Western New York
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THE LOCAL VOICE OF PRACTICE MANAGEMENT AND THE BUSINESS OF MEDICINE

The New Golisano Children's Hospital at the University of Rochester Medical Center

Next Generation Facility Dedicated to Kids and Families

Managing the EHR Optimization Phase

What is Your Practice Worth?

Chances are Good that the Next Patient You See may Have Autism


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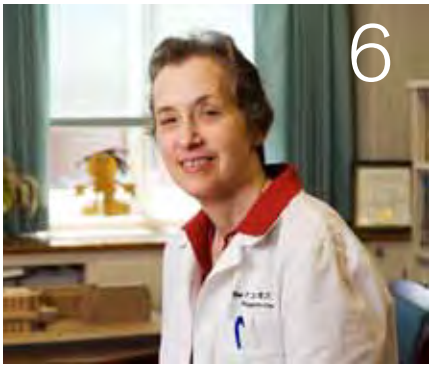

The New Golisano Children's Hospital at the University of Rochester Medical Center

Next Generation Facility Dedicated to Kids and Families

Under the helm of the esteemed Dr. Nina Schor and bolstered by the lead gift of $20 million from B. Thomas Golisano, Rochester will soon have a dedicated children's hospital. Our cover story highlights the design of the new Golisano Children's Hospital and shares how this innovative model of family-centered care promises to transform the way we care for our littlest patients and their families that move through the care process with them and beyond benefit.

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Welcome to Vol #4 of *Western New York Physician* where you will find informative stories and articles about and for physicians in western NY.

Our cover story highlights the new Golisano Children's Hospital at the University of Rochester Medical Center. This dedicated facility with a convenient and strategic connection to the URMC medical campus brings together best-in-class design elements from leading children's hospitals around the county.

In this issue we look at some of the unique health issues facing pediatric patients. Experts from URMC discuss the prevalence of Autism and suggest valuable resources to providers. The use of synthetic and designer drugs is a dangerous, deadly trend that continues to be a problem throughout the US, Dr. George Nasra offers perspective on why the signs of abuse are more difficult to detect and screening strategies to uncover usage to help move treatment forward more expeditiously.

In our practice management section, Boylan Code offers the third installment on transitioning your medical practice focusing this month on Estate Planning Considerations, while Steven Terrigino, CPA from Bonadio helps the question, What is your Practice Worth?

We hope you enjoy and find value in these and all the other articles included in this issue. As always, please feel free to contact me with any comments or suggestions.

Many thanks to all of those who shared their expertise in this issue and to our loyal advertisers – your continued support ensure that ALL physicians in the region benefit from this collaborative sharing of information.

Best,

Andrea

Vol #5 focuses on Oncology – if you would like join in the discussion or submit an article, please email the publisher – Andrea Sperry at:

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Chances are Good That the Next Patient You See may Have Autism

Tristram Smith, Ph.D.

Susan Hyman, M.D.

WITH THE PREVALENCE OF AUTISM SPECTRUM DISORDERS NOW estimated at 1 in 88 people (1 in 54 males), all physicians are now seeing patients with the neurodevelopmental disorder. We know caring for these patients can be challenging, especially at a time of rapid change in health care systems, but there are many reliable resources to help health care providers.

The American Academy of Pediatrics (AAP) recommends screening all children for autism at 18 and 24 months old and it provides developmental screening tools in its autism toolkit. That toolkit, which faculty at the University of Rochester Medical Center (URMC) and Golisano Children's Hospital helped create, includes sample referral forms, fact sheets for physicians, and handouts for families. The handouts give families the knowledge they need to bring developmental concerns to their providers, so they are a great resource to help families prepare for health care visits.

The AAP's physician fact sheets help providers throughout the screening, diagnosis and treatment process, keeping in mind that the medical home is often the first place families turn to for help with safety, sleeping and eating issues and advice on treatments and toilet training. An updated version of the toolkit is expected this fall.

Another great resource for providers and parents, alike, is the Centers for Disease Control and Prevention (CDC) "Learn the Signs. Act Early." website: http://www.cdc.gov/ncbddd/actearly/. Physicians can send their patients' parents there to help monitor a child's development and better ensure that potential problems are caught as early as possible. The site includes interactive quizzes, videos and a milestone checklist for families to record their child's developmental progress over time and show to the child's health care providers.

In western New York, our support network for children with developmental disabilities includes the Golisano Children's Hospital's Kirch Developmental Services Center where more than 1,200 children with autism are seen every year, with 450 for new diagnosis. That number is likely to keep rising. Children under 3 years old are referred to county Early Intervention programs for developmental evaluation and services in parallel to referral for diagnosis. Those older than 3 are referred to their respective school districts for educational and therapeutic services. Physicians should be prepared to play the role of advocate more and more as the number of children identified as having autism grows and autism insurance legislation provides coverage for more services related to treatment. The developmental clinic at Golisano Children's Hospital can help families advocate for their children as well.

In addition to the clinical services, URMC has a robust array of ongoing autism research. We have the only clinical site in New York State for the Autism Treatment Network (ATN). This network is funded by Autism Speaks and the U.S. Health Resources & Services Administration to establish a standard of care for children with autism. The ATN has many helpful tools for families, including a decision aid to help families decide if they should choose medication to help their child's behavior: http://www.autismspeaks.org/sites/default/files/documents/atn/medicine_decision_aid.pdf. ATN also has toolkits to help families with blood drawing, sleeping and getting through those first 100 days after diagnosis, which can be filled with confusion.

The next child – or adult – who walks into your exam room may have autism, but these tools will help you to effectively screen, refer and continue to treat your patient with autism throughout the spectrum of care.

Susan Hyman, M.D., chief of Neurodevelopmental and Behavioral Pediatrics, URMC's Golisano Children's Hospital
Tristram Smith, Ph. D., associate professor of pediatrics, URMC's Golisano Children's Hospital

Competitive Soccer Linked to Increased Injuries and Menstrual Dysfunction in Girls

Regular warm-up exercises can significantly decrease ACL injury risk

In the US, there are nearly three million youth soccer players, and half of them are female. New research presented today at the 2012 Annual Meeting of the American Academy of Orthopaedic Surgeons (AAOS) found that despite reporting appropriate body perception and attitudes toward eating, elite youth soccer athletes (club level or higher) face an increased risk for delayed or irregular menstruation. In addition, female soccer players are more likely to suffer a stress fracture or ligament injury. A separate study found that a consistent 15-minute warm-up substantially decreases knee injury risk.

The Female Triad (Menstrual Dysfunction, Eating Attitudes, Stress Fractures) in Soccer Athletes"

The "female athlete triad" – menstrual dysfunction, eating attitudes and stress fractures – puts female athletes at risk for diminished performance and long-term health problems.

To determine the prevalence of the female triad among soccer players, investigators recruited 220 athletes, median age 16.4, from an elite youth soccer club, an NCAA Division I university team, and a women's professional team. The participating athletes completed questionnaires regarding age of menarche (first menstruation), menstrual history, and history of musculoskeletal injuries including stress fractures. The Eating Attitudes Test was used to assess each athlete's body image, and attitudes toward eating.

The average age of menarche was 13 years of age among the participants. Irregular menstruation cycles, or absence of menstruation, were reported by 19 percent of the participants in the 15-17 age group, 18 percent of the college-age players, and 20 percent of the professional athletes. A history of stress fractures was reported in 14 percent of the players, with a majority of the injuries in the ankle and foot.

Only one player scored in the "high risk" range, and 16 in the "potentially high risk range," in terms of body perception and eating attitudes.

"Elite female soccer athletes are at risk for delayed onset of menarche, menstrual dysfunction and stress fractures, which may be due to an imbalance of energy intake and output," said Robert H. Brophy, MD, co-investigator and assistant professor of orthopaedic surgery at Washington University School of Medicine in St. Louis, Mo. "The risk for soccer athletes appears to be lower than for female athletes in aesthetic (gymnastics, dancing, etc.) and endurance sports. More research is needed to identify the underlying causes, and potential remedies, for these findings in elite female soccer athletes, and whether these findings translate to female athletes participating in other team sports."

A Randomized Trial of Anterior Cruciate Ligament Injury Prevention in Adolescent Female Soccer

In another study, investigators studied the effects of a regular, progressive warm-up exercise program on knee injuries and health.

The study involved more than 4,500 female soccer players in Sweden, age 12-17, from 309 elite clubs. The players were randomly assigned to one of two groups: an intervention group instructed to complete a 15-minute muscular warm-up consisting of six progressively more difficult knee and core stability exercises, twice a week throughout the 2009 season, and a non-warm-up "control" group. Team coaches documented player participating during the season, and acute knee injuries were examined by the physical therapist and/or physician assigned to each club.

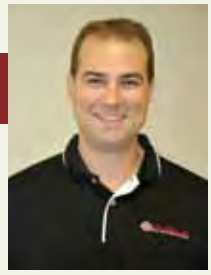
There was a 64 percent decrease in anterior cruciate ligament (ACL) injuries in the intervention group, and an 83 percent reduction among "compliant," fully participating players. In addition, there was a "significant" decrease in the rates of all severe knee injuries.

"We showed a statistically significant reduction – by almost two-thirds – in ACL injuries in (participating) female teenage soccer players in a coach-directed neuromuscular warm-up program," said Markus Waldén, MD, PhD, lead investigator, and an orthopaedic surgeon at Hässeleholm-Kristianstad Hospitals in Hässeleholm, Sweden. "Interestingly, players (who complied) had a reduction in other acute knee injuries as well.

"The program is intended to replace the ordinary warm-up and thus does not steal time from soccer training," said Dr. Waldén.

Disclosures: The authors for these two studies do not have anything related to disclose.
Courtesy of American Academy of Orthopaedic Surgeons.

MUSCLE MAINTENANCE MINUTE



Brett Phillips LMT, PDMT

Anterior Pelvic Rotation

Could there be a common cause for a 78-year old female with Iliopsoas tendonitis, a 42 year old athlete with Iliopsoas tendonitis, a 21-year old female with low back and hip pain and history of posterior disk bulges, a 16-year old male athlete with low back pain, and a 56-year old male golfer with mid thoracic pain?

Anterior Pelvic Rotation is the primary dysfunction of the muscles which stabilize the pelvis and are intended to keep it level. For example, the hip flexors consist of basically five operative muscles iliacus, Psoas Major, Sartorius, Tensor Fasciae Latae and Rectus femoris. Iliacus has a greater mechanical advantage than the Psoas Major which, over time allows the Psoas Major to weaken and causes the Quadratus lumborum to spasm in compensation. Another factor of the imbalance is that Hamstrings and adductors aren't as strong as the Quadriceps and the Iliascus, which allows the pelvis to rotate forward.

Compensating for the pelvic rotation are the gluteus maximus, medius, minimus and piriformis. The forward-rotated pelvis results in a medial rotation of the femur and a lateral rotation of the tibia, which accounts for trochanteric bursitis, ITB tendonitis, patellar-femoral tracking disorders and arch pronation.

In treatment, the goals are to: release the spasm in the Iliacus, stimulate function in the Psoas Major, and to remove the inflammation from the Iliopsoas tendon.

The low back and hips are where the client typically complains of pain, and the immediate actions are to relieve spasms and the adherency of scar tissue. The pain here will subside when the APR is stabilized. Hamstrings and adductors are typically the other weak tissues. Therefore, stimulating function and strengthening the muscles will mitigate the rotation.

There is a set of home care stretches and exercises that are taught to the client in order to continue the stabilization process, with instruction for proper application of heat and ice.

Parenthood a Possibility after Cancer Treatment

Fertility preservation specialist an important part of multidisciplinary team

In last month's article Dr. Vitek provided insightful information for those patients who have received a cancer diagnosis prior to realizing their dreams of parenthood. These summary Guidelines were missed.

GUIDELINES FOR FERTILITY PRESERVATION

Put cancer treatment first – above all, treating the cancer takes priority.

Create a partnership – all options can be explored when a multidisciplinary team – including the oncologist and a reproductive endocrinologist – work together.

Act quickly – Assess potential for fertility preservation as early as possible after diagnosis

Explore all options – having options can help patients feel empowered at a time when they may be feeling powerless over their cancer diagnosis

With a plan backed with options, primary physicians can help their patients navigate choices, treatment approaches and opportunities.

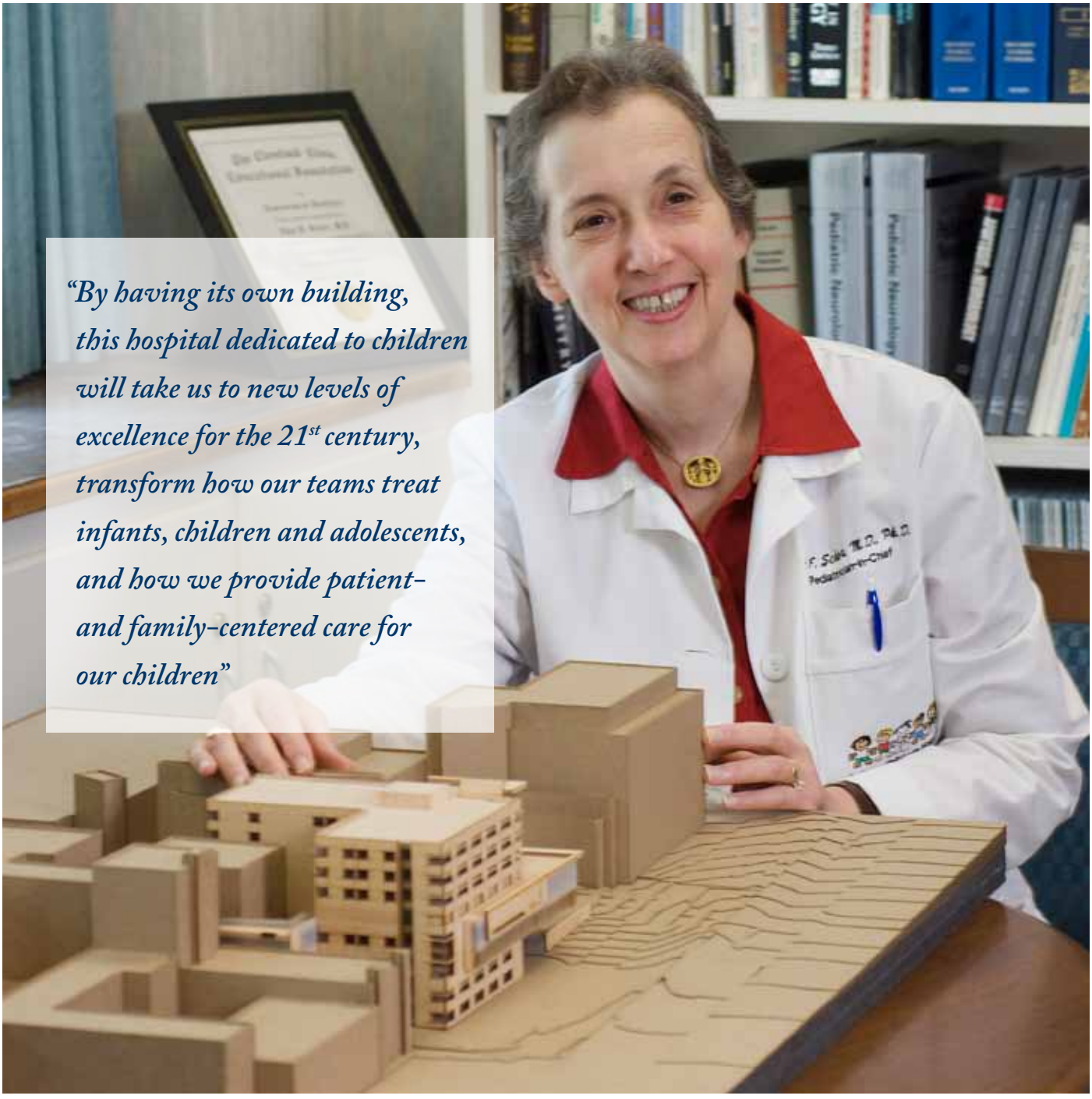
ABOUT THE AUTHOR

Wendy S. Vitek, MD, will join the Strong Fertility Center at the University of Rochester Medical Center in August. A fellowship-trained reproductive endocrinologist, Dr. Vitek specializes in fertility preservation consultation and treatment. After earning her bachelor's in molecular and cell biology from the University of Pittsburgh and her medical degree from the University of Rochester School of Medicine and Dentistry, Dr. Vitek did a residency in obstetrics and gynecology at Magee-Women's Hospital (University of Pittsburgh) and her fellowship in reproductive endocrinology at Women & Infants Hospital, Warren Alpert Medical School of Brown University. Dr. Vitek may be reached at (585) 487-3378.

The New Golisano Children's Hospital at the University of Rochester Medical Center

Next Generation Facility Dedicated to Kids and Families

By Julie Van Benthuysen



"By having its own building, this hospital dedicated to children will take us to new levels of excellence for the 21st century, transform how our teams treat infants, children and adolescents, and how we provide patient- and family-centered care for our children"

In April 2007, the Milburn family's lives were turned upside down when their son, Cory, was born at just 25 weeks – a micropreemie weighing a mere one pound, eight ounces. As Cory was whisked off to the neonatal intensive care unit (NICU) at Golisano Children's Hospital, his parents Patti and Mike weren't even able to hold their tiny baby boy.

AT FIRST CORY EXPERIENCED WHAT HOSPITAL STAFF CALLS A "honeymoon period," but within a month, he was having trouble breathing through a ventilator, and his central line through which he received life-saving medications, began to fail. He was going downhill fast. Cory was given steroids to help his lungs develop, with the following two weeks a blur of medical interventions and seemingly endless hours in the NICU. Despite the grim outlook and potential risks, the Milburns asked to have a second dose of steroids administered when Cory faced his darkest hours. Miraculously, his vital signs improved and he began a slow but steady recovery. After more than 100 days surviving in the NICU, Cory came home on August 10.

Over those exhaustive months, Patti Milburn essentially lived in the NICU. The team of doctors, nurses and other caregivers became like family to her, their diligence and professionalism helping her maintain hope for Cory's survival. Yet the NICU's innate lack of privacy, the countless tests and interruptions within a large, crowded room, often took its toll.

Cory is now a vibrant, happy, five-year-old, and the NICU but a fuzzy dream to him. For his mom, the dream is still vivid and heart wrenching, but her connection now is a vibrant, happy one. This fall, Patti will watch as ground breaks on the construction of a $145-million, eight-story, 245,000 square-foot dedicated children's hospital. The innovative and family-focused approach to the building design will not only be state-of-the-art, but its NICU will have been directly influenced by Patti herself and bear her stamp of approval.

While Patti recognizes there is no such thing as an "ideal hospital stay," her arduous months at Strong magnified the importance of maintaining some semblance of privacy, despite the

critical nature of the NICU with its cadre of caregivers. "Trying to determine what the ultimate NICU would look like has been the best part of the process so far."

Evolving Philosophy

The new building represents the largest capital project in the history of the Medical Center and the University of Rochester. Despite its nationally ranked and recognized programs, researchers, physicians, nurses and staff, Golisano Children's Hospital has lacked the ideal facilities to match these high caliber qualities.

Bolstered by a $20 million lead gift from B. Thomas Golisano, the new hospital will feature dozens of private rooms and a new Hospitality Suite that parents can use to shower, eat home-cooked meals as a family or even run a load of laundry. A resource library will allow families to learn more about their child's illness or injury and a Concierge Service will assist parents with errands so they can spend more time with their children.

"By having its own building, this hospital dedicated to children will take us to new levels of excellence for the 21st century, transform how our teams treat infants, children and adolescents, and how we provide patient- and family-centered care for our children," says Dr. Nina Schor, Professor and Chair, Department of Pediatrics at the University of Rochester Medical Center.

A confluence of several factors has driven the project forward. "We realized that our overall thinking about a children's hospital had to change," says Dr. Schor. "We needed to find the right way to house young patients and their families that reflected the changing needs and expectations of our community."

She notes that what the hospital was capable of providing when it was built 30 years ago had dramatically changed. "Years ago, patients came in for care, but their families weren't really involved." In an effort to spare families from the often painful procedures or medical logistics of care, they were kept far removed from their loved one.

"We now know differently," she says. "Patient safety still comes first. Kids with infections still need to be isolated especially during the flu season, but we know the importance of socialization. Not involving the family means we're missing an opportunity to learn from the people who know the patient best."

Building a dedicated children's hospital will better support that philosophy, she adds. "Our physical plant has limited how much we could carry out this new notion that creating a family-first environment makes the most sense for patient safety and comfort."

Dr. Nina Schor, Pediatrician-in-Chief of Golisano Children's Hospital, Professor and William H. Eilinger chair of Pediatrics at the University of Rochester Medical Center. Professor and Chair, Department of Pediatrics at the University of Rochester Medical Center.

Functional Design

Determining the ultimate design for the new hospital has been a daunting task. As a resident, Dr. Schor saw first-hand the completion of new inpatient space at Boston Children's Hospital, and years later helped establish the new Children's Hospital of Pittsburgh campus before coming to Rochester.

"We took a lot from different places," she says. "It was critical that we involve everyone in the process – patients, parents, residents, providers. The Philadelphia-based architects we hired need to know how we do business here in Rochester." Even Strong National Museum of Play and the Rochester Museum and Science Center have been consulted to help make the hospital a mirror of the community and to augment Rochester pride.

Liz Lattimore, Program Administrator for all children's clinical programs at Strong, has been involved in the minute-to-minute details of the planning process. "Liz has led the design phase and theming component and is doing the lion's share of educating the staff and community at large," says Dr. Schor. "The theming of the new hospital is critical. It's 100% of a

first impression. Everything matters when that family walks through the door."

The planned 52 private pediatric rooms will ensure greater comfort, space and privacy for children, families, and caregivers, and enhanced infection control. "These rooms will say to families that they are welcome here."

The facility will allow patients to be grouped by disease or injury, affording the hospital deeper opportunities to specially train nurses and staff to become experts in treating childhood diseases, injuries and common ailments. It will also support the growing and integral role parents play in their child's care, from closely interacting with the medical staff during their child's stay, to ensuring an optimal transition from hospital to home.

While the exact look and feel of the new hospital is not yet finalized, numerous spaces will be created for families and children that fully embrace a child's need for play and normalcy, including a toddler playroom, a two-story playdeck, a school room and a teen room. An outdoor rooftop playspace and a healing garden are also planned.

Maximum work flow and noise control were key to the new design. "We didn't want to lose the team approach, so we knew we needed space for a provider to stand at a computer outside a given room to review charts, but be able to watch the patient at the same time."

Ensuring Contiguous Inpatient Care

Another key driver in the development of the new children's hospital was ensuring that services for inpatient children were better integrated. As it stands today, an inpatient child requiring radiologic procedures and tests like x-rays or MRIs must be wheeled through adult and non-patient space. "It can be scary for kids," says Dr. Schor. To enhance patient comfort levels and safety, pediatric services will be in close proximity to the inpatient floor. Currently, several adult units exist on the hospital's third and fourth floors. During the first wave or relocation in 2015, all pediatric services on those two floors will move to the new building.

In 2017, the hospital will maintain its own Operating Suite just for children, encompassing an entire floor with several rooms, including a waiting area for family and other visitors. "Currently, our pediatric surgeons have to vie for the use of the OR with their colleagues in adult care – from ENT and orthopedics to urology. "Unfortunately, kids often get bumped. Families have to rearrange their lives for surgeries, and it can be a real problem. Under this new design, it's all about considering the family," she says. "It's the right thing to do."

In tandem, the Pediatric Intensive Care Unit/Pediatric Cardiac Intensive Care Unit (PICU/PCICU) will also become part of the new building, and the relocation of the Ronald McDonald House will follow. Plans for the building's top floor are still underway pending FAA approval for building height.

Once complete, the hospital itself will complete a symmetric loop with the Medical Center's other buildings. "We'll be right across the bridge from Ob/Gyn, and will still have some service connections through our main lobby to the main lobby at Strong," adds Dr. Schor.

New Hospital Benefits Existing Hospital

Strong hospital administration has also been a notable driver in getting the green light for the endeavor. Four years ago, the Prism Project was established in an effort to build a new children's hospital, but it was put on hold due largely to the weak economy. "It would have been irresponsible of us at that time to go forward with a capital campaign and construction," she says.

But last year, when major hospital benefactor Thomas Golisano came back to the table to address the need, hospital administration agreed the time was right. "The thrust of this

capital campaign is unheard of nationally," says Dr. Schor. "But it needed to be built." With three years remaining in a five-year campaign, the hospital has already raised about 60% of the capital needed. "We're blessed with administration that understands the importance of families and kids."

The NICU's New Look

Patti Milburn is one of many community members invested in the design of the new children's hospital. As part of its Advisory Council for the new NICU, Patti has maintained her involvement with the hospital long after her son has had need for its services. "When the hospital asked me to be involved from a parent's perspective, I knew they really wanted my opinion. I'm not some 'token parent' on the committee. I'm constantly asked how I think each decision in its design will impact families."

"It's all about bringing some kind of normalcy to the families' lives"

The Committee has considered everything from whether a nurse should have a direct line of sight to the infant to determining the best location where private phone calls can be made. A Lactation Room was determined to be a must for breast-feeding mothers, who can pump without inhibition. "For a first-time Mom trying to learn how to pump, this is a big deal."

The hospital's current NICU cares for up to 60 babies zoned in one large room, separated into three sections – the first section for those infants on ventilators or in post-op care, the second for those considered in stable condition, and the third for babies considered "feeders and growers." "It's tough sometimes," says Dr. Schor. "We want families to feel their babies have "graduated" out of intensive NICU, but it's hard to feel the progress when they're all still together in the same room and haven't 'stepped down' into a regular nursery."

The 60-bed expanded NICU will give families more space, flexibility and privacy, while also providing more opportunities for families to learn how to care for their fragile child before being discharged. "Everything doesn't have to be so 'public' in the NICU," adds Patti. "You're caring for the sickest, most delicate babies, and so it's important to have a family area, a waiting space where parents can bring other kids, where there's simply more space to be more relaxed."

In the Milburn's case, the Ronald McDonald house located nearby was not an option, as they live locally in Spencerport. "It's all about bringing some kind of normalcy to the families' lives," she says. "While I could stay overnight in the NICU or go home, I knew that staying with our name on the door was like saying to everyone I'm there because my baby might not make it. With the new hospital, families won't be hearing other peoples' business, she says. "The privacy will give them a more natural setting, and put everyone on more of a level playing field, so to speak. Whether your child has jaundice or is a preemie fighting for his life – it can be equally traumatic to a parent."

She also notes that the new NICU will also be a learning process for the nurses and other health providers getting accustomed to having family members there a longer time. "It will be a whole culture shift for that unit."

Patti is also actively involved in Parent to Parent, a support system for NICU families. "We're fortunate that we were able to bring Cory home, but other parents never do. We invite moms out to talk to those of us who have walked through their journey. They can see our stories." She expects that once the new hospital is in place, support groups will grow exponentially. "More people will want to be involved when it's more personal meeting space," she says.

Paving Way for Continued Excellence

Dr. Schor, who came to Rochester six years ago, recognized the exciting new chapter in her professional career as she foresaw this new hospital coming to fruition. "I accomplished what I needed to in Pittsburgh, and once I knew what I truly wanted to do for the next phase of my career, Rochester was the clear choice. There has been such an incredible cross-section of the community involved in this endeavor," she says. "I've met so many wonderful people because of this."

Not to be understated in the project is another key driver – the strength of our community's academic pediatricians. "We're fueling the legacy of what we leave behind when we're no longer practicing medicine here in town," she says. "If Rochester wants to maintain the high pediatric standards we have today, our best shot is through training and retaining our current subspecialists and recruiting more top-notch practitioners."

For Patti Milburn, these standards are a key reason her "wild and crazy" Cory will be heading off the kindergarten in September. "It's amazing how far we've come,' she says. "We're saving babies younger and younger now. A bond gets created when the hospital becomes part of your life day in and day out, so having it be the most family-friendly environment is really the way of the future." ■

New Huntington's Treatment Shows Promise

A new study shows that the compound coenzyme Q10 (CoQ) reduces oxidative damage, a key finding that hints at its potential to slow the progression of Huntington disease. The discovery, which appears in the inaugural issue of the Journal of Huntington's Disease, also points to a new biomarker that could be used to screen experimental treatments for this and other neurological disorders.

"This study supports the hypothesis that CoQ exerts antioxidant effects in patients with Huntington's disease and therefore is a treatment that warrants further study," says University of Rochester Medical Center neurologist Kevin M. Biglan, MD, MPH, lead author of the study. "As importantly, it has provided us with a new method to evaluate the efficacy of potential new treatments."

Huntington's disease (HD) is a genetic, progressive neurodegenerative disorder that impacts movement, behavior, cognition, and generally results in death within 20 years of the disease's onset. While the precise causes and mechanism of the disease are not completely understood, scientists believe that one of the important triggers of the disease is a genetic "stutter" which produces abnormal protein deposits in brain cells. It is believed that these deposits – through a chain of molecular events – inhibit the cell's ability to meet its energy demands resulting in oxidative stress and, ultimately, cellular death.

Scientists had previously identified the correlation between a specific fragment of genetic code, called 8-hydroxy-2'-deoxyguanosine (80HdG) and the presence of oxidative stress in brain cells. 80HdG can be detected in a person's blood, meaning that it could serve as a convenient and accessible biomarker for the disease. Researchers have also been evaluating the compound Coenzyme Q10 as a possible treatment for HD because of its ability to support the function of mitochondria – the tiny power plants the provide cells with energy – and counter oxidative stress.

The study's authors evaluated a series of blood samples of 20 individuals with HD who had previously undergone treatment with CoQ in clinical trial titled Pre-2Care. While these studies showed that CoQ alleviated some symptoms of the disease, it was not known what impact – if any – the treatment had at the molecular level in the brain. Upon analysis, the authors found that 80HdG levels dropped by 20 percent in individuals who had been treated with CoQ.

CoQ is currently being evaluated in a Phase 3 clinical trial, which is the largest therapeutic clinical study to date for HD. The trial – called 2Care – is being run by the Huntington Study Group, an international networks or investigators.

"Identifying treatments that slow the progression or delay the onset of Huntington's disease is a major focus of the medical community," said Biglan. "This study demonstrates that 80HdG could be an ideal marker to identify the presence oxidative injury and whether or not treatment is having an impact."

Additional co-authors include Karl Kieburtz, MD, MPH and Ryan Evans MD with URMC, Ray Dorsey, MD with Johns Hopkins University, Steven Hersch, MD, PhD with Massachusetts General Hospital, and Ira Shoulson, MD with Georgetown University. The study was supported by grants from the National Institutes of Health. Funding for the original Pre-2Care study was provided by the CHDI Foundation.

URMC RESEARCH

Protecting Hearts of Childhood Leukemia Survivors

ABOUT 75 PERCENT OF CHILDREN WITH LEUKEMIA WHO TAKE chemotherapy face life-threatening heart problems as they age, but an international study led by a URMC investigator shows that giving a cardio-protective drug during cancer treatment may prevent the damage.

Researchers and physicians will debate how to make young cancer patients and their families aware of the risks of heart damage, and the best ways to manage the risks, in a special session today at the American Society of Clinical Oncology (ASCO) meeting in Chicago.

Led by Barbara L. Asselin, MD, professor of Pediatrics and Oncology at URMC, the study was sponsored by the Children's Oncology Group and the National Cancer Institute. It is believed to be one of the largest trials to evaluate the effectiveness of the drug Zinecard (dexrazoxane), at protecting the heart during treatment of acute lymphoblastic leukemia. Asselin presented data and will also take part in a larger ASCO forum, during which hundreds of pediatric cancer experts will discuss heart disease and second malignancies – the unfortunate, severe risks associated with aggressive treatment of children.

"Today the majority of children with leukemia will be cured," Asselin said. "As our young people survive, though, we believe we will see many more cardiac issues. It is a problem that must be fixed because it is the leading cause of death later in life among these patients."

One part of the equation involves getting teenagers and young adult cancer survivors, who tend to engage in riskier behaviors, to be aware of potential problems and make healthy lifestyle choices (no smoking; exercise; careful follow-up appointments with a physician), Asselin said.

Drugs such as Zinecard are also important, although the data so far has been inconsistent. The URMC study evaluated 537 patients for more than 10 years after they were treated for leukemia between 1996 and 2001. All received multi-agent chemotherapy that included doxorubicin, known to be toxic to the heart.

Patients were randomized to two groups, with or without a dose of intravenous Zinecard immediately prior to receiving the chemotherapy. Later, researchers assessed each patient for heart damage at three different points after chemotherapy. Using standard measures, they looked at heart muscle function and structure. (A common problem following doxorubicin therapy is heart enlargement and thinning of the ventricular walls.)

For both groups of patients, the five-year survival with no evidence of leukemia was the same. That data was encouraging and very important, Asselin said, because of concern in the pediatric community that adding Zinecard to the treatment regimen might interfere with the chemotherapy's ability to attack the leukemia.

In addition, the group that did not receive Zinecard had more episodes of acute heart problems, and researchers saw more damage over time to the heart structure and function, as compared to the group that did receive the cardio protective drug.

Earlier clinical trials of Zinecard in women with breast cancer, who had already received high doses of doxorubicin and needed more chemotherapy, showed that the drug could protect the heart during retreatment, Asselin said.

A problem with Zinecard, however, is that the URMC study also showed an increased rate of second malignancies in the children who received the heart drug. Although the higher rate did not reach conventional levels of statistical significance by research standards, it is worth noting and studying further, Asselin said.

One of the goals of the ASCO forum, in fact, will be to review all data on the use of the Zinecard and to debate the risks and benefits.

"We now have some very effective cancer treatments at our disposal," Asselin said. "But we really need to focus on promoting the good health of our survivors. Our care does not end with chemotherapy. Being there for many years into the future, and to help childhood survivors understand their risks, is so important."

Risky Synthetic Drugs find an Audience with Teens

George Nasra, MD

Nearly one in nine high school seniors have gotten high in the past year on synthetic drugs, such as "K2" or "Spice," second only to the number of teens who have used marijuana.

Source: Monitoring the Future Study funded by grants from the National Institute on Drug Abuse, a part of the National Institutes of Health.

Synthetic drugs are a hot topic today, not only in the medical community but also with educators, parents, lawmakers, the media, and teens. Still the knowledge we have about it is minimal at best while the impact of these drugs is significant.

That's one of the biggest problems with this synthetic drug epidemic.

Risks of the Unknown

Because so much is known about common drugs of abuse--their pharmacology, signs of intoxication, withdrawal, short- and long-term side effects; practitioners can reliably predict how a patient will present and what to expect as they synthesize.

With synthetic drugs, like synthetic marijuana (herbal mixtures laced with synthetic cannabinoids, chemicals that act in the brain similarly to THC) or bath salts (a family of designer drugs often containing substituted cathinones, which have effects similar to amphetamine and cocaine,) it's hard to predict what the effects will be. Not only are we are still learning about their effect on the body, but one can never be sure that one batch of the drug is similar in composition to another.

Some may use a significant amount of the drug without significant side effects while others may become extremely agitated, confused and psychotic. One person may have mostly physical symptoms of heart palpitation, chest pain and complaints of headaches while others will experience severe panic attacks, hallucinations and delusional thinking. Several cases have been reported of individuals developing seizures and dying of aspiration after vomiting.

Genetic Predisposition to Mental Illness

The variation in response to synthetic drugs could be due to a wide variation in composition and potency of the drugs, but there is a significant genetic predisposition to consider. An individual with a family history of psychotic illness is likely to respond differently than someone without such history.

The teenage years are often the time where psychiatric illness manifests. Often, illnesses such as schizophrenia, depression, and anxiety, start to show their first symptoms at this time.

For teens, using synthetic drugs can often trigger the mental illness that might have remained dormant without the drug use. This is known as the stress diathesis model for mental illness. It is well documented that a genetic predisposition interacts with environmental factors to produce the disease in an individual. Here the drugs serve as an additional environmental stress which uncovers mental illness.

Practitioners must consider the importance of the Adolescence phase - a critical period of transition when children are making important decisions and choosing paths that will guide their future. These powerful synthetic drugs are poisoning their brains with grave potential for adverse long term effects on physical and mental health possibly even killing them.

A New Layer of Users

Despite significant recent legal efforts synthetic drugs are still accessible, they're packaged professionally in attractive colors, and they're sold on store shelves and online.

The drug makers and retailers have openly advertised and sold these products until recently – basically telling teens that it's ok to use this product. This is where the confusion sets in amongst this group about the concept of what's legal and what's safe, which in turn brings out a whole new layer of users.

Many teens that normally would be afraid to use illegal drugs as a result of education programs at school or from conversations at home can be tempted to use. When they are approached with something that's 'legal' and sold on the shelves and professionally packaged, they think it's safe.

So now, we have a new group of users that most likely would have smoothly gotten through the impressionable years that instead are battling addiction.

Difficult to Detect

Some synthetic drug users use these substances because they are very difficult to detect. If a person is in legal trouble and is on probation, or perhaps a parent has picked up on the drug use – a person may pass a traditional drug test giving a false impression of sobriety.

Parents seeking a psychiatric evaluation may describe severe and/or strange behavior that they do not understand and cannot explain. That's the time to initiate the conversation. First, we need to ask these adolescents if they're using synthetic drugs. Surprisingly, sometimes they admit it. If they don't, the next step is for the provider to have the conversation with the lab. The provider can explain the behaviors and identify what substances to screen for at the lab.

Adding synthetic drug use to the patient screening tool is often helpful too. If it's not asked, we don't know, so the process for trying to help the patient is prolonged.

Education and Communication

Parents, educators, and providers need to talk to teens specifically about synthetic drugs. We need to educate ourselves, keep up on the new information, and ask our adolescents what they're hearing in school and from their friends.

We, as providers, parents, educators need to impact the course of where this is international trend is headed through education and communication. Reaching out to patients, families, parents, and educators can allow us to take a stand and keep our community safe and stop the future course of this disease.

George Nasra, MD, serves as medical director of Unity Health System's Inpatient Psychiatric Unit and PROS (Personalized Recovery Oriented Services).

A New Picture of Ambulatory Imaging

Jonathan Broder, MD

With the Imaging Center at Alexander Park, Rochester General Health System is breaking new ground. The plans behind this Imaging Center reflect the future of outpatient services in a post-reform era.

While Rochester General Hospital's Radiology services support the needs of inpatient, OR, and ED patients, providing an optimal outpatient experience from within the hospital has presented a unique challenge. Access to RGH imaging, built in the center of the hospital to meet urgent inpatient needs, can be less convenient for outpatients. Added to the growing demand for high-quality, cost-effective ambulatory imaging, this made the decision to expand our services a logical one.

Alexander Park was an ideal site for a number of reasons, including the dozens of Rochester General Medical Group physicians at that campus and the downtown professionals who have a hard time getting to these services during their busy workdays. Also, the catchment area includes lower-income city residents who have difficulty accessing services like mammography and first-trimester ultrasound. With this highly accessible facility, many underserved patients now can easily fulfill this important aspect of their care.

To be truly competitive as an ambulatory provider, customer-focused attention is going to be more important than ever. To accommodate patients' busy schedules, our technologists have been cross-trained on all modalities so lunch hours for our teams won't interrupt our exceptional all-day service. We added longer weekday hours and a Saturday half-day schedule, and instituted a policy of accepting early or late flexible appointments when needed.

Our customers also include referring physicians, who need service that's both prompt and high quality. Because of this, we're keeping an experienced radiologist on site at all times and committing to a policy of speedy notifications of positive findings. We've also linked our Alexander Park facility with other RGHS affiliates, including RGMG practices, via our Care Connect electronic medical records system. This allows RGHS-affiliated physicians to easily share patient data, including "paperless" electronic appointment scheduling that is efficient for practices and patients alike.

Clinical integration with the rest of RGHS was a must. Team members at the new location were trained at RGH to ensure consistent quality of care. Also, thanks to digital technology the on-site radiologist can easily share scan data with off-site subspecialty radiologists for complex cases – accelerating the delivery of findings to referring physicians and their patients.

The RGHS Imaging Center at Alexander Park is more than just another step in our commitment to providing world-class ambulatory care – it's a part of our ongoing commitment to the men, women and children who live and work in the city of Rochester. Improved health services translate to a stronger, more vital community as a whole.

Jonathan Broder, MD, is Chief of Radiology for Rochester General Health System.

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Medical Practice Transition Planning

Estate Planning Considerations

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

We have embarked on a series of articles explaining legal matters that arise in the context of medical practice administration and transfer of ownership. Our first article addressed the importance of buy-sell agreements, and in our second article, we described the crucial interplay between business law advisors and estate planning advisors when planning for the sale or other disposition of a medical practice. We also addressed what skills and experience you should expect from your legal counsel to ensure that all legal issues are considered and all business and personal needs are met. We now move to a case study, the details of which are rife with "real life" issues that need to be addressed when considering the eventual transfer of a practice from retiring physicians to the remaining practicing physicians.

Our fictional medical practice is the Mensch Medical Group, P.C. (the "Group"), a professional corporation formed in Upstate New York. The Group is comprised of three shareholders: Henry, who at age 70 is their senior physician; Samuel, who at age 54 has a physical disability which, while currently not prohibiting him from practicing, is of a degenerative nature, and Lucy, who at age 35 is their youngest physician and who recently became a shareholder in the P.C. Henry is at the zenith of his career and has amassed a large patient following owing to his excellent reputation at general medicine. The Group currently has a waiting list for new patients, and is considering bringing in a new physician on an employee basis, with the expectation of an equity position in the P.C. within a few years.

Henry is in excellent health and is happily married to his wife, Linda, and they have one son from their 25 year marriage. They both have adult children from their first marriages and several grandchildren, who delight at their visits to Henry and Linda's summer cottage on Lake Michigan. Henry is quite set in his ways around the office and has somewhat stodgy perspectives steeped in tradition. His great-grandfather, for example, believed life insurance was the ultimate "gamble," and this tenet has held through Henry's paternal generations.

> Not only are the three equity owners in different stages of life, they have vastly different financial goals and concerns.

Marriage has never been on Samuel's radar and he has no children. His parents are deceased and his siblings are scattered around the country – none are local, and therefore Samuel rarely sees them. Samuel's life work has been his medical practice, and for the most part, he spends his evenings researching new theories and studies. Samuel is the Managing Partner of the Group and finds that this responsibility for administration, in addition to his patients and his love for research, keeps him more than busy. He was diagnosed with distal muscular dystrophy several years ago, with mild symptoms that have progressively become more apparent to him while not yet impeding him from his active schedule of patients on a daily basis.

Lucy married Todd while she was is medical school and is now expecting their second child. Todd is a computer programmer and, at the behest of Lucy, has reluctantly elected thus far to work from home and simultaneously care for their

first child. Unfortunately, their first child was colicky and lactose-intolerant and the stress of working from home and caring for the baby has taken its toll on Todd. Todd wants to hire a caregiver and take employment outside the home and is threatening a divorce from Lucy if these events do not happen. Lucy is beginning to re-think her marriage to Todd, as it seems that their goals at this stage in life have diverged from one another and she is, frankly, becoming weary of Todd's repeated expressions of discontent.

Not only are the three equity owners in different stages of life, they have vastly different financial goals and concerns. Lucy has significant student loans incurred during her education, and her primary focus is building the medical practice and making money given her substantial student loan debt. Lucy is also very concerned with saving for retirement, and is not satisfied with the group's lack of a defined benefits plan and its failure to match any percentage of contributions to the 401K plan.

Samuel's simple lifestyle tastes have permitted him to tuck away quite a nest egg; however, he is concerned with his pending disability and its effect on his practice and on the group as a whole. He is, moreover, wary of the costs the Group may incur in bringing in another physician as an employee with a promise of ownership, who may or may not fit well within the Group.

Henry has been quite carefree with his spending during his lifetime, and instead of rebuilding his finances after his expensive divorce from his first wife, Henry has continued his spendthrift habits since his remarriage. Henry is not worried, however; he believes that either he will bought out by the other physicians in the practice when he wishes to retire, or the practice will be sold to an area hospital for a handsome sum, and in either case, the proceeds will be sufficient to fund his retirement.

In our upcoming articles, we will illustrate the challenges that arise with respect to Henry's expectations upon retirement, Samuel's progressive disability and Lucy's pending divorce and keen interest in maintaining the practice intact. Problems will arise, and we will explore the Group's options and explain the solutions that the Group employs to achieve continuity of practice.

MANAGING THE EHR OPTIMIZATION PHASE

By Elizabeth Amato Fleck, MSHA

So, your practice is live on your new EHR. Congratulations! The software trainers have left and life has essentially returned to normal now that the Implementation phase has ended. Your providers are documenting care they provide to patients into the EHR. Nurses and medical assistants are entering vitals and other information into the EHR. Billers are using information from both the EHR and practice management systems to submit claims. Staff is no longer searching for charts (at least for new patients). These are all great things and hopefully your practice is experiencing efficiencies that didn't exist before.

Now that the Implementation phase is complete, your practice is on the brink of the Optimization phase. When you optimize something you take full advantage of all that it has to offer, you make the best of it, and you improve upon it. In the EHR adoption process, Optimization comes after the dust has settled in your practice and you take a step back to say, "How can we really get the most out of this big investment?" In order to optimize your EHR, it's key to recognize that managing this phase is just as important as it was to manage the implementation.

Here are important considerations for physicians and administrators planning for EHR Optimization:

Determine Your Timeline

Will your Optimization phase be driven by initiatives such as Meaningful Use, Patient Centered Medical Home accreditation, state or local grants, or payer incentives related to EHR use? Knowing the requirements of such initiatives as well as deadlines will shape your Optimization strategy and approach. By being clear about what is driving your Optimization phase, it will be easier to determine what items and tasks should be given priority over others to meet requirements. If initiatives such as these are not relevant to your practice, then you are able to determine your own timeline based on your practice's optimization tasks, resources, and level of urgency.

Organize a Team

Every practice functions differently in terms of project execution, decision-making, and change management. Using the knowledge of the way your practice operates, it is time to develop a team to focus on optimizing your EHR. Ideally, this will be a cross-functional team consisting of providers, administrative staff, billers, front desk, nursing, and medical records. This team will need to develop the "rules of the road", specifically, who makes final decisions regarding the use of the EHR and workflow, meeting schedule and frequency, and responsibilities of team members. Once you have defined your team, you are ready to begin planning.

Developing Your Optimization Plan

Planning for Optimization can feel like a daunting task. Oftentimes there are so many things that a practice wants to do, it can be difficult to know where to start. One of the first things your team should do is create a list of all requests and/or issues that are known at the time. However, it is important to remember that Optimization tasks are different from normal support/maintenance tasks. Items such as password problems, corrections to spelling in templates, and corrections to medication dosages or directions are examples of support tasks. These should not make it onto your Optimization work plan, but should be dealt with by your internal EHR system administrator, IT vendor, or EHR vendor. Now, onto the Optimization tasks. One of the most common areas addressed during Optimization is your office's workflow. With new technology in place, it is a great time to make sure that the way your office operates is efficient and effective.

Workflow areas that may be evaluated and redesigned include:

- Front desk (check in/check out)
- Rooming a patient
- Clinical point of care processes for nurses and providers (documenting the visit, injections, procedures, charge capture)
- Order entry
- Referrals (inbound and outbound)

In addition to focusing on workflow, practices may decide to optimize their EHR by turning on additional system functionality or modules. Some common tasks (or projects) include:

- ePrescribing (eRx)
- patient portal
- interfaces to ancillary devices, labs or RHIOS
- secure messaging with patients or other providers
- clinical decision support systems (CDSS)
- automated patient reminders
- disease management/health maintenance protocols
- order tracking
- referral tracking
- clinical quality measures reporting

Once you have determined your timeline, assembled your team, and created your Optimization plan, you are ready to get started! Don't forget that your EHR vendor will play a role in this process, as will your IT vendor, and any Health IT consultants who can provide assistance, and certainly your providers and staff. Optimization is an on-going process and while individual tasks and projects may get completed, practices that take full advantage of their EHR will always be planning for ways to optimize the use of the system.

Elizabeth is the Manager of Health Information Technology at Innovative Solutions based in Rochester, NY. She provides strategic consulting to medical organizations related to their use of Health IT.

What is Your Practice Worth?

Steven M. Terrigino, CPA

"Time is more valuable than money. You can get more money, but you cannot get more time." ~Jim Rohn

WHAT IS THE VALUE OF YOUR INVESTMENT PORTFOLIO, YOUR home, or perhaps the value of other property you own? You likely can answer these questions with some degree of certainty and accuracy. However, can you answer the question, "what is your practice worth?" Conceivably, this may be one of your biggest assets. Yet, generally, most business owners cannot answer this question accurately.

At some point in time, you will need to know what your practice is worth and a valuation will have to be performed. Some examples of events triggering a valuation include, the sale of your practice, preparing a "buy-sell" agreement, physician buy-ins or buy-outs, or perhaps the death or disability of a partner.

Logically, the next question you probably have is: How is the value of my practice determined? There are three general approaches to valuing a business. These approaches include the cost approach, the income approach and the market approach. Each approach may identify specific practice attributes that may be important in determining the final value of the practice. A basic summary of each approach is as follows:

The Cost Approach

This approach attempts to value the assets of the practice at their current market value. If this method is used, accounts receivable is usually a key figure. Keep in mind; you cannot merely use the face amount of receivables as factors such as collectability need to be considered. Practices have to determine what their machinery and equipment is worth as well. Often times, a medical machinery and equipment appraiser is engaged to help determine their value. Most valuation experts would also recommend determining the value of "goodwill", an intangible asset, and include that in the overall valuation. Goodwill generally includes things like name recognition, patient lists, reputation, and expertise in a specialty and so forth. In certain circumstances, it can be the highest valued asset in a practice. Thus, it deserves due consideration. In summary, this approach looks at the practice's balance sheet items.

The Income Approach

This approach looks to determine what the future economic benefit of the practice will be, and quantify that into a single present value amount. In simpler terms, the value under this approach is the present value of anticipated future cash flows. The practice's revenues and expenses are projected over a reasonable amount of time, typically three to five years. Projected growth and on-going capital requirements (i.e., working capital needs and capital expenditures) to support this growth are then incorporated into this model to arrive at an estimate of the future annual cash flow of the practice. This cash flow is then present valued to "today's" dollars to derive an indication of value.

The Market Approach

Finally, the market approach is just that. It attempts to value the practice based upon what comparable practices have sold for. Similarly, this approach is utilized by realtors when you are buying or selling a home. Typically, the realtor will run the "comps" in your area to determine a predictable range of value. Much like home sales, practices of different size, specialty, and location will each have different values. These and many other factors need to be taken into consideration.

Which Approach to Use?

Commonly, value is determined considering two or even all three of these valuation approaches. Then, the ranges of these results are assessed to arrive at a reasonable estimate or conclusion of value. However, since the different approaches can

yield very different results, an experienced and professionally credentialed business appraiser should be consulted regarding the appropriate valuation approach, rather than stipulating that a specific approach be used in the practice's partnership and/or buy-sell agreement.

> "the ever changing healthcare climate makes the predictability of the calculation of value harder to determine"

Other Considerations

While having your practice appraised may not happen very often, it is important to recognize what drives value, either up or down. As such, if you have a time horizon as to when a sale may take place, you may have the opportunity to perhaps increase the value of your practice. Frequently, a business owner's perceived value and expectation do not align with actual value. This can have several negative consequences, especially if a partner/owner is expecting to use the business transition to fund their golden years.

To complicate matters, the ever changing healthcare climate makes the predictability of the calculation of value harder to determine. Valuation experts will frequently use past results to predict future expectations. However, predicting future results gets extremely complex when you have to consider several unknown variables. The future impact of the Patient Protection and Affordable Care Act, Stark Laws, a decrease in the number of physicians entering the profession, declining reimbursements, along with an unsteady economic climate makes estimating the value of a practice increasingly complex. Predicting becomes more like guessing and can weigh heavily on your practice's value. So what a practice may be worth today can be certainly different than it may be worth tomorrow. Ultimately, the practice is only worth what a buyer is willing to pay for it.

Summary

There will come a time when you will have to determine what your practice is worth. A valuation will be imperative if you are selling your practice, admitting a partner, or for a myriad of other reasons necessitating the determination of worth. If you are counting on the sale of your practice as a means to fund your retirement, I would strongly encourage you to begin to quantify what you could reasonably expect to receive upon the sale, versus relying on what you ***think*** you will receive. As previously mentioned, quite often these numbers are at opposite ends of the spectrum. Moreover, as the state of the economy, healthcare and number of physicians entering the market change, so will value. Remember, you may only have so much time to increase the value of your practice, and if you use this time wisely, you may be rewarded richly.

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,

What is My Liability?

The Disruptive Physician

James E. Szalados, MD, MBA, Esq.

Issue

Within the current regulatory and legal healthcare climate of healthcare, it can be a career-ending event for a physician to even be labeled as 'disruptive.' Thus, there are two separate threats to physicians: first, there is the physician whose behavior falls clearly outside accepted norms; second, there is the physician who is unpopular, costly, or competitive and is labeled as disruptive to facilitate his or her removal from the medical staff.

THE AMERICAN MEDICAL ASSOCIATION (AMA) CODE OF Medical Ethics states that 'physicians must recognize a professional responsibility not only to patients, but also to society, other health professionals and to oneself.' The Institute of Medicine, in its report entitled 'To Err Is Human' acutely sensitized policy leaders, patients, and the legal system to the problem of adverse patient outcomes resulting from disruptive physician behavior. Disruptive physician behavior may impact patient care and safety, increase the risk of malpractice litigation, exposes the physician to adverse peer review and credentialing actions, and can result in disciplinary action by federal and state regulatory bodies.

There is no clear definition of "disruptive" – it represents both a cultural norm and a legal term of art. Suspect behaviors will typically fall along a spectrum. Behaviors which might be construed as 'disruptive' may include, for example, foul language, physical contact, threat of physical contact, threat of litigation or retribution, harassment, and even nonverbal mannerisms. In a July 2008 Sentinel Alert, the Joint Commission suggested that intimidating and disruptive behaviors might include "overt actions such as verbal outbursts and physical threats, as well as passive activities such as refusing to perform assigned tasks or quietly exhibiting uncooperative attitudes during routine activities." The Joint Commission has also defined "inappropriate conduct" as behavior which although not disruptive in itself, can become actionable if it is repetitious or persistent. Inappropriate conduct is behavior which may be reasonably interpreted to be demeaning or offensive; such as, for example, berating statements, inappropriate comments, deliberate failure of cooperation without good cause, and refusal to return phone calls or pages. Interestingly, the Joint Commission definitions closely parallel the definition of 'workplace bullying' that is defined in Section 55A (1) of the Occupational Health, Safety and Welfare Act 1986 as 'any behavior that is repeated, systematic and directed towards an employee or group of employees that a reasonable person, having regard to the circumstances, would expect to victimize, humiliate, undermine or threaten and which creates a risk to health and safety.' Not surprisingly, hospitals are wary of the institutional liabilities stemming from the behavior of disruptive physicians.

Effective January 2009, the Joint Commission implemented Leadership Standard LD.03.01.01 requiring hospitals to implement a code of conduct which defines acceptable and disruptive and inappropriate behaviors and empowers hospital leadership to create and implement a process for managing disruptive and inappropriate behaviors. The Joint Commission standard is linked to the six core competencies addressed in the credentialing process. Thus, hospital bylaws, rules and regulations, and policies are now setting definitions for 'disruptive behavior' and then linking such behavior to quality measures. The link between policy, behavior, and the outcome of care together form a nexus for adverse peer review and credentialing actions including suspension and dismissal from the medical staff, National Practitioner Databank reporting, and reporting to the Department of Health. The HCQIA provides hospital medical staff with significant authority to act with reasonable belief

against the medical staff privileges of a physician determined to be disruptive, and where such actions result in an action longer than 30 days, the disciplinary action must be reported to the NPDB. In writing or ratifying such hospital policies, physicians should realize that terminology that is overly vague can expose them to arbitrary or discriminating disciplinary actions; whereas terminology which is overly restrictive can expose them and their patients to the bad behaviors of their colleagues.

Court decisions have long favored hospitals over physicians when a behavioral issue that may impact patient care is at issue. In *Nanavati v. Burdette Tomlin Memorial Hospital* (NJ 1987) the New Jersey Supreme Court joined the then other majority of jurisdictions by deciding that a hospital may adopt a bylaw providing that the 'inability of a physician to work with other professionals' is a ground for denying, terminating or limiting staff privileges. The court in *Nanavati* ruled that the physician behavior must be related to questions of patient care and that although there need not be demonstrable patient harm to limit privileges, there must be documentation of misbehavior sufficient to raise a reasonable presumption of potential future adverse impact on patient care. More recently, in *Isaiah v. WHMS Braddock Hospital Corp*. (MD, 2008), a physician's medical staff privileges were revoked after hospital staff members reportedly expressed concerns about his skills and allegedly compulsive behavior; the court sided with the hospital determining that the hospital acted within the federal Health Care Quality Improvement Act (HCQIA) in its intention to protect the quality of care at the hospital. Similarly, in the Tennessee case of *Abu-Hatab v. Blount Memorial Hospital* (TN, 2009), a physician's medical staff membership and clinical privileges were terminated due to allegations disruptive behavior. Although the physician argued that the allegations were untrue, the court determined that the veracity of the allegations was subordinated by the medical staff's reasonable beliefs.

Therefore, physicians are exceptionally vulnerable to liability under the 'disruptive physician' label, and the shield by which harmony and quality are maintained has become a sword by which restrictive credentialing and adverse peer review may be perpetuated. The rules intended to protect harmony and quality have, under some circumstances, been weaponized. Physicians who complain about systemic inefficiencies, incur higher utilization or costs, rebel against internal utilization or referral mandates, or present a competitive threat, can be labeled 'disruptive' and coerced off a medical staff. A physician who begins to suspect that documentation is being assembled in a potential case against him or her should immediately contact a healthcare attorney.

Notwithstanding, the truly disruptive physician who manifests genuinely inappropriate behaviors may also unknowingly be increasing her civil and criminal liability. The same behaviors which may be viewed as disruptive by hospital staff are those which may result in miscommunications or deviations from accepted medical practices in the course of direct patient care. Data supports the contention that physicians with abusive or overly aggressive personality traits are more likely to be involved in medical liability lawsuits, harassment suits, OPMC investigations, and *qui tam* or whistleblower actions. The harassment, abuse or intimidation of a patient either physically or verbally is a violation of New York State Education Law § 6530(31) OPMC definitions of Professional Misconduct. Harassment can also be against coworkers and is legally defined as 'systematic and/or continued unwanted and annoying actions, including threats and demands, against another and can be the basis for a variety of legal actions. Finally, a person is guilty under a charge of assault if it can be established that he or she behaved in such a way as to put another in fear of imminent bodily harm, for example, by raising a hand in a threatening way; and, although civil battery can be costly to defend, a criminal charge will jeopardize one's medical licensure.

It cannot be underemphasized that physicians who have been, or expect to be, disciplined as a 'disruptive physician' immediately seek the help of legal counsel experienced in healthcare law in order to best protect their interests, their medical license, and their reputation.

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

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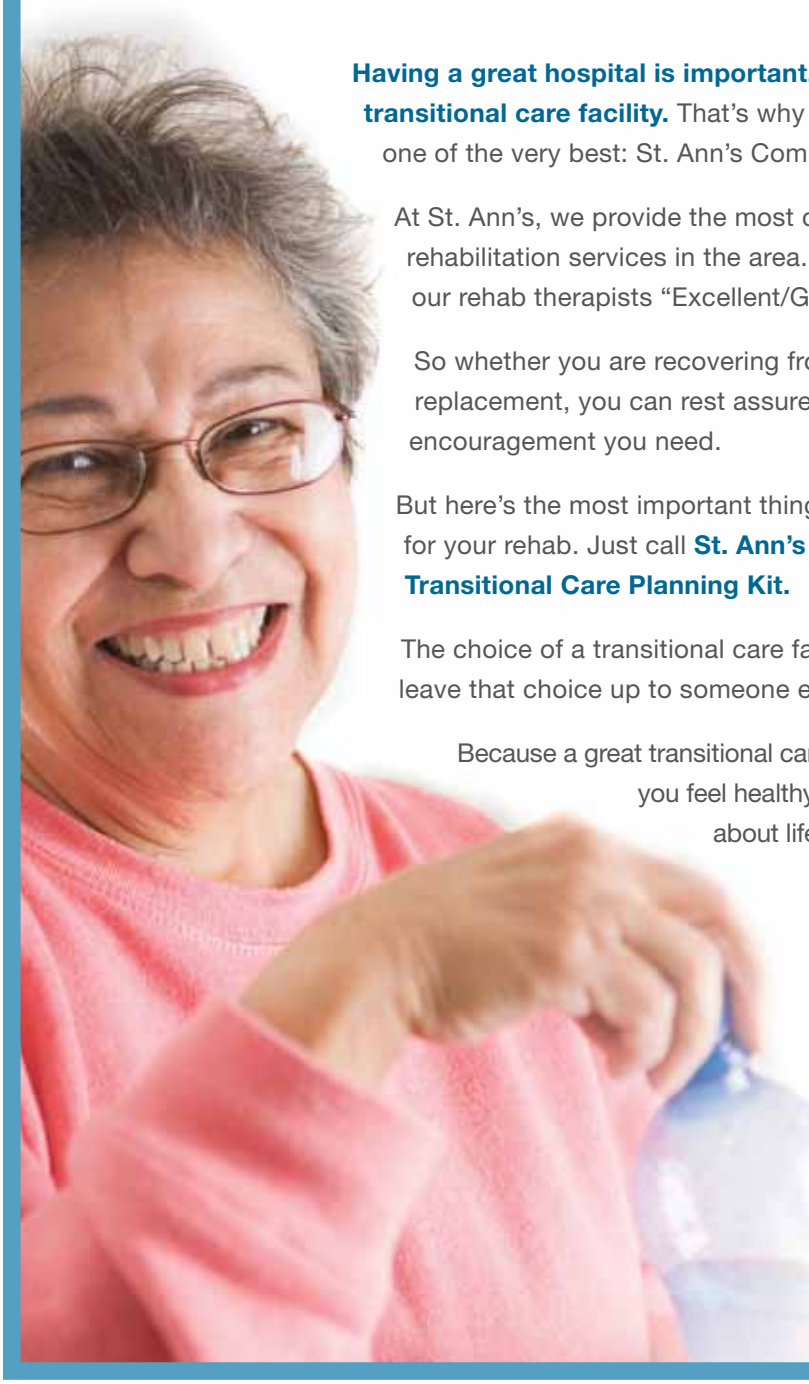

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WHAT'S NEW

in Area Healthcare

URMC NEWS

URMC Dermatologist Tapped for Two National Leadership Positions

Marc Brown, MD, professor of Dermatology and Oncology at the University of Rochester Medical Center (URMC), was elected president of the American College of Mohs Surgery (ACMS) and also named to the Board of Directors of the American Society of Dermatologic Surgery (ASDS).

Brown joined the URMC Department of Dermatology faculty in 1989, developing its Division of Dermatologic Surgery and Cutaneous Oncology. An expert in the Mohs technique to treat various forms of skin cancer, he performs about 2,000 cases annually and has completed more than 25,000 in his career.

Brown earned his medical degree at Georgetown University and completed an internal medicine residency at the University of Rochester. He served two years in the Public Health Service followed by a dermatology residency at the University of Michigan. After becoming board-certified in dermatology, he completed a two-year fellowship in Mohs Surgery and Cutaneous Oncology at the University of Michigan.

A frequent national lecturer, Brown has published two books and 50 scientific articles, primarily relating to skin cancer. He previously served as president of the New York State Dermatology Society and of the International Transplant Skin Cancer Collaborative, among other leadership positions.

ACMS is a national organization, founded in 1967 by Frederic E. Mohs, MD, creator of the Mohs micrographic surgical technique. ACMS promotes the highest standards of patient care relating to Mohs micrographic surgery and includes close to 1,000 members, all of whom have received advanced fellowship training in Mohs surgery, pathology and reconstructive surgery. Founded in 1970, ASDS boasts nearly 5,400 members who are at the forefront of the development of safe, in-office procedures to diagnose and treat deadly skin cancers earlier and more effectively.

RGH NEWS

RGH Awarded Funding to Train New Physicians in Community Settings

Rochester General Hospital has received a grant from the State of New York, totaling more than $547 thousand, for the clinical training of medical residents at freestanding ambulatory care sites.

The awards, distributed over a three year period, are being provided through the "Doctors Across New York" program. The 17 State grants totaling $10.6 million, are designed to help defray the costs of the clinical training provided at ambulatory care institutions, including diagnostic and treatment centers (D&TCs) and physician practices.

Rochester General Hospital will use the state funding to cover associated physician costs at five of its ambulatory sites. As the delivery of healthcare continues to migrate toward community-based settings, the State has determined that funding clinical training of new physicians at freestanding care sites is both a critical and timely investment.

UNITY NEWS

Joint Replacement Center at Unity Hospital Awarded Certification from the Joint Commission

The 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. "In achieving Joint Commission certification, the Joint Replacement Center at Unity Hospital has demonstrated its commitment to the highest level of care for its patients," says Jean Range, MS, RN, CPHQ executive director, Disease-Specific Care Certification, The Joint Commission. "Certification is a voluntary process and I commend Unity Hospital for successfully undertaking this challenge to elevate its standard of care and instill confidence in the community it serves."

"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 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 Joint Replacement Center at Unity Hospital the choice for more people in the greater Rochester area than any other hospital."

Unity Health System is pleased to welcome Anthony DiGiovanni, MD and Jane Hong, MD to the team of Unity Behavioral Health providers

Dr. DiGiovanni joins Unity Mental Health's Greece Clinic located on Pinewild Drive. Most recently he served as attending psychiatrist, Cayuga Medical Center, Ithaca, New York. He will focus on treating adult outpatients at Unity and work in private practice treating children. Dr. DiGiovanni completed his General Psychiatry Residency at the Maine Medical Center, Portland, ME, completed his Child and

Adolescent Psychiatry Fellowship at Stanford University, Stanford CA and is board certified in general and child psychiatry.

Dr. Hong joins Unity Mental Health's Greece Clinic on Pinewild Drive. Most recently she served as attending psychiatrist, Bay Psychiatric Associates, Berkley California. She has experience working with adults, adolescents, ages 12 and older, and in geropsychiatry. She will focus on treating adult outpatients at Unity and work in private practice in the community. She is board certified in general psychiatry.

New Physician Joins Unity Medical Group

Unity Health System announces the addition of **Valentina Antonova, MD** to its medical staff. Dr. Antonova will work at Unity Internal Medicine at Park Ridge. She earned her medical degree from Kahraov Medical University, Ukraine.

Dr. Antonova completed her residency in internal medicine at Internal Medicine Aurora Sinai Health Care Program, Milwaukee, WI and also completed a residency in neurology in Kharkov Medical. She was a neurologist from 1997 to 2001 at Kharkov Turboatom Hospital #1 in Ukraine.

Unity Health System is pleased to welcome Jane Dimopoulos, MD, and Vanessa E. Junor, DO, to Unity Ob/Gyn at Brockport

Dr. Dimopoulos completed her ob/gyn residency at the University of Patras/Kalamata General Hospital and Mercer University, Macon, GA. She is a clinical instructor for the physician assistant program at the Rochester Institute of Technology. She is board certified in ob/gyn and is a member of the American College of Obstetrics and Gynecology.

Dr. Junor completed her ob/gyn residency at the Philadelphia College of Osteopathic Medicine, Philadelphia, PA. She is board certified in ob/gyn and is a member of the American College of Obstetrics and Gynecology.

Existing Unity Ob/Gyn at Brockport and ACM Medical Laboratory will be joined by a range of additional services and doctors

Unity Health System is bringing services that patients want closer to their homes by relocating and expanding its office space in Brockport.

The new Unity at Brockport medical office will enable Unity to better accommodate Unity Ob/Gyn at Brockport and ACM Medical Laboratory Patient Service Center, and eventually to offer a family medicine practice, along with a range of new services—including diabetes care, geriatrics, neurology, physical therapy, and pulmonary medicine.

"We are modernizing and enlarging our Brockport office for one major reason—greater convenience for our existing patients," said Stewart Putnam, president of Unity's Health Care Services Division. "Our patients have been telling us for quite some time that they would like more services closer to where they live.

Unity's ACM Medical Laboratory Opens New Patient Service Center in Gates at Elmgrove Crossings

Residents of the Gates area have a new place to go for fast, convenient medical laboratory services.

On September 4, ACM Medical Laboratory will open a new Patient Service Center for collection of samples for medical laboratory testing in the Elmgrove Crossings plaza at 906 Elmgrove Road, next to the Westside Family YMCA.

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.

GENEVA GENERAL

Geneva General Hospital Awarded Advanced Certification for Primary Stroke Centers from the Joint Commission

The Joint Commission, in conjunction with The American Heart Association/American Stroke Association, recently recognized Geneva General Hospital with Advanced Certification for Primary Stroke Centers. Achievement of Primary Stroke Center Certification signifies an organization's dedication to fostering better outcomes for patients. Geneva General Hospital's Primary Stroke Center Certification has demonstrated that their program meets critical elements of performance to achieve long-term success in improving outcomes for stroke patients.

"In achieving Joint Commission advanced certification, Geneva General Hospital has demonstrated its commitment to the highest level of care for its stroke patients," says Jean Range, MS, RN, CPHQ executive director, Disease-Specific Care Certification, The Joint Commission. "Certification is a voluntary process and The Joint Commission commends Geneva General Hospital for successfully undertaking this challenge to elevate its standard of care and instill confidence in the community it serves."

Geneva General Hospital's Women's Health Services Receives Three Year Accreditation

Geneva General Hospital's Women's Health Services recently received a three year accreditation from the American College of Radiology (ACR).

"The staff in this department takes great pride in this accomplishment. This type of clinical excellence is a tribute to their dedication to the patients of Finger Lakes Health" said Jeff Fultz, director of diagnostics.

Geneva General Hospital's Women's Health Services provides mammography, ultrasound, stereotactic breast biopsies, bone density scanning and diagnostic imaging services.

EWBC NEWS

The Elizabeth Wende Breast Care is Proud to Welcome Wade C. Hedegard, MD

Dr. Hedegard attended the University of Minnesota Medical School and went on to complete his diagnostic radiology residency at the University of Rochester Medical Center where he served as Chief Resi-

dent. Dr. Hedegard also completed a Breast Imaging Fellowship at Massachusetts General Hospital in Boston in June 2012.

HIGHLAND HOSPITAL

Highland Welcomes Sorour Rahgoshay, MD to Internal Medicine and Ronald Bossert, MD, to Plastic Surgery

Dr. Rahgoshay will be working as an attending physician at Highland, seeing outpatients in the Geriatrics and Medicine Associates (GAMA) practice and in the hospital. She will also be assisting with patient care at the Highlands at Brighton.

Dr. Rahgoshay recently completed a fellowship in Geriatric Medicine at the University of Rochester School of Medicine and Dentistry. She did her residency in Internal Medicine with Unity Health System.

Dr. Rahgoshay earned her medical degree from Iran University of Medical Sciences School of Medicine and Health Sciences in 1998. From 1998 to 2002, she was Assistant Faculty at Semnan University Affiliated Hospital in Iran. From 2003 to 2007, Dr. Rahgoshay provided medical interpretation in Farsi-English for patients at UMass Memorial Medical Center.

Dr. Rahgoshay is Board Certified in Internal Medicine and will complete her Geriatrics Board Certification this fall.

Ronald Bossert, MD, has joined the University of Rochester Medical Center (URMC) as Assistant Professor of Surgery and the Director of the Life After Weight Loss Program. He will be collaborating with Highland Hospital's Bariatric Surgery Center to provide safe and effective surgical options to meet each patient's goals.

Dr. Bossert recently completed a fellowship in body contouring surgery at the University of Pittsburgh Medical Center in Pennsylvania. He did his internship and residencies in general and plastic surgery at URMC and earned his medical degree from the University of Rochester School of Medicine and Dentistry.

In addition to being the recipient of several prestigious awards, including an Office of Medical Education Research Grant Award, Dr. Bossert has authored a wide variety of publications in plastic surgery. His special interests include plastic surgery following massive weight loss, surgery of the breast, hand surgery, wound care and general reconstructive surgery.

Family Care or Business Care?

Thoughts on Looking at your Practice through an Investor's Eyes

Joel T. Redmond, CFP

"What did your son Dale want to do after finishing high school?"
"He said he wanted to join the family business."
"But you're a medical doctor."
"Believe me, I've told him that." ***- From the movie Step Brothers***

THE COMMENT MADE BY THE GOOD-NATURED DR. DOBACK in the 2008 Will Ferrell/John C. Reilly movie makes a decent point: not just anybody can buy into your business.

The highest professions have two primary objectives, and they are generally the same as those of all professions: to help others, and to make money. Medicine is no exception – one of the great conundrums facing medical professionals today is balancing these two countervailing forces. Consider a comment by Craig Koniver, MD, a contributor to the KevinMD social media medical blog:

> *"...the choice becomes this: will you choose to downsize and limit how many patients you can take care of, reducing your staff and all of the administrative burden – maybe even choosing to not file insurance any more? Or will you super size and join a big group or corporation or hospital practice where there are lots and lots of staff and lots and lots of doctors to treat lots and lots of patients?"*

Faced with these burdens, those medical professionals who have chosen to remain in the "twilight war" of managing their own small-to-medium professional practices have to deal with the same problems any closely-held business owner does. Faced with such uncertainties as decreasing reimbursements, increased strain on the nation's medical entitlement funding status, and accelerating tax burdens, the ability to run a profitable practice can be a challenge. What's the solution for those in such a situation? One is to work diligently to improve the value of the practice and then sell it.

Of course, there are challenges with this simplistic notion. But instead of dealing with each problem separately, let's look broadly at a major concern of a shareholder in a closely held medical practice, and how it can be addressed. For this article, we'll assume that the preferred path that the owner of this practice will take – once again – is to work diligently to increase the value of the practice, ensure the proper agreements are in place prior to sale, sell the practice, and then either retire to hospital (i.e. "super size") work, or the second childhood of retirement.

The problem we speak of here is not common to all practices, though it is not uncommon: an uncertain practice valuation due to uncertain or unsustainable cash flows. This is the same problem that faces corporations, local governments, and sovereign powers across the globe: spending outpaces income. When you analyze your practice, ask yourself a few questions that echo those of private investors evaluating any privately held capital market instrument:

What are the average annual net earnings of the business? This includes not only salaries paid to owners, but can include bonuses, personal use of corporate assets, and excess rents. It will also include the amount not paid out to owners – the amount added to retained earnings or net income.

How consistent are these earnings? Many selling closely held businesses will use averages of the past 3-5 years or more, often placing greater weight on the more recent earnings of the business.

What is a typical required rate of return on equity for a prospective buyer? A practice with a very steady and satisfied client base may need to earn far less on its equity than one with volatile billings.

What is the goodwill? In the corporate world, goodwill represents the purchase price that a buyer pays to a seller *in excess* of the net identifiable assets of the business. When we apply the concept of goodwill to small businesses, we also call it *excess earnings* – the actual earnings of the practice, *less* what the buyer was expecting to receive (the *required* rate of return on equity).

What is the cap rate? The cap rate, very simply, equates to the excess earnings multiplier you can use to sell your practice. If a practice has $2MM of annual net income and the required rate of return on equity amounts to $1.25MM annually, the excess earnings is $2MM – $1.25MM = $750M. Let's say the multiplier is six. If this is the case, then the owner of this practice could reasonably expect an asking price of 6 x ($750M) = $4.5MM.

The cap rate, very simply, equates to the excess earnings multiplier you can use to sell your practice.

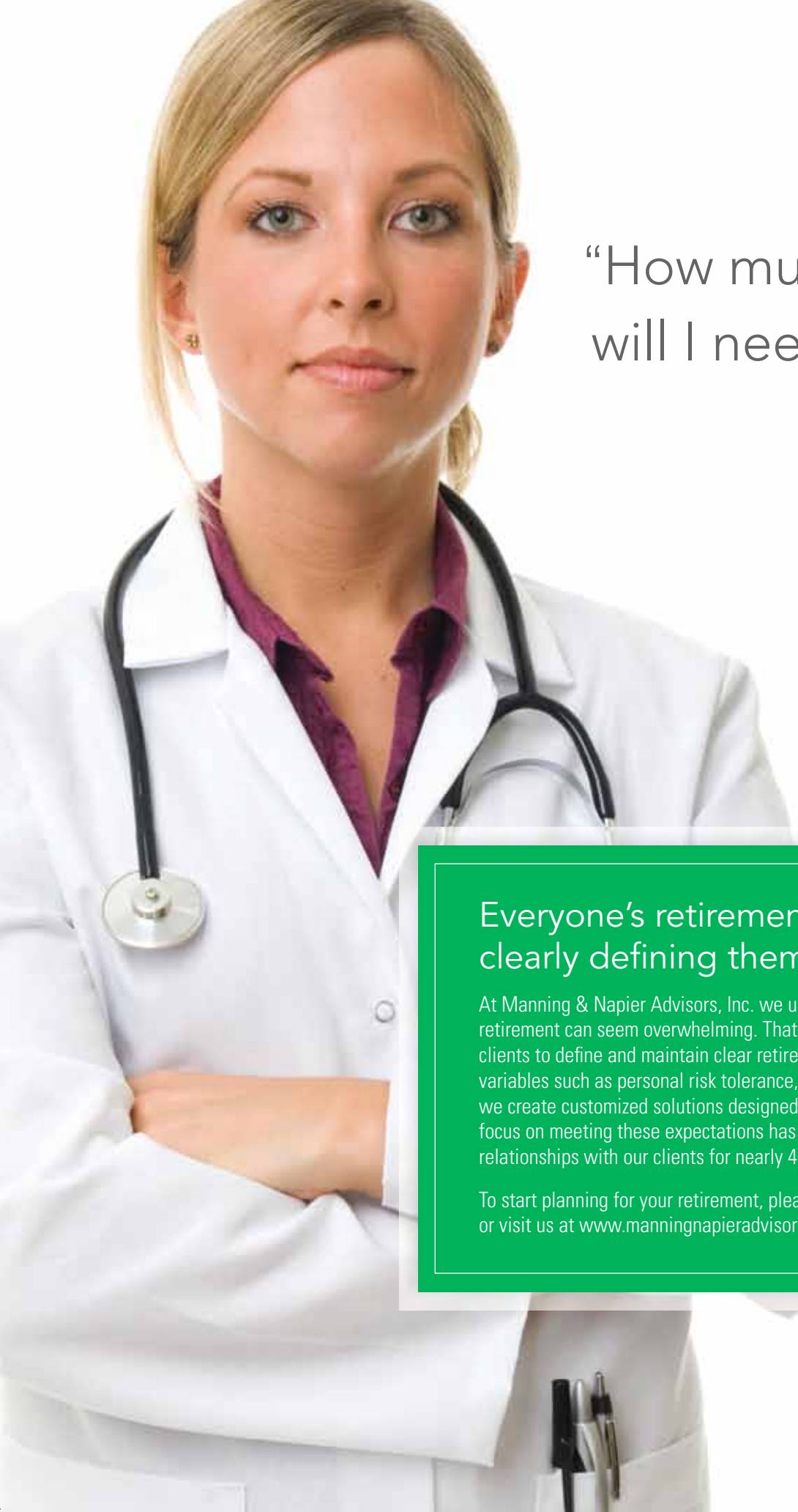
What is the value of the tangible assets? Keep in mind we want *net* values here: the value of the equipment net of payments owed. (Depreciation is a topic for a later time.) This value must be added to the product of the excess earnings and the multiplier described above.

Once these sums are calculated, it becomes relatively straightforward to assign values to the complicated components of a closely held medial practice. Keep in mind, too, that there is more than one way to value such practices: this is just one of them.

If you've deduced that the assumptions and other inputs in practice valuation can require some work, you're absolutely right. For this reason, it's imperative to have someone conversant with the intricacies of medical practice valuation at hand when you get the "sunset itch." Otherwise – wittingly or unwittingly – you just might end up having no prospects for purchase. That is, except for your 41-year-old who's still living at home, spends an unusual amount of time in the tree house in back, and insists on being called "Dragon."

Joel T. Redmond is a senior financial planner for Key Private Bank in Rochester. He is the author of The One-Minute Financial Planner, available at www.amazon.com. He is a native of Central New York.

Note: Opinions, projections or recommendations contained herein are subject to change without notice and not intended as individual financial advice.



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