardiac Rehab Program.

St. Ann's Community is proud to introduce HeartMatters, a new evidence based program that was developed in collaboration with Cardiologists and Cardiothoracic surgeons including Rochester General Hospital Chief of Cardiology, Gerald Gacioch, M.D. and St. Ann's Chief Medical Officer, Diane Kane, M.D.

HeartMatters provides the region's best program for patients with cardiac conditions such as heart failure, myocardial infarction and post cardiac surgery (i.e., CABG, valve replacement).

We recognize the uniqueness of each individual and will work with you to develop a plan of care that will improve your quality of life and reduce the likelihood of readmission back to the hospital. You and your family will receive the knowledge necessary to better manage your condition after returning home.



For more information or to learn how to preplan a rehab stay, **please call 585-697-6311 or visit [stannscommunity.com](http://stannscommunity.com).**

The HeartMatters cardiac rehab program is available at: St. Ann's Community, Irondequoit and St. Ann's Care Center, Cherry Ridge Campus in Webster.



*Caring for The Most Important People  
on Earth*

HeartMatters Cardiac  
Medical Director,  
Gerald Gacioch, M.D.  
and St. Ann's Chief  
Medical Officer,  
Diane Kane, M.D.



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