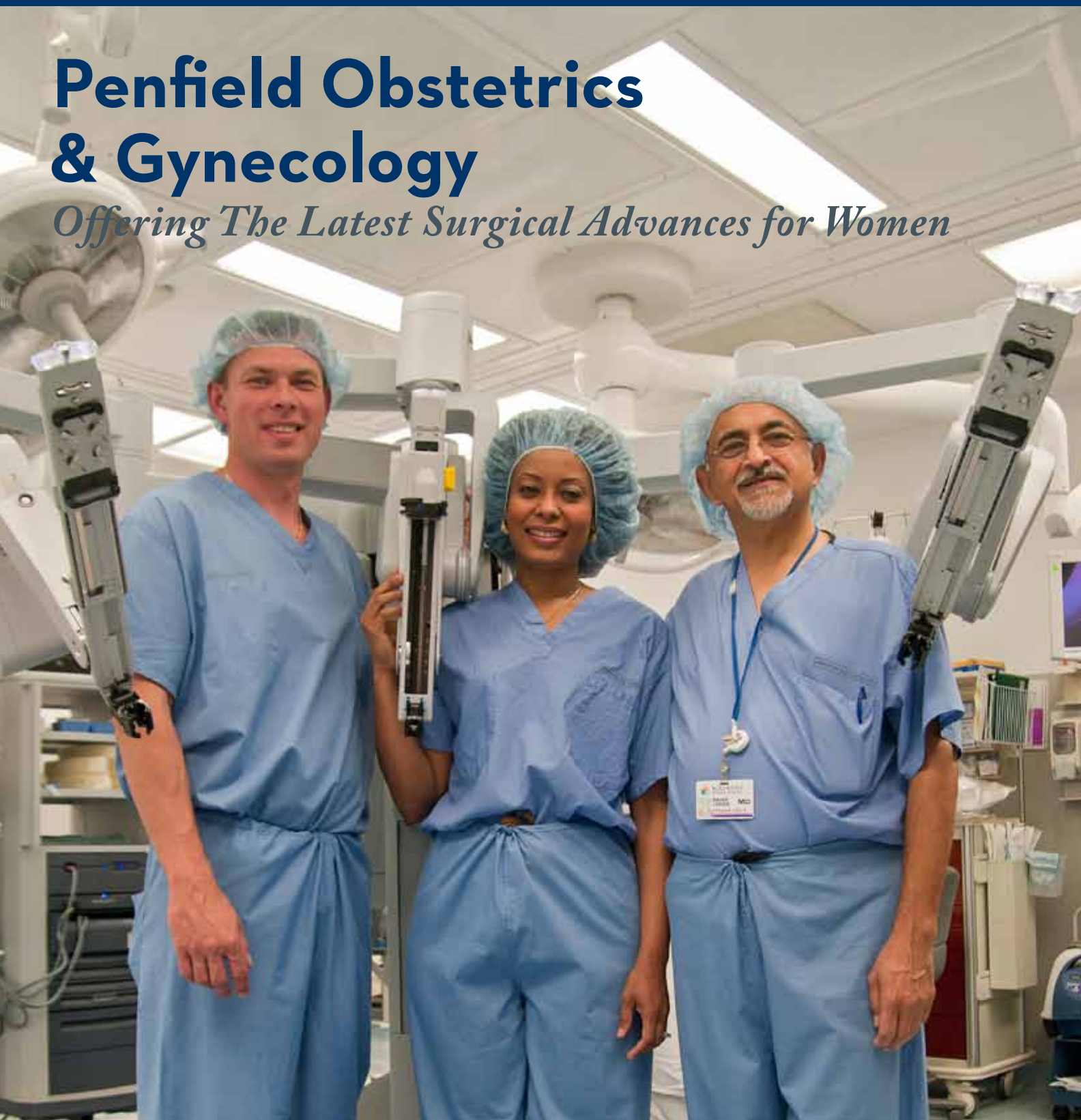
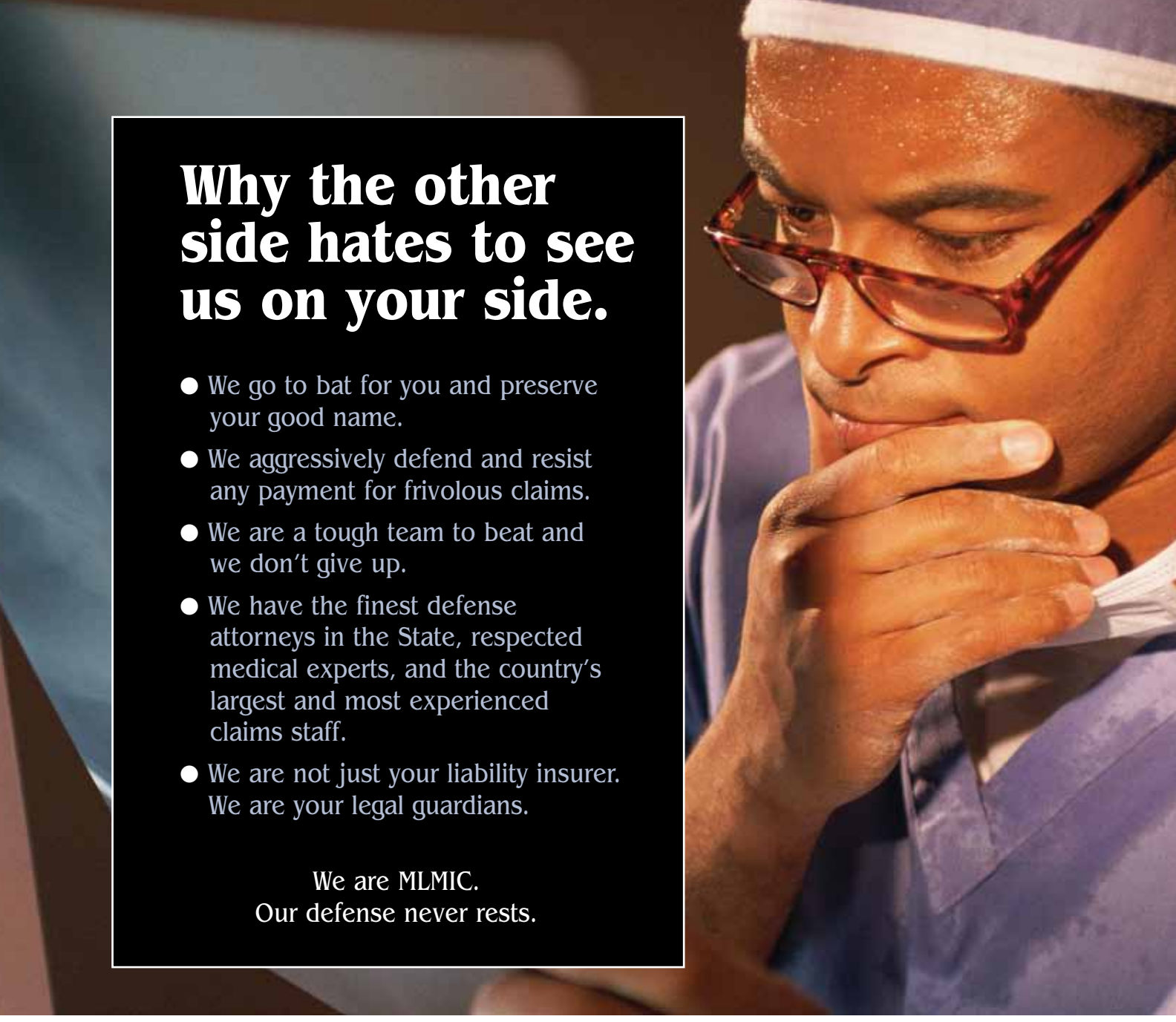
ROCHESTER / JULY 2011

Western New York
PHYSICIAN

Penfield Obstetrics & Gynecology

Offering The Latest Surgical Advances for Women





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In one of the robotic surgical suites at Rochester General Hospital. From left to right: Waldemar Klimek, MD, FACOG, Johann Piquion, MD, MPH, FACOG and Rahul Laroia, MD, FACOG

Welcome to the July Issue

If there were one question I'm asked most often – it is "How do I select the cover stories for Western New York Physician?" There's no easy answer – if you've been one to ask, you might agree, my response often doesn't sum it up definitively.

I meet with many practices and physicians in the region to gain insight – learn about their guiding mission and practice goals – *whether to expand referrals and awareness, share perspective, introduce a new practice or resource to physicians and their patients or educate on the latest innovations.* All of this plays a role in the cover story decision.

What I find most interesting is what makes them unique among their peers. I enjoy the process of "getting to know" the personalities and am intrigued by their lives outside of medicine as it helps to understand them as people and connect. The process tends to have a life all its own - often guiding me to a future story. And so is the case with this issue.

I was curious to learn the stats on how many hysterectomies continue to be performed without the advantage of a robotic approach. I turned to my Medical Advisory Board with questions. Their response led me to the leaders at Penfield OB GYN highlighted in this month's cover story on advanced surgical options for women.

As the role of PCP is poised to play an increasing and vital role in affecting efficiency in the health care delivery system, we meet Dr. Robert L. Smith of Finger Lakes Family Care and learn how this innovative group incorporates Virtual Care tools into his practice under the progressive Medical Home Concept model.

Other supporting clinical articles

Hear from regional urological experts, Drs. Valvo and Madeb, on *Erectile Dysfunction and Cardiovascular Disease*. The growing linkage seen in recent studies between ED and cardiovascular disease suggests a significant opportunity for all physicians to use patient complaints or treatment of ED as an opportunity to detect and prevent cardiovascular disease.

Also in this issue, our medical legal expert, James Szalados, MD, MBA, Esq discusses liability issues regarding *The Physician as Employee* in our *What's My Liability* column. And as private practices continue to operate under increasing competitive pressure, decisions to take on new partners present numerous considerations. Steven Terrigino, a partner and specialized CPA at The Bonadio Group offers perspective in *Bringing a New Partner into Your Practice…A Marriage of Sorts*.

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All the best,
Andrea

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PHYSICIAN

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Erectile Dysfunction and Cardiovascular Disease

John R. Valvo, MD, FACS

Ralph R. Madeb, MD

A 42 year-old male in otherwise good health presents to you with erectile dysfunction (ED). *You should:*

A.) Provide samples of Viagra, Levitra or Cialis.

B.) Send him for psychiatric evaluation.

C.) Encourage him to begin jogging.

D.) Perform a detailed history and physical examination with strong assessment of cardiovascular risk factors.

Cardiovascular disease is the leading cause of death in the United States, accounting for almost 40 percent of all deaths. We are well aware of the traditional risk factors for cardiovascular disease in men. They include high LDL, cholesterol, low LDL, hypertension, diabetes and smoking. However, can ED now also be considered a red flag for early cardiovascular events? Not only can we use ED as a means of detecting cardiovascular disease but can we use ED as a means of preventing cardiovascular disease. Several recent studies indicate a significant increased risk of CVD (cardiovascular disease) occurring within 10 years following the presentation of ED in men between the ages of 40 and 59 (Mayo Clinic Proceedings; 2009; 84(2): 108-113 and JAMA; 2005; 294(23) 2996-3002). While this has been shown to be highly significant in diabetic men it may also be a predictor in non-diabetic men as well.

Age does matter and ED and cardiovascular disease (CVD) frequently coexist equally in older men greater than 70 years of age (Journal of the American college of cardiology; 2008; 51(21) 2040-2044).

While the answer to our above question may seem obvious it may not always be the most expedient. Expectations of healthy middle-aged men may be unrealistic when it comes to diagnosis and treatment of ED. Many think they know why it develops and should be simply treated with medication. The physician needs to educate men as to their normal erectile function and overall good health. That requires understanding of the disease and its' multiple etiologies and convening these in a non-discriminatory way.

CVD and ED share etiologies as well as pathophysiologic

According to a recent survey reported by Reuters.

Almost 70 percent of American men said they find it easier to care for their cars than their personal health.

40 percent said they would be more likely to address issues with their car than their health.

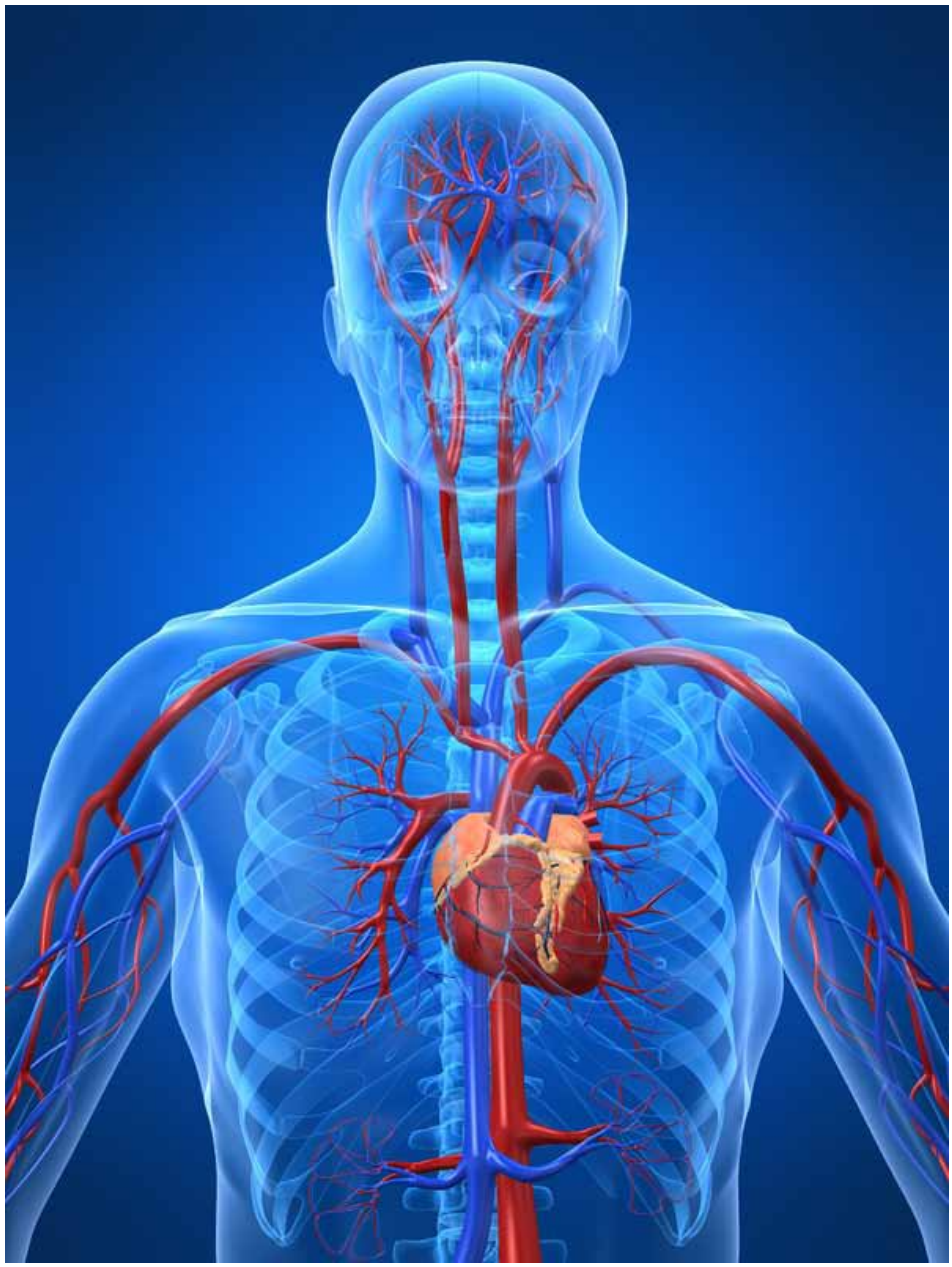
"For many men, tuning up our cars is easier than getting checkups for our health," NASCAR driver Terry Labonte said in a statement.

Labonte, who was named one of NASCAR'S (National Association for Stock Car Auto Racing) top 50 greatest drivers, is a spokesman for a national campaign launched by Men's Health Network and the drug company Abbott Laboratories which both conducted the poll, to encourage men to visit their doctors more often.

The survey of 501 men, aged 45 to 65, and their spouses or partners revealed that 28 percent of men do not visit the doctor regularly, and more than 40 percent of the women questioned said they are worried about their husband's or partner's health.

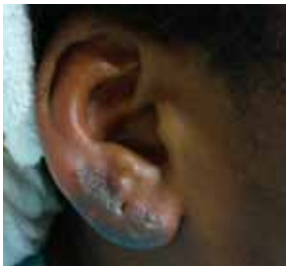
A similar number of women also said they are more concerned about their men's health than their own.

Can ED now also be considered a red flag for early cardiovascular events?



mechanisms that lead to endothelial dysfunction and plaque buildup (see studies mentioned above). Research now shows vascular damage often shows up first in the small penile arteries and is manifested in the form of erectile dysfunction. The penis contains two cylindrical, sponge-like structures that run along the length of the penis. Nerve impulses cause the blood flow to increase to about seven times the normal amount when a man is sexually aroused. Vascular disease can restrict the blood supply to the penis, causing ED. Since the degree of ED coincides with the severity CVD, it has been suggested that ED can be a presenting symptoms to one with occult CVD (European Urology; 2005; 512-518).

Fifty percent of deaths due to coronary artery disease occur in men without a history of the disease. With recent observations that men are not seeking regular medical assessment "unless something is not working right", the most common presenting symptom to a urologist in men age 40 to 59 may be ED. Similarly patients with CVD frequently describe pre-existing ED. Evidence is accumulating that ED and CVD are simply manifestations of a common underlying vascular pathology. Some longitudinal studies have suggested that ED is associated with approximately 80% higher risk of subsequent CVD (Journal of the American college of cardiology; 2008; 51(21) 2040-2044, JAMA; 2005; 294(23) 2996-3002). This can be explained partially by blood vessel size, penile arteries are 1 to 2 mm. in diameter compared to coronary arteries which are 3 to 4 mm. and carotid arteries which are 5 to 7 mm. Smaller arteries plug earlier then the larger ones. Another link is from endothelial dysfunction. Many men exhibit endothelial dysfunction and plaque buildup independent of cardiac status. This would also include inappropriate vaso-constriction in open vessels. The worst that can happen to an impotent young male is a flaccid penis. However, an egregious form of a penile heart attack is a major catastrophic cardiovascular event. We feel strongly, that current day evidence based medicine, mandates an aggressive CVD risk assessment in any male presenting with ED between the ages of 40 to 59.



Contaminated Cocaine Triggers Decaying, Dying Skin

Mary Gail Mercurio, M.D.

Physicians See Looming Public Health Problem with Levamisole, Approved to Treat Worm Infestations in Livestock

If the obvious reasons for avoiding recreational drug use aren't off-putting enough, physicians have yet another detrimental consequence to add to the list – crusty, purplish areas of dead skin that are extremely painful and can open the door to nasty infections.

The condition is called purpura. Typical causes include a range of rare disorders, but it is also associated with the use of cocaine. Not just any cocaine, though: Physicians, researchers and health officials believe cocaine contaminated with a de-worming drug commonly used by veterinarians is the culprit. The drug, called levamisole, was found in 30 percent of confiscated cocaine in 2008 and 70 percent in 2009, according to the U.S. Drug Enforcement Administration.

In the Journal of the American Academy of Dermatology, physicians highlight six new and very similar patient cases of purpura, mostly on and around the ears, following cocaine use. The cases – four seen in Rochester, N.Y., and two in Los Angeles – closely resemble two additional cases in San Francisco that were reported previously in the journal. In each case an extensive battery of blood tests ruled out the usual causes of purpura.

The cases were reported by the University of Rochester Medical Center and the University of California, Los Angeles.

Because testing for traces of levamisole in the blood is complex and unreliable, researchers cannot say for sure that it is the direct cause of purpura in these instances. But, due to the striking similarity of these cases, and the presence of another condition caused by levamisole called agranulocytosis – low blood counts that up the risk of infection – in the majority of the patients, doctors say there is strong reason to suspect the drug and to focus greater attention on what could become a widespread health concern.

"We believe these cases of skin reactions and illnesses linked to contaminated cocaine are just the tip of the iceberg in a looming public health problem posed by levamisole," said the study authors.

According to Mary Gail Mercurio, M.D., an author and associate professor in the Department of Dermatology at the University of Rochester Medical Center, "When we first started seeing these patients they all had a similar clinical picture, but they were really an enigma because they weren't falling into any other pattern we'd seen before. When a colleague at the National Institutes of Health mentioned levamisole contamination, we did toxicity screens and lo-and-behold, all the patients came up positive for cocaine. We had our diagnosis."

Drug enforcement officials have detected levamisole – which was once used to treat colon cancer – in cocaine since 2003, but have watched it increase rapidly in recent years. The Drug Enforcement Administration says that the drug, which is inexpensive, is used more and more as a diluting agent in order to stretch supplies. Study authors report that levamisole is known to increase dopamine, a neurotransmitter that helps control the brain's reward and pleasure centers, causing experts to believe it is also added to cocaine to further enhance or prolong the user's high.

Researchers don't know how levamisole causes purpura, which occurs when vessels become plugged and blood can't flow to the skin, leading to skin death and the resulting purplish, crusty appearance. Cocaine alone constricts blood vessels, which is probably the first step, but how levamisole contributes is not yet understood, Mercurio said.

Both smoking and snorting tainted cocaine can lead to purpura and both men and women can be affected. Treatment options include steroids to prevent inflammation, but stopping the exposure to cocaine is the best medicine: Mercurio and the other study authors observed that once patients stopped using cocaine, the purpura and low blood counts improved.

"We've seen a lot of cases in Rochester alone, so it is important to alert the gatekeepers of medicine, the primary care physicians who are in the trenches every day, of this diagnosis," said Mercurio. "This is one of those entities that with familiarity and recognition can go a long way in helping physicians to quickly make a diagnosis and intervene without embarking on an elaborate workup where nothing will pan out."

Penfield Obstetrics & Gynecology

Offering The Latest Surgical Advances for Women

Julie Van Benthuysen

With one out of every three American women undergoing a hysterectomy by the age of 60 – about 650,000 each year – it's startling that close to 80% of those procedures are still performed as an open abdominal surgery. Yet some physicians are hoping that groundbreaking new surgical procedures in recent years will begin to dramatically improve patient outcomes for millions of women.

Here in the Western New York Region, a progressive team of surgeons at Penfield Obstetrics & Gynecology has been performing robotic gynecologic surgery ever since the FDA approved the da Vinci Robotic System in 2005.

These doctors recognize that while the need for hysterectomies will continue to grow for a variety of conditions like excessive bleeding, fibroids, endometriosis, uterine prolapse, cancer and pre-cancer – they can be achieved in a far less invasive, less painful and inexpensive way. For this reason, they have extensively studied and trained in advanced techniques to provide patients with a far more high-tech, high-touch approach.

The Wonders of Robotic Surgery

Patient Tonye Savage, 36, speaks first-hand about her life-transforming experience with robotic surgery. Extremely frustrated with her gynecologic care, she was referred to Dr. Johann Piquion at Penfield Ob/Gyn by her primary care doctor.

Ms. Savage, who suffered from severe endometriosis since the age of 19, had undergone 15 surgeries within a dozen years' time. "I begged doctors for a hysterectomy for years, but was always refused because of my child-bearing age, and the fact that it wasn't considered a life or death situation," she says. Ms.

Savage also struggled with insurance companies to cover costly shots to ease the pain, and resorted to birth control pills to help regulate the endometriosis so that she wasn't bedridden.

"I loved Dr. Piquion as soon as I met her," she says. After listening to the number of surgeries Ms. Savage had undergone with no success, Dr. Piquion carefully walked her through the available options, insisting there would finally be resolution to her problem. Ultimately, she recommended a hysterectomy with conservation of one ovary because of her young age and to avoid possible hormone therapy down the road. She thoroughly explained the process of robotic surgery.

"We want to offer patients less invasive surgical options with much less pain, risk of infection and scarring, shorter hospital stays and an earlier return to normal daily activities as opposed to a typical 6-8 week recovery," says Dr. Piquion. While laparoscopic surgeons benefit from better visualization of the procedure, drawbacks include two dimensional imaging, and rigid instrumentation with limited dexterity and precision. "It's difficult to perform complex gynecological surgeries and those needing extensive suturing laparoscopically."

"That's where robotic surgery comes in," she says. The da Vinci robotic system has become the standard of care for this procedure. It provides an alternative to traditional open surgery and conventional laparoscopic surgery by enabling the surgeon's hands to control the state-of-the-art robotic system. It provides the advantage of three-dimensional imaging and unparalleled precision and dexterity – magnifying one's view up to 10 times. "We're very pleased with the surgical outcomes."

The Instruments on the da Vinci robot are designed to provide surgeons with natural dexterity and full range of motion for precise operation through tiny incisions.

Thanks to recent advances in da Vinci robotic surgery instrumentation and technique, advanced endometriosis surgery has become much more precise. Using high-definition binocular lenses allows surgeons an almost microscopic view with

In April, Ms. Savage underwent robotic surgery under Dr. Piquion's expert direction. "The entire crew was just phenomenal," she says. "I was scheduled for surgery at noon and actually went in early. Dr. Piquion doesn't mess around."

Within a day post-op, Ms. Savage says she felt great, getting out of bed and taking a shower with no assistance. With such a short recovery time, she was anxious to get back within days. Several months post-op, Ms. Savage says she feels like a new person. "What an amazing difference. Dr. Piquion is the only ob/gyn I ever hope to have." instruments that enable them to elevate lesions for easy excision. The daVinci robotic surgi-

cal system enhances the surgeon's ability to remotely perform fine motor skills such as intricate dissections and intracorporeal suturing – sparing of nerves and surrounding structures to all patients.

Taking the Lead in Robotics

Surgical robotics has taken minimally-invasive surgery to a whole new level in the gynecological realm, say the surgeons, and they are working hard to make it catch on. Only six years ago, robotic surgery for women's conditions was unheard of in the region. After da Vinci robotics was FDA-approved for urological surgery in 2000, the doctors at Penfield Ob/Gyn took a look at its value and the opportunity to improve their surgical skills. Within a year, they underwent formal training, with Dr. Piquion and Dr. Laroia performing the practice's first case of robotic surgery and one of the Northeast's firsts for benign gynecological procedures.

"Having already been trained in laparoscopic surgery, the learning curve wasn't as long and it was an easier transition to robotics," she says. Dr. Piquion and Dr. Laroia were also the region's first to perform a robotic hysterectomy and removal of ovaries. For two years, Penfield Ob/Gyn was the only regional practice performing this advanced technique.

In a six year span since that first milestone, Dr. Piquion and her partners Dr. Rahul Laroia and Dr. Waldemar Klimek have collectively handled close to 600 robotic surgeries, from hysterectomy to vaginal reconstructive surgery to removal of severe adhesions – with a close to zero major complication rate. "In that time, only one case resulted in an open surgery," says Dr. Laroia, who has been with the practice for 12 years. Both Dr. Piquion and Dr. Klimek completed their residencies under Dr. Laroia's guidance while he served on the faculty at RGH.

"Both are outstanding physicians and surgeons," he says. "Dr. Piquion is one of finest robotic surgeons around," says Dr. Laroia. "Considering all the training and conferences in which I've participated, she is amongst the finest I've seen."

Referring physician Dr. Peter Kouides, who has been practicing hematology, oncology and internal medicine in Rochester for the past 25 years, agrees. "Both Dr. Piquion and Dr. Rahul Laroia have been pioneers in this field locally. "Theirexpertise is much appreciated in managing women with uterine and menstrual disorders who may benefit from less invasive surgery, with less bleeding risk from a hematologist's perspective."

The doctors have also trained several other surgeons locally and around the state on the da Vinci robotic system and incontinence surgery. "As physicians, we're constantly researching new ways to provide our patients with the most advanced expert healthcare possible," says Dr. Klimek. Handling three to four major cases a day, the doctors are thrilled to send many of their patients home in typically less than an overnight stay. Recently, one of their patients ran a three- mile race just three days after a robotic hysterectomy.

Pelvic Organ Prolapse and Urinary Incontinence

Another major area where robotics is benefiting patients is Pelvic Organ Prolapse and Urinary Incontinence (UI)– a condition with numerous causes including heredity, childbirth, weakening of the pelvic floor and menopause. While UI affects millions of American women, only about 10% of those with UI get the help they need. Urinary Incontinence is a huge quality

of life issue, which can truly take over someone's life. Patients lose out on family time, and it can lead to sexual inhibitions as well.

"This condition isn't normal and shouldn't to be taken lightly," says Dr. Laroia. The doctors have found that since many patients are reluctant to discuss their condition even during a routine exam, they're encouraged to complete a pre- exam form identifying any troubling issues. "Many of patients thank me for the opportunity to talk about UI and for putting their mind at ease."

Since the first step in addressing UI is for patients to actually talk to a physician, the doctors are greatly appreciative of area primary care doctors who initiate those delicate conversations. Numerous PCPs continue to refer their patients to the practice, keenly aware of its reputation for addressing UI in a sensitive yet progressive way. "It's grossly unfair for a woman to suffer for lack of awareness and because she's embarrassed. It's so important that we take the time with our patients," he says.

Dr. Katherine Lammers, FACOG, in private practice at Greece Ob/Gyn for 20 years, speaks highly of her relationship with the doctors. "They're all very dedicated physicians," she says. "We have a warm collegial relationship, which makes referring patients very easy." "I can be sure my patients are in excellent hands and will be treated with skill and kindness, after which they return to us happy with their surgical experience.

"When hysterectomy is necessary; the demonstrated safety, efficacy, and cost-effectiveness of vaginal hysterectomy and laparoscopic hysterectomy mandate that they be the procedure of choice."

"Surgeons without the requisite training and skills required for the safe performance of VH or LH should enlist the aid of colleagues who do or should refer patients requiring hysterectomy to such individuals for their surgical care."

Source: AAGL Position Statement:
Route of Hysterectomy to Treat Benign Uterine Disease

For the doctors, evaluating each patient thoroughly to determine what will work best is standard operating procedure. "We try to avoid the unproven benefits of certain techniques and focus on improving the skills we have." Treatment options include simple behavioral techniques, medications, or ultimately, surgery to improve bladder control. "Urinary Incontinence is not normal for any age group and is treatable for all ages," says Dr. Laroia.

A robotic approach has resulted in numerous success stories. The team has become experts at addressing UI largely by surgically inserting pelvic slings with a 90-95% success rate. Per-

formed as an outpatient procedure, patients incur a one-time cost as opposed to the long-term costs associated with adult diapers an $8 billion industry.

This approach applies to Pelvic Reconstructive Surgery as well. Dr. Laroia feels better results with less complication are achieved by using the patient's own tissue for Pelvic Reconstruction. The use of large meshes in the vagina have been associated with 10-20% of complications like erosion, pain and bleeding, without significantly improving the reoccurring rate of pelvic organ prolapse.

Performing robotic-assisted sacrocolpepexy for uterine or vaginal vault prolapse results in only a few small incisions to insert the mesh that holds pelvic floor organs in place – but is equally as effective as an open procedure. "It's better cosmetically, and it's done with far less pain or blood loss for the patient."

The physicians at Penfield Obstetrics and Gynecology are dedicated to providing expert healthcare for a lifetime of changing needs.

Optimizing Hospital Time

The efficiency of robotic and minimally-invasive surgeries means the team at Penfield Ob/Gyn has optimal time with patients within the hospital setting. "We have to put the welfare of patients first. Their satisfaction is critical."

"Much credit goes to the professionals in RGH's Operating Room. Within 15 minutes, its amazing staff can transition from one surgery to the next, which ranks far above the national average for efficiency," says Dr. Laroia. With an exemplary team approach, its reputation within the hospital setting remains strong and steady. "Our colleagues at RGH know that we blend well, despite our different personalities. We all think alike and staff there feels they have a partnership with us," adds Dr. Klimek.

"We have to put the welfare of patients first. Their satisfaction is critical."

Promising Future of Women's Health

In Penfield Ob/Gyn's 35 years serving area patients, its mission to expand and advance the field has never wavered. As the practice moves forward, robotic and minimally invasive procedures will keep these busy surgeons at the forefront of women's health. In fact, industry projections suggest that robotic-assisted hysterectomies may eventually become more commonplace than robotic-assisted radical prostatectomies, now the most common performed using the da Vinci Robotic Surgical System.

"Over the years, we've found that women want expert obstetric and gynecologic care provided with respect and with an opportunity to reach personal goals in their own health and well being," says Dr. Laroia. "That's why we really try to educate our patients about robotic-assisted surgery so they recognize all the benefits to be achieved from such a minimally invasive procedure. In our minds, it represents the future for women's surgical care."

"Patients need to be offered all the options," adds Dr. Piquion. "Our hope is that our Primary Care colleagues will become more comfortable with what is available for the patient. There's no question of the great promise robotics has on a woman's health and quality of life."

Weedkilling

And Uterine Atery Embolization

Raj Pyne, MD

Uterine artery embolization, or UAE, is a minimally invasive procedure performed by interventional radiologists that treats all fibroids present in a symptomatic uterus, regardless of number or location. A microcatheter is advanced under fluoroscopic guidance into the uterine artery and tiny particles are injected, which are preferentially taken up by parasitic, hypervascular fibroids and cause occlusion at the terminal arteriole level. The uterus does not become ischemic due to rich collateral blood supply. The procedure usually takes less than hour, is performed with conscious sedation rather than general anesthesia, and is done as an outpatient procedure or as an overnight observation. Moreover, the recovery time is short and the success rate at improving symptoms is outstanding.

Imagine you have a beautiful flower garden. Now imagine that tiny weeds start growing in the middle of that garden. A small patch may not cause much trouble, and may even go unnoticed. But as years go by, with roots spread out, those pesky weeds now steal water, sunlight, and nutrients from other plants, and completely disrupt the balance of the garden. So what can you do about those parasitic weeds? For a single patch, simply pulling them out may be your answer - just be sure to get all the way down to the roots, otherwise regrowth is a possibility. On the other hand, if the weed situation is so catastrophic, maybe pulling out the whole garden is the answer. But what about a less invasive means to eradicate them, such as a substance taken up selectively by the weeds (rather than the flowers) that then kills them? Certain herbicides are specifically known as weed killers while not harming surrounding plants.

The parallel of the effects of weeds on a garden to fibroids in a uterus are uncanny. Fibroids, or leiomyomas, are benign tumors that are the most common pelvic tumor in women. They are exceedingly common in women over 35, with up to 50% of all women in this age range having them, and are especially prevalent in African-American women. Classic symptoms arise from either effects on the endometrium or mass effect on adjacent organs. Fibroids are hormonally driven, and therefore grow rapidly during pregnancy, and conversely may involute at menopause.

Typically, only 10-20% of fibroids become large enough to cause symptoms that require treatment. However, that still amounts to 5-10% of all women, many of whom do not realize the etiology of these relatively nonspecific symptoms. There are multiple treatment options for fibroids. If amenable by size and location, surgically resecting an accessible fibroid with myomectomy may be optimal as it leaves the remainder of the uterus intact. For a fibroid uterus causing severe symptoms, many women choose hysterectomy as the 'be all end all' treatment. In fact, uterine fibroids are the most frequent indication for hysterectomy in premenopausal women; of the 600,000 hysterectomies performed annually in this country, one-third are due to fibroids. Other hormone-based options also exist and include hormone therapy to reduce fibroid burden versus waiting for menopause to naturally decrease hormone levels.

Fibroid Symptoms

- menorraghia
- pelvic pressure
- bloating constipation
- urinary frequency
- dyspareunia
- infertility

Finally, there is the medical version of weed killing, a relatively new option over the past 20 years, called uterine artery embolization. Theoretically, the UAE concept is similar to killing weeds. Instead of introducing a substance into the water supply of the garden that is preferentially taken up only by weeds and which is toxic to them, small particles measuring 500-700 microns are injected into the uterine blood supply which are preferentially taken up by the neovascularity of the parasitic, hypervascular fibroids and which ultimately kills their blood supply. Although some particles travel towards normal uterine musculature, the uterus will not become ischemic due to rich collateral blood supply.

The origins of UAE came about after a French gynecologist sought an interventionalist to embolize the uterine arteries of patients prior to their hysterectomies to minimize intraoperative bleeding. Soon, the gynecologist started to note that these patients were canceling their hysterectomies weeks before their surgeries as their symptoms were suddenly abating. Follow-up evaluations demonstrated the fibroids were decreased in size but the uterus was unharmed. Thus, minimally invasive fibroid intervention was born.

For many women, UAE is an alternative to hysterectomy, but does not preclude possible need for future hysterectomy. However, with success rates at improving symptoms routinely shown up to 94%, UAE has become a mainstay of fibroid treatment. The effect of UAE on fertility have long been questioned; although it has clearly been seen that many women preserve their fertility and have children after UAE, there have been no scientific studies proving this and therefore informed consent with the patient is a must. However, fibroids themselves are a cause of infertility in younger women and hysterectomy obviously eliminates any chance of preserving fertility, thus making UAE a viable option for many women of reproductive age.

UAE Summary

- treats all fibroids in uterus
- uses minimally invasive catheterization (no surgical incision)
- done as outpatient or overnight observation
- uses conscious sedation (no general anesthesia)
- quick recovery time
- up to 94% success rate at improving symptoms

In sum, UAE is now a commonly utilized minimally invasive treatment in the arsenal for combating uterine fibroids. It is increasingly becoming an outpatient procedure, it has a short recovery time, and the success rates are outstanding. If only weed killing were so simple.

Dr. Raj Pyne is an interventional radiologist at Rochester Radiology Associates and is also on staff at Rochester General Hospital. He is board certified in Diagnostic Radiology with subspecialty board certification in Vascular and Interventional Radiology. He completed his fellowship in Vascular and Interventional Radiology at Brigham and Women's Hospital/Harvard Medical School. He performs a host of minimally invasive interventional procedures, specializing in UAE as well as interventional oncology, vascular malformations, and varicose vein ablations.

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Sleep Medicine
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Special Columns

Healthcare Reform Update
Invited experts offer perspective on the impact of healthcare reform – what it means, what it might cost, and the impact to the healthcare system and patients in western New York.

Primary Care Perspective
A forum created to share insights from the physicians who deliver primary care to area patients.

Medical Innovation
Learn about the latest developments in technology to improve practice management, patient care and the delivery of medicine.

Electronic Health Records
Area experts and practitioners share valuable expertise in managing the implementation process, avoiding pitfalls and guiding your practice into the through the transition.

Business Continuity Planning (BCP) for Medical Practices

Cheryl Nelan, President,
CMIT Solutions of Monroe

BCP is the blueprint for how organizations plan to survive everything from local equipment failure to global disaster. Data-oriented BCP, an indispensable component of practice planning regardless of the organization's size, poses many challenges. Smaller practices generally lack the in-house IT resources necessary to implement BCP because of the demanding planning and technical processes required. Therefore, many practices either neglect to implement any data-oriented business continuity plan or else approach data backup and recovery in a sporadic, rudimentary fashion that fails to conform to the best practices of BCP.

Understanding the risks of not having a plan in place:

- Adhering to Regulatory Compliance requirements, such as the Healthcare Insurance Portability and Accountability Act (HIPAA).
- Knowing how to mitigate the risk of losing vital practice data, such as patient records.
- Being aware of the environmental hazards that the infrastructure is exposed to in your geographical location.
- Estimating time it would take to build the practice back if disaster strikes without having any BCP in place.
- Calculating Return On Investment (ROI) for having a BCP in place.

Technical Challenges:

- Identifying the lowest-cost, highest-performance data solution while keeping abreast with the latest trends in the industry.
- Ensuring that all backed-up data is encrypted and otherwise safeguarded from theft.
- Knowing that backed-up data can be restored to different kinds of hardware.
- Ensuring that data backup continues even during active recovery phases.

Operational Challenges:

- Identifying what data to back up.
- Identifying how frequently to back up and related costs and ROI.
- Retaining the ability to recover not only the most recent data,but also archived and older data from past quarters and years.
- Retaining the ability to monitor and manage the integrity of ongoing data backup processes so that backup failures can be diagnosed and remedied before adversely impacting the BCP lifecycle.
- Hiring staff who can understand, design, implement and keep a BCP running 24/7 and who will be available when disaster strikes, night or day, to get the practice back up and running.

Traditional Solution vs. Emerging Technology

In talking with practice managers, the first reaction is typically – "Yes, we back up our data." But, when asked questions like how often, to what medium, is it encrypted, have you ever tested a recovery, do you have offsite back-up, etc.... There's often a wide-eyed expression and the answer "I don't know."

The first step in implementing a data-oriented BCP strategy is a full assessment to understand the current situation and risks to the practice. Here in Western NY, environmental disas-

ters are rare but practices can still be affected by theft, employee-error, hardware failure, fire or other potential data catastrophes. Recognizing this and determining how long a practice can survive until it gets its data back and computer systems running is a key element to determine the plan to be put in place. Knowledge of the type of data stored (and how much) and the systems currently in place, help determine the best course of action.

Once the plan is developed and implemented, it is important to document it and test it. Too many times, practices believe they are protected and their data is safe and recoverable until disaster strikes. Then, they realize they don't even know how to retrieve their data and reset their systems. Is there a fully documented plan so that anyone with access to the plan could get the practice up and running again? Then, test, test, test... Is the data fully recoverable? How long does it take to get up and running? What level of risk can the practice take while still operating after a data loss?

For those practices that are unable to invest in the human expertise and infrastructure support systems necessary for data-oriented BCP, there are outsourcing options like CMIT Solutions available. These firms enable practices to leverage their data backup and recovery solutions, while removing cost and complexity burdens from their staff. With the peace of mind that their data is protected and accessible, practice managers and physicians can focus on their patients and the growth of their practice.

Advertiser Index

What is My Liability?

The Physician as Employee

James E. Szalados, MD, MBA, Esq.

Issue

In ever-increasing numbers, physicians are choosing to be employed by hospitals or health systems. The reasons physicians elect to become employees varies, ranging from an increased healthcare focus on integrated delivery models to the increasingly rigorous regulatory and administrative responsibilities associated with private practice..

Legally, an “employee” is defined by Black's Law Dictionary as "a person in the service of another under any contract of hire, express or implied, oral or written, where the employer has the power or right to control and direct the employee in the material details of how the work is to be performed." In contrast, an "independent contractor" is one who, "in the exercise of an independent employment, contracts to do a piece of work according to his own methods and is subject to his employer's control only as to the end product or final result of his work." The key distinction between “employee” and “independent contractor” lies in the degree of control that the employer exercises, and, that distinction forms the basis for a generous amount of employment law litigation. It is generally considered a red flag when a physician who is expecting to be hired as employee receives a contract specifying that he or she will work as an ‘independent contractor’. Special regulations and prohibitions apply to independent contractors which may expose both parties to substantial IRS and also fraud and abuse penalties. Also, employment status can have significant ramifications on shared liability in event of a medical malpractice suit.

In general, the right to contract, to provide services not prohibited by law, is upheld by the courts. Contracts define the rights and obligations of the parties and, before signing a contract, both parties should identify the financial and personal goals which are important to them. Contracts also allocate risk, and the courts will assume that the parties entered into the contractual agreement willingly and knowingly. A good employment agreement will typically balance the interests of both the employer and employee. Practitioners should carefully consider their expectations and obligations, and also be fully aware of any undue risk exposure before the final contract is signed; and the contract should be carefully scrutinized with the help of legal counsel. Physicians considering contracting as employees should consider every contract presented to them by the employer as a draft, and be prepared to negotiate material clauses which are unfavorable to their interests. It is important to realize that even pre-contract negotiation letters may constitute a ‘letter of intent’ and therefore be contractually binding.

Employees are subject to a variety of contractual nuances which must be understood at the onset of an employment relationship. The “at-will employment” doctrine generally states that an employee can be terminated at will and without liability, provided that the contract did not specify a definite term, and provided that collective bargaining or other due process considerations do not apply. Thus, for example, a contract which includes a clause requiring a 90 day notice for termination of the contract, without cause, by either party, is actually a 90 day

renewable contract. Termination provisions typically fall into one of two types: 'for cause' provisions which allow termination for specific good reason causes such as loss of prescribing privileges or inability to meet patient care obligations; and 'without cause' termination clauses which allow contract termination at any time, for no specific reason, by providing due written notice.

The due process protections inherent in medical staff bylaws should never be contractually waived in physician employment agreements. Moreover, employment contingent upon medical staff privileges provides a level of protection in the event that the employment relationship concludes or is terminated. Physicians are therefore strongly advised to be familiar with the medical staff bylaws which are in effect in the hospital at which they are to be employed. The converse, where medical staff privileges are contingent upon employment, leaves a physician with minimal legal recourse when the employment relationship concludes or is terminated.

"Physicians who sell their practice to a tax-exempt hospital may see their compensation substantially reduced"

When a physician is in private individual or group practice, an entrepreneurial physician's compensation is derived from a number of sources including salary, bonus, personally performed services, personally supervised ("incident to") services, ancillary services, and return on ownership interest. Physicians who sell their practice to a tax-exempt hospital may see their compensation substantially reduced; partly because the hospital assumes financial risk and management obligations, and partly because Stark Law requires that contracted services be compensated at 'fair market value', 'commercial reasonableness', and that the compensation 'not be based on the volume or value of referrals'. The Anti-kickback Statute represents an additional consideration, although it is less likely to pertain where a bona fide employment contract exists. Another area of financial risk potentially faced by physicians selling their practice to a hospital and becoming employees is that of permanently and irreversibly relinquishing control of patient records, which represent a career of practice development. In the event that the employment relationship does not work out favorably, physicians can lose their patient base, and may even be barred, through contractual non- compete clauses and/or confidentiality clauses, from reestablishing their practices within that particular geographic area.

Nevertheless, classification as an "employee" is associated with potential protections and benefits. Hospital employment can eliminate concerns about the financial viability of a private medical practice. In addition, the law imposes obligations on employers with respect to protecting the rights of employees, for example: employers are required to pay an employer's share, and withhold the employee's share, of employment taxes, such as those mandated by the Federal Insurance Contributions Act (FICA) which funds Social Security; the Fair Labor Standards Act (FLSA) mandates minimum and overtime wages; Title VII of the Civil Rights Act, the Americans with Disabilities Act (ADA), and the Age Discrimination in Employment Act (ADEA) prohibit discrimination; Employment Retirement Security Act (ERISA) defines qualified employee benefit plans; and, the Family and Medical Leave Act (FMLA) addressees unpaid leave. It is important to note that some benefits will be contractually stipulated where as others may be mandated by law. Employers may, at their discretion, also offer a wide range of benefits to employees. Thus, physicians who choose to become employees, after careful consideration of available options and the prospective employment contract, may be able to achieve a desired balance of compensation and lifestyle.

"In the event that the employment relationship does not work out favorably, physicians can lose their patient base"

Bringing a New Partner into Your Practice... *A Marriage of Sorts*

Steven M. Terrigino, CPA

"All marriages are happy.
It's trying to live together afterwards that causes all the problems." ~ Anonymous

While the above anonymous quote is a bit comical, it also has merit as statistically the divorce rate in the United States has climbed to nearly fifty percent. Bringing on an additional partner may be easily paralleled to a marriage. If approached properly, the more likely your practice will not have to "divorce" one of your partners.

Many practices would like to bring on additional partners for several reasons. The rationale perhaps are to enhance financial results by sharing expenses or resources, reducing on-call time, or even offering additional services to patients. These motivations have generally all proven to be sound business factors in wanting to admit a new partner. As enticing as these motivations are, prior to doing so, some crucial steps should be followed.

When a sole practitioner or physician group decides to bring on a new partner, the process can easily be compared to the steps transpiring before a marriage. These three steps or phases include the dating phase, the engagement phase and ultimately, the marriage.

During the first stage, which can be compared to the dating stage, the existing partners of the practice search for a potential candidate to join them. During this time period, the physician may be hired by the group as an employee. This phase allows everyone the ability to see if there are commonality of interests, philosophies and most importantly, to see how personalities will work together. Each physician group has their own culture and it is necessary to make sure that there will be a fit. To help the success rate of this process, it is generally advisable to have an employment agreement in place. This agreement should clearly outline the expectations of the employed physician, what their compensation and perhaps bonus arrangement will be as well as the responsibilities of the practice to the employee. Moreover, the agreement may also define the next step or time frame when the employed physician may be considered for partnership. When expectations are clearly outlined in advance, there is less of a chance that later "events" would be subject to interpretation.

Presuming the first stage went well, the next stage of bringing on a partner can be compared to the engagement stage. During this stage, while the physician remains an employee, there may be more financial incentives offered. Generally, this can be accomplished through higher compensation, bonuses, and/or pension contributions. Moreover, the employed physician begins to be treated as a partner in other respects. This may be accomplished by including them in partner meetings and allowing them to share

their opinions during decision making processes. This allows the group to continue to evaluate the individual on a different level and again determine if synergies exist. During this stage it may also be important to begin to share more financial information and operational metrics with the prospective candidate. Again, it is advisable to maintain an employment agreement as well as update it for any new agreed upon arrangements.

The final process is the admission or "marriage" to the partnership. This stage is the result of a few years of assessment by each party to make sure there are good synergies and thus high prospects for long term success. While it is relatively easy to form a partnership, it can become very difficult and expensive to break one up. Therefore, I caution you: if the "dating" and/or "engagement" stage, did not go well, do not go thru with the marriage! The most critical aspect of the marriage stage is to have a signed partnership agreement in place. This agreement should clearly define every aspect of a practice's operations both known and unknown. This will include the profit allocation methodology, buy-in amounts, what happens in the event of death, disability, retirement or voluntary withdrawal, as well as management structure just to name a few. In my years of practice, I have assisted with several successful partner admissions and fortunately, just a few break ups. Again, to reiterate it is much easier to bring on a partner whereas it becomes very costly and time consuming to break up with one.

In summary, if the necessary time is taken to evaluate a potential partner, the greater the chances for success. I have assisted many practices in bringing on new partners from both a financial modeling and valuation standpoint as well as assisting with reviewing employment and partnership agreements. Assuring the financial viability of the admission of a new partner is extremely important. However, knowing that a synergistic relationship exits today and having the confidence it will exist well into the future..... priceless.

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

Re-examining The Exam Room Environment

Tele-Health at Finger Lakes Family Care

Julie Van Benthuysen

Imagine you're on vacation and have contracted a nasty case of poison ivy. You're hundreds of miles from your primary care physician, it's after hours, and the nearest Urgent Care facility is 30 miles away. You text your doctor with a photograph of the rash and a description of your symptoms. Within minutes, a prescription has been electronically prescribed into the pharmacy nearest your hotel.

Thanks to a progressive primary care group in Canandaigua, NY, Finger Lakes Family Care, situations like these are becoming more commonplace for patients with a host of non-life threatening conditions. No longer does a patient require a traditional office visit in an exam room when a problem like poison ivy can be evaluated and treated via smartphone, computer, or even iPad.

As an early embracer of a new model for Primary Care called the Patient Centered Medical Home, doctors at Finger Lakes Family Care have been using Virtual Care tools for the past several years to help patients receive care outside of the traditional and somewhat antiquated realm of office visits. The Medical Home Model is based on the idea of patient-centered care and proactive chronic disease management – an approach that has proven to result in higher quality, more cost effective care with more long-term positive outcomes.

Finger Lakes Family Care is one of seven regional practices following this innovative Medical Home model as part of the Rochester Medical Home Initiative's pilot project. The practice has been awarded a Level 3 Recognition by the National Committee for Quality Assurance (NCQA) as a Physician Practice Connections® - Patient Centered Medical HomeTM. The PPC-PCMH standards emphasize the use of systematic, patient-centered, coordinated care that supports access, communication, and patient involvement. Regional insurance companies Blue Cross/ Blue Shield and MVP strongly support the initiative and are reimbursing these groups to test the concept.

Robert L. Smith, M.D.

"So many patient interactions can be handled via email, secure chat instant messaging, telephone and even videoconferencing," says Dr. Robert L. Smith, who founded Finger Lakes Family Care five years ago with a commitment to combining old-fashioned values and compassionate healthcare with state-of-the-art medical technology.

Finger Lakes Family Care is aggressively exploring options for Virtual Care within the Finger Lakes Region and has begun discussions with local hospitals to create a Virtual Care network. "We want to build a robust, affordable communication platform independent of various technology infrastructures that patients, physicians, hospitals and insurance companies use in the course of their own daily workflow."

Medical Home Concept Explained

"Our mission as a Patient-Centered Medical Home consists of combining the fundamentals of access to care, meaningful use of electronic health records, and care management of chronic diseases and preventive screening services," says Dr. Smith. With

Dr. Rob Smith consulting with Dr. Barbash in Bethesda, MD from his office in Canandaigua.

insurance company support, Dr. Smith and his collaborators in the Medical Home model hope to ensure a better way for doctors to be properly reimbursed for the services they provide, but in a manner most cost-effective to all parties involved. This would mean insurance provides extra payment, per member per month, for things handled "behind the scenes," from referrals to coordinating special care. Currently, e-health consults and virtual visits are not reimbursed.

While it's important to see patients in the office for a physical exam, many other patient interactions can be handled more efficiently and cost effectively without that visit. "Unfortunately, the only way I am reimbursed for my services is if I see a patient face to face," he says. "I would rather treat certain visit types by phone or conduct an online meeting, but insurance companies do not pay for emails or phone conversations," he says. "We're looking for an all-inclusive change to the insurance model – a system that pays for care through a set amount for taking care of someone whether you see them face to face in the office or through newer technologies including virtual care."

Dr. Smith and his collaborators hope that if this Medical Home model takes off, they will have far more leeway in how they practice care. The technology costs next to nothing, but it's a better way of handling care in their minds. "We're not practicing the kind of tele-medicine where a robot is actually coming down the hallway," he says. "Those patients still have to physically go somewhere to "see" their doctor for a consultation, and the units are expensive." His goal is to genericize the whole process, by bringing it down to the small office level, to the patient's home or workplace.

Within its Proactive Chronic Disease Management component, Dr. Smith foresees Virtual Care as the most effective way for patients to stay healthy. By monitoring their condition in a more interactive way, at the patient's convenience, diabetics are more likely to follow their health regimen. Part of the project concentrates on reducing admission and readmission rates for patients, and the seven practices involved in the pilot already show numbers better than the Rochester community at large.

Entrepreneurial Approach

When Dr. Smith opened Finger Lakes Family Care in 2006, he knew he wanted a better practice model. His work as a consultant with other practices moving toward Virtual Care helped launch his own initiative. He is the Chief Medical Officer for Apractis Solutions, LLC and co-founder of NowDox, a service supporting virtual care based on its mission of enabling a new "eco-system" of healthcare based on practical collaboration.

"Doctors like Dr. Smith who think outside the box are the ones allowing advancement of healthcare in more cost-effective manner," says Dr. Ralph Madeb, Director of the Department of Telemedicine at Rochester General Hospital (RGH) and Newark Wayne Hospital. "It takes dedication and ingenuity for a program like this to succeed.

In addition to his collaborative efforts with RGH, Dr. Smith works closely with colleague Dr. Andrew Barbash, Chief of Neurosciences at Holy Cross Hospital in Silver Spring, Maryland, whose video-conferencing project there is connecting doctors and patients at any hour in various locations without investing a lot of capital in equipment.

These doctors are pioneering new technology for patients, their families and other specialists by creating an experience as if they are all in the same room. Using affordable video conferencing tools, doctors can oversee the ICU while in a meeting, videochat with patients and consult with specialists around the country, review test results on the same high-definition videoconference screen. In essence, they're recreating the exam room environment virtually while still maintaining connected relationships with their patients.

"The use of telecommunications in health care has been widely accepted by patients, as we've seen in our own program at RGH. This is yet another tool in the same kit," says Dr. Madeb. "We look forward to working with Dr. Smith to advance tele-medicine in our region. I feel the same benefits we've seen with less utilization costs, time, ER services and loss of patient income will be seen in his program as well."

Patients Embrace New Way of Care

Patient Kerry Johnson has been an early embracer. "One of the best things about using tele- medicine is the way Dr. Smith and his staff are available to us at any time, especially when the office isn't normally open," she says. "Dr. Smith has been able to accurately diagnose and treat acute illnesses this way, saving us the time and trouble of an office visit with a sick, anxious child."

She also appreciates his interest in the latest technology to ensure everyone stays well and informed. "I really love the practice's Facebook page, which keeps me in the loop with interesting and useful health and wellness information and important reminders about regular health maintenance like flu shot clinics."

Finger Lakes Family Care's Patient Portal allows for secure, online access to a patient's medical records, and online chat and videoconferencing. Prescription refills and appointments can be requested at the touch of a button. Personal Health Records are updated in real-time for access at home, work, or on vacation.

"We're definitely changing patients' perceptions, and now we're getting more doctors to change how they work," says Dr. Smith. "We want our partnering insurance companies to now see the value in this new model." By expanding virtually, primary care doctors can stratify things to the appropriate level of care, he says, so whenever there's a need for a referral, PCPs can instantly videoconference a specialist right in the exam room to look at a tumor, for example. "It's by no means replacing a specialty visit, but it's an instant curbside consult," he says. "To have a primary care doctor bring in a specialist in real time says a lot about the amazing care patients can receive."

"Doctors like Dr. Smith who think outside the box are the ones allowing advancement of healthcare in more cost-effective manner"

Wave of Future Is E-Health

Dr. John Valvo, Chief of Urology at RGH, agrees. "Physicians are becoming informational engineers," he says. "Medical Home Telemedicine will not replace the physician but will only amplify the doctor's role in day-to-day care."

Dr. Smith has far bigger plans for the near future, like securing a webcam in the F.F. Thompson's Hospital ER to bring the entire experience right into his own exam room. Home health care nurses out on call can use the webcam for instant communication. He can look at a live video of a patient's wound and dressing change from his car and see immediately what's going on.

"Virtual care is really the next big wave in health care," says Dr. Smith. "Looking down the road, we face fewer doctors entering primary care, uncertain reimbursement protocols, and a larger number of patients needing primary care. Virtual care offers us the ability to expand our medical office's reach in non-traditional ways and care for patients in a high quality-low cost environment. I remain excited and optimistic about the future of family medicine and primary care, but at the same time realize that great strides in changing the mindsets of patients, physicians, and third party payers also needs to occur."

WHAT'S NEW IN Area Healthcare

CDC Advisory Committee Taps Expertise of URMC Expert


Nancy M. Bennett, MD

Nancy M. Bennett, MD, director of the **Center for Community Health at the University of Rochester Medical Center**, has been named to the federal **Advisory Committee on Immunization Practices (ACIP)**, part of the **Centers for Disease Control and Prevention**.

Bennett, a professor of Medicine and Community and Preventive Medicine, will serve a four-year term, through June 2015.

URMC Geriatrician Appointed to Medicare Payment Advisory Commission


William J. Hall, MD

Geriatrician **William J. Hall, MD**, has been named to the **Medicare Payment Advisory Commission (MedPAC)** by **Gene L. Dodaro**, Comptroller General of the United States and head of the U.S. Government Accountability Office. MedPAC advises Congress on payments to health plans participating in the Medicare Advantage program and providers in Medicare's traditional fee-for-service programs.

Hall is the **Paul Fine Professor of Medicine, Oncology and Pediatrics at the University of Rochester Medical Center** and director of the **Center for Healthy Aging** based at **Highland Hospital.** The first geriatric specialist to be elected to the AARP's board of directors, Hall has also served as president of the **American College of Physicians,** and as a member of its board of governors and its board of regents, and held leadership positions in the **American Geriatrics Society.**

"Given the challenges facing Medicare, MedPAC's expert advice will be more important than ever," said Dodaro. "We were fortunate to be able to consider many highly qualified applicants for MedPAC. The two new individuals selected this year have impressive credentials and will bring valuable knowledge and experience to the commission."

URMC Recognized for Outstanding Heart Failure, Stroke Programs

UNIVERSITY of ROCHESTER MEDICAL CENTER

The American Heart Association/American Stroke Association has once again honored **Strong Memorial Hospital** of the **University of Rochester Medical Center** for meeting its highest standards for heart failure and stroke care.

Strong Memorial is the only Rochester area hospital to be recognized in two categories and the only Rochester area hospital to receive any level of **American Heart Association** recognition for its heart failure care. **URMC's Highland Hospital** received the **Gold Plus Performance Award** for its outstanding stroke care.

Strong Memorial excelled in the heart failure and stroke care program modules of the ***AHA/ASA Get With the Guidelines (GWTG) program*** – earning a **Gold Performance Award** for heart failure and a **Gold Plus Performance Achievement Award** for stroke care. Hospitals that have earned a Gold Performance Achievement Award have maintained this performance level for two or more consecutive years.

"As the region's leader in patient care, research and training, we are committed to advancing care for people with heart problems," said **Charles J. Lowenstein, MD**, chief of the **Division of Cardiology** and director of the **Aab Cardiovascular Research Institute.** ***"The Gold Award for heart failure care demonstrates our success in meeting the most up-to-date AHA/ASA guidelines and recommendations."***

Curtis G. Benesch, MD, MPH, associate professor in the departments of Neurology and Neurosurgery and director of the Strong Stroke Center, said, ***"This award reflects the ongoing commitment we have to providing the highest level of care possible for our patients who've suffered a stroke. We've assembled an outstanding group of nurses, therapists, and physicians dedicated to this common goal."***

Stephanie L. Ahmed, MD Earns Board Certification

Stephanie L. Ahmed, MD

Stephanie L. Ahmed, MD, recently became a certified Diplomate of **The American Board of Obstetrics and Gynecology, Inc**. She received her medical degree from **Wake Forest University School of Medicine** in Winston-Salem, NC and completed her residency at the **University of Rochester Medical Center** in Rochester, NY. She is an active staff member at **Geneva General Hospital** and sees patients at **Finger Lakes Medical Associates** in Geneva.

Clark Joins Medical Center's Internal Medicine Team

Nancy S. Clark, MD

The University of Rochester Medical Center's Department of Medicine welcomes **Nancy S. Clark, MD**, to the **Division of General Medicine** and faculty-resident practice.

Clark, a clinical assistant professor in Medicine and Geriatrics, is a respected clinician in the Medical Center's primary care network and an outstanding medical educator. Her energy and enthusiasm for the practice of medicine further URMC's goals of providing high quality medical care and resident education.

She has been actively involved in medical school committee work, curriculum design and course instruction and has extensive experience in resident ambulatory medicine. Her community service work includes serving as advisor of the first UR Well Site at **Asbury United Methodist Church**.

Clark has been recognized for her educational skills by being named as a **Kohn Senior Teaching Fellow**. She has received the **University's T. Franklin Williams Prize in Geriatrics** and the **Manuel D. Goldman Prize for Excellence in First Year Teaching.**

She received a bachelor's degree from **Hamilton College** and her medical degree from the **University of Rochester School of Medicine and Dentistry.** After completing her internal medicine residency at **Strong Memorial Hospital**, she completed a geriatrics fellowship at **Monroe Community Hospital**. Clark has published research in the geriatrics literature and she is board certified in internal medicine and geriatrics.

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