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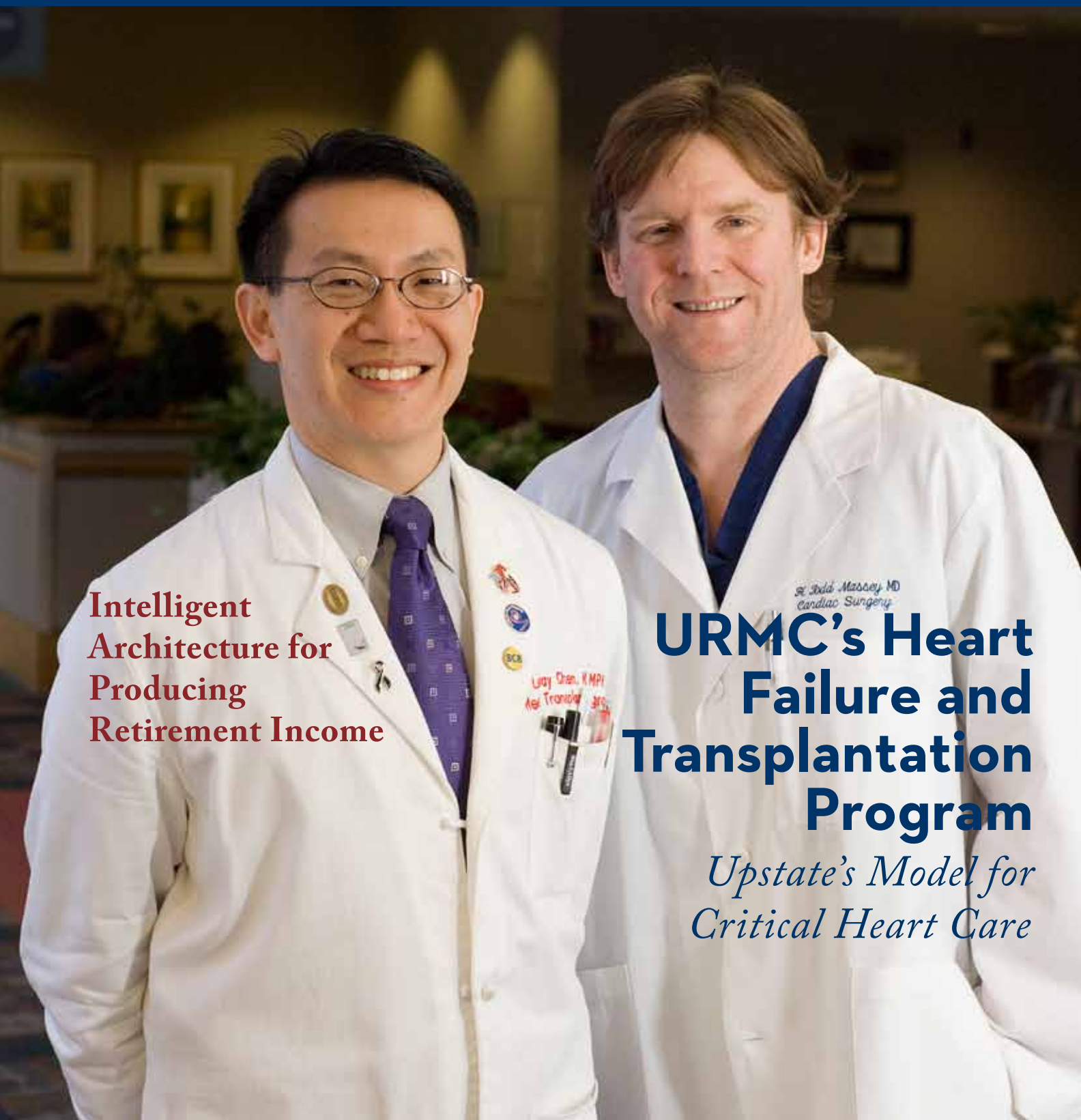
Western New York

PHYSICIAN

THE LOCAL VOICE OF PRACTICE MANAGEMENT AND THE BUSINESS OF MEDICINE



Intelligent Architecture for Producing Retirement Income

URMC's Heart Failure and Transplantation Program

Upstate's Model for Critical Heart Care

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Contents

University of Rochester Medical Center heart transplant cardiologist Leway Chen, MD, MPH, left, and surgeon H. Todd Massey, MD, have built a strong and successful Program in Heart Failure and Transplantation to provide the full continuum of cardiac care in Upstate New York. The program helps patients who need a transplant stay near their family and friends, and close to familiar physicians.

FROM THE PUBLISHER

Welcome to the March Issue

It's about that time in western New York when we begin to eagerly look forward to spring. Here at ***Western New York Physician*** *magazine, we also have our eye on celebrating our first year anniversary. As a locally owned and published publication, our commitment is unwavering – each month will deliver perspective from regional experts –* ***names you know, people you trust*** *- on topics, resources and services relevant to your practice, to your patients and to your business.*

Our cover story this month explores the Heart Failure and Transplantation Program at URMC, the state's most comprehensive program outside of New York City. Under the helm of Dr. Leway Chen and supported by a growing team of highly-trained specialists, critically ill patients in our region and the surrounding area have access to the highest level of care and treatments – often times much closer to their home, family and physicians.

The Profile this month highlights Transitional Care at St. Ann's Community. With expanding expertise and offerings and to meet the projected need in the community, St. Ann's recently celebrated the ground breaking of a $75 million dollar expansion due to open in the spring of 2012.

Also in this issue, find articles from other experts in our region on assessing depression, protecting from medical liability, retirement planning insight and EHR implementation.

We hope you enjoy the issue. If you would like to share your expertise or would like to see articles on particular topics, please email me directly to discuss your ideas and scheduling.

My thanks to each of you who contribute articles, sharing your expertise with your colleagues and enhancing the relevance of *Western New York Physician*. These informative and educational articles provide all physicians in our region a more in-depth look at the resources available to their patients and their practice.

A special thank you to our advertisers – your continued support serves to ensure that all physicians in our region benefit from this collaborative sharing of information and positions you as an invested leader in the healthcare community in western New York.

All the best,
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Western New York
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PROFILE BY
JULIE VAN BENTHUYSEN

St. Ann's Transitional Care

A Continuum of Care from Hospital to Home

Each year, more than a thousand patients pass through the doors of St. Ann's Transitional Care. Combining the latest best practices with state-of-the-art equipment, St. Ann's supports patients recovering from cardiovascular surgery, amputations, fractures, stroke, hip and knee replacement and motor vehicle accidents, and those with swallowing impairments, neurological or cardiovascular diseases. Its seasoned staff has been providing individualized rehabilitation treatment plans for a dozen years, ensuring a smooth transition from hospital to home.

Historic Roots

One of the region's largest private employers, St. Ann's rich tradition began in 1873 when it was founded by the Sisters of St. Joseph. That ministry continues through a person- centered, continuum of care philosophy providing everything from independent senior living to 24-hour skilled nursing and hospice care.

When President & CEO Betty Mullin-DiProsa joined St. Ann's 14 years ago, transitional care was non-existent. Her charge was to build a strong clinical support staff providing a variety of rehab support.

"We've grown substantially in sophistication and capacity," she says. Unique to the region, St. Ann's employs its entire staff, ensuring an on-site, 24/7 presence. Its cohesive clinical team consists of board certified internists and geriatricians, NP's, PA's rehabilitation therapists, social workers, clinical dietitians, RN's, CNA's and therapeutic recreation specialists. They take admissions 7 days a week to accommodate their patients and referrers needs.

Complex Offerings, Specialized Staff

Only through a continuum of care can staff manage the complexity of cases admitted, says Chief Medical Officer Dr. Diane Kane. "With a closed medical model, we have dedicated physicians, and an NP or PA caring for the patient." Its rehab program is aggressive, and studies prove it works. "We provide intense intervention, with the most comprehensive clinical care available, to maximize patient success."

Its three full-time speech and language pathologists provide NDT stroke care to move their patients quickly back to baseline. Certified in Fiberoptic Endoscopic Evaluation of Swallowing (FEES), they provide immediate, on-site assessment of swallowing and recommendations for the safest eating/feeding plan. Parkinson's patients receive voice training, and staff with specialized wound care certification help speed healing and reduce complications. "Providing care onsite is critical to our patients' recovery and state of mind."

Diane Kane, MD

Consistently high success rates show 75% of patients are discharged back to the community. Its 30-day readmission rate – 16% – surpasses the state's 21%. Patients leave with a higher functional status than regional and national averages – despite an older average patient age of 80.

In 2007, the facility volunteered to seek a rigorous accreditation by the Commission on Accreditation for Rehabilitation Facilities. (CARF) Every three years the facility is reaccredited. "This accreditation tells our doctors and patients we've achieved proven business standards and clinical outcomes aimed at improving quality," says Dr. Kane.

Feels Like Home

Staff responsiveness means patients are admitted when they need to be admitted, says Director of Admissions Kristan Tabacco. "Discharge planning begins the very day of admission." Patient attentiveness is reflected in its 'home away from home' atmosphere. Patients often compare their stay at St. Ann's to a high-

end hotel. "People are realizing they have a choice in their rehab care," adds Sharon Osborne, Director of Rehabilitation Services. "Even though all private rooms are rare in rehabilitation facilities, younger patients in particular expect it."

Numerous patients choose to return to St. Ann's when preparing for an elected surgery like a knee or hip replacement. "They already know our staff, so they 'book their stay' long before surgery." Maintaining long-term relationships with patients includes 'preferred member' cards, ensuring VIP status upon return. "For many of our patients, they're patients for life."

Ernie Coleman pre-planned his second knee replacement after a successful first round. "If you need rehab, this is the best place in the world," he says. "It's wonderful -- I've already sent four people here."

Securing patient peace of mind is the St. Ann's standard. Potential patients and their families are given a full facility tour. "With an average stay of 16 days depending on the diagnosis, our patients' anxiety levels are much lower versus those who haven't pre-planned their stay," says Dr. Kane. "Critical care patients with longer recoveries are reassured they'll have all the time they need."

St. Ann's encourages regular visitation and active family participation. "We offer every convenience to make life more pleasant for everyone," says Ms. Osborne. This includes access to telephone, computer and internet, daily newspapers, and an on-site interfaith chapel.

Partners through Recovery

Partnerships provide an extension to St. Ann's staff – from long-term relationships with area hospitals Rochester General (RGH), Highland and Unity, referring physicians and other post-acute providers. "Our partners recognize the benefits of collaboration, including a shortened hospital stay."

Dr. Ted Tanner, RGH's Chair of Orthopedic Surgery, is a regular referring physician and active visitor to St. Ann's. "When we admit a patient" says Osborne, "we rely on a strong linkage with our community doctors, closing that continuity loop." Dr. Tanner shows great respect for his patients and offers incredible support, she says. "He and other partnering doctors are always looking out for their patients." Staff also works closely with certified home health agencies so patients seek independence after discharge, with in-home visits from physical therapists.

Branching Out

Growth in expertise and offerings has culminated in the construction of a $75 million, state-of-the-art facility located directly on its Irondequoit campus, slated to open in next Spring. The building is designed as a "household" model with 72 transitional beds – hardly the industry norm – with all private rooms including toilet, shower, kitchenette and fireplace. The design accommodates piped in oxygen and suction housed discretely within the room's walls. A palliative care center in partnership with Visiting Nurse Service will provide ten additional beds.

Its Capital Campaign, set at $7.2 million over three years, has nearly reached the halfway point, including $1 million donated by its own board of directors.

With the dismantling of The Heritage nursing home, a new building on St. Ann's Cherry Ridge campus in Webster will house a long-term care center with 60 beds and a transitional care center with 12. Despite only a seven mile span between its two campuses, a broad community need is being met. "Our experience and research shows a growing need for more support in the region," says Mullin-DiProsa. "Patients will be thrilled by the convenience and amenities available."

St. Ann's staff also believes in preparing the next generation of caregivers for rising rehabilitation needs. For the fifth straight year, RGH interns make rounds with patients each month as part of the continuum of care.

"Our vision was to enable every patient to experience life fully in a place filled with warmth and compassion," says Mullin-DiProsa. "That spirit continues in every respect today."

Our protocol is your protocol

As sure as the seasons change, so do the diagnoses. Right now, primary care physicians and pediatricians are probably seeing patients with flu-like symptoms, sore throat, upper respiratory problems including cough and possibly pneumonia, sinus infections, and more. The fact is, so are the urgent care centers such as **Rochester Immediate Care.**

To reassure our colleagues of the protocols we follow with patients with these kinds of complaints, here are a few:

Sore throat. Clinical criteria are used to determine which patients need diagnostic testing such as rapid strep, mono spot and others. In general, symptomatic treatment is recommended but empiric antibiotic therapy is not prescribed.

Cough. The differential diagnosis for cough is quite broad. Based on history and physical examination findings, further diagnostic testing and therapy is provided. Blood testing, chest radiographs, peak expiratory flow rates and pulse oximetry are some examples. Nebulizer, antibiotics, and glucocorticoid therapy are available if needed.

Sinus congestion. In general, patients who present with fewer than 10 days of symptoms are managed with supportive care including analgesics, systemic or topical decongestants, and intranasal glucocorticoids. Antibiotics may be prescribed for patients with moderate to severe symptoms of bacterial sinusitis.

Flu-like symptoms. Acetominophen or nonsteroidal anti-inflammatory drugs are used to treat fever, headache and myalgias. Anti-tussives may be recommended. Secondary complications such as pneumonia, otitis media and sinusitis may require antibiotic therapy.

After providing care, RIC sends complete reports to the PCP practice for appropriate follow-up, and follows each practice's referral patterns when specialists are needed. We use electronic healthcare records and the Regional Health Information Organization exchange to ensure optimal coordination of care. And if a patient we see does not have a PCP, we help the patient find one. (If your practice is accepting new patients, let us know.) And this leads us to a final thought.

Why not make arrangements with an urgent care center such as RIC to augment your office during times when you'll be away or when your office is closed?

Rochester Immediate Care is available to assist primary care physicians to see patients after hours, weekends and holidays and is also available to provide temporary coverage, such as when physicians are on vacation, ill or have personal situations that prevent them from seeing patients.

RIC's mission is to provide episodic care when the PCP is unavailable and a trip to a hospital emergency department is unwarranted. We provide a value-added service for PCP practices, including pediatricians, and we save patients time and money over a visit to the ED.

Our care model benefits providers, insurance payors and, most importantly, patients.

Janet M. Williams, MD, FACEP
Medical Director
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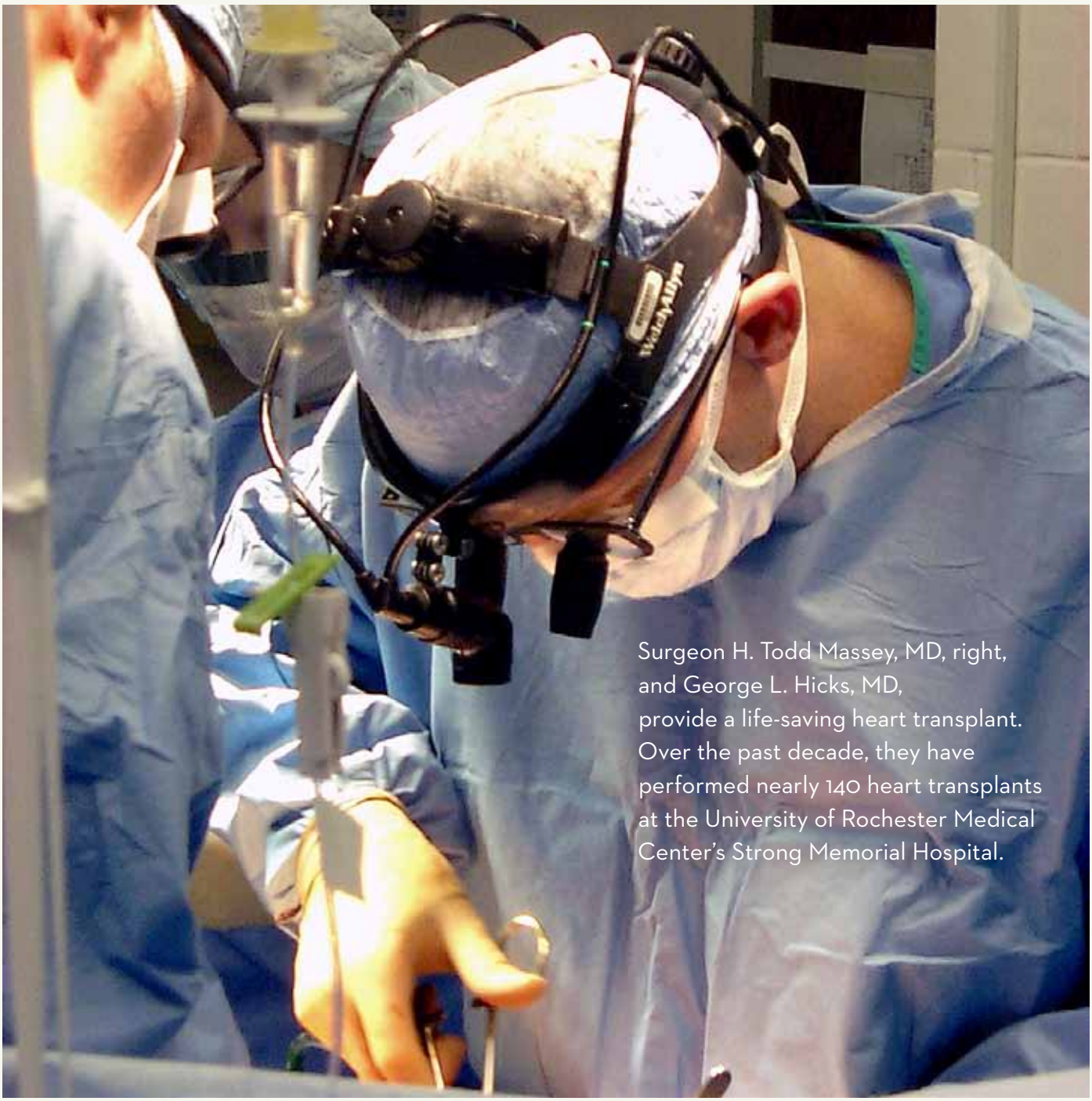
URMC's Heart Failure and Transplantation Program

Upstate's Model for Critical Heart Care

By Julie Van Benthuysen



Surgeon H. Todd Massey, MD, right, and George L. Hicks, MD, provide a life-saving heart transplant. Over the past decade, they have performed nearly 140 heart transplants at the University of Rochester Medical Center's Strong Memorial Hospital.

Even for patients with a critical heart condition, undergoing a transplant remains the last resort. Assuming a patient becomes one of the rare, approved candidates, risks are considerable – from typically long donor wait times, to post-surgical complications like infection, reaction to anesthesia, arterial problems, kidney damage from immunosuppressant drugs, or ultimately, rejection of the donated heart. But as long-term success rates have improved in recent years, the prospect of leading a healthy, active lifestyle after a transplant has become a reality for many patients in the Western New York region.

The nationally-recognized Program in Heart Failure and Transplantation at the University of Rochester Medical Center (URMC) has been providing a multi-disciplinary approach to heart transplant cases since 2001. As the state's only comprehensive heart failure and transplant program outside of New York City, its road to success has been slow and steady. Despite the sizable challenges of gaining accreditation in a smaller metropolitan area, unlike the Cleveland Clinic or University of Pennsylvania Medical Center, the URMC's heart transplant efforts alone represent the region's largest and most successful.

"There are actually very few heart transplant programs in the country," says Dr. Leway Chen, MPH, Director of the URMC's Program in Heart Failure and Transplantation. "We've developed ours from the ground up against many obstacles, gaining a better understanding along the way of all that's required."

Working closely with the Finger Lakes Donor Recovery Network, the URMC Program in Heart Failure and Transplantation serves the needs of patients across Upstate New York.

Well beyond heart transplant expertise, this exemplary team of specialists provides care in blood and marrow, kidney, liver, and pediatric transplant care. Enhancing its clinical success, physicians in numerous subspecialties serve as consultants to every transplant procedure.

Major Milestones

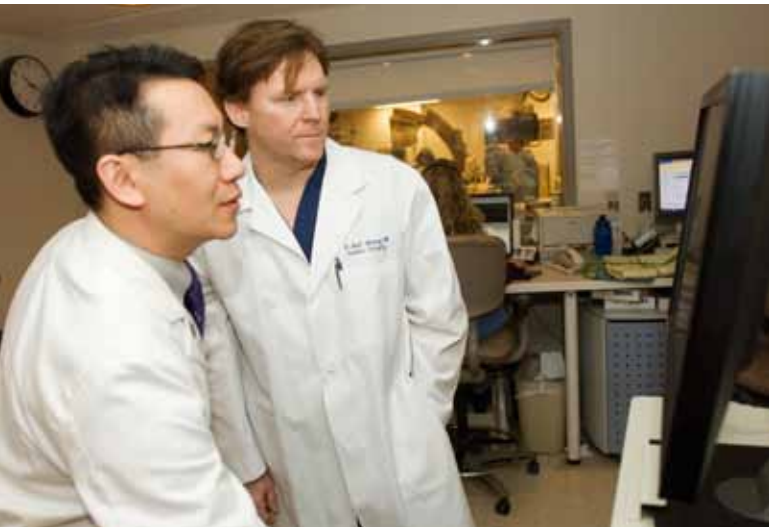
In February 2001, the Program listed its first patient, David Beatson, and performed his heart transplant just 12 days later. Mr. Beatson enjoyed another decade of precious time with his family and friends. His procedure marked the first of nearly 140 heart transplants performed since, with the team averaging more than a dozen each year. "Our outcomes consistently compare favorably to the nation's best heart transplant centers," says Dr. Chen, "most recently with a 91% one-year survival rate."

Since that historic first transplant, more than 1,500 patients across upstate New York and northern Pennsylvania have received critical heart care – not only transplants, but state-of-the-art medical therapy, heart failure surgery, and implantation of ventricular assist devices (VADs) that supplement or replace heart function to keep patients alive and as healthy as possible while awaiting a new heart. VADs are also used as long-term therapy for patients ineligible for transplant.

The VAD program is considered one of the country's top 10. "As a regional program, we've given patients the highest level of personal attention to help them through the challenging process of heart failure," says Dr. Chen. "Where other programs have had to pull back from VADS, we currently have 75 patients on the pump."

Road to Fruition

When fellowship-trained Dr. Chen was recruited in 1999 to develop a comprehensive heart failure and transplant program to serve regional residents, he knew it would be no small task. "The impetus for a program began a long time ago," he says, "when patients were actually leaving the region to receive



The URMC Heart Failure and Transplantation Program offers a broad range of treatment options for patients, including medication, ventricular assist devices (VADs) and heart transplants. The program was among the nation's leaders in the development of VADs for the treatment of heart failure.

care." The passionate support of URMC's leadership, particularly Drs. Bradford Berk and George Hicks, became a driving force. "Although Buffalo didn't have the volume to warrant it, we recognized as a region the need was there."

After a state assessment confirmed that regional deficit, and regulators, hospital administrators and insurers got on board, the program became a reality. "The URMC made a major investment, committing to the intense accreditations required to launch it," says Dr. Chen. "It was a difficult bar to cross over, but we succeeded the first year and continue today.

Under his leadership, its four-member core team of transplant cardiologist, surgeon, transplant coordinator and secretary has grown to nearly 20 – including five cardiologists, four surgeons participating in transplant cases, three transplant coordinators, two VAD coordinators, a registered nurse, three secretaries and a program administrator, as well as additional support from dozens more. "Back then, only our original foursome had ever seen a heart transplant. "We started with 0 patients and a 0 referral pattern."

Additional support includes a dedicated physical therapist, social worker, nutritionist and pharmacist, as well as pathology, infectious disease, psychiatry specialists and numerous other departments. All provide pre- and post-transplant care and heart failure treatment.

New Heart, New Life

The process of determining the viability of a heart transplant is a long and arduous one. Six years ago, Earl Stott, 69, of Wilson, New York, was referred to the Heart Transplant team by his family physician. Even after seeking specialist opinions elsewhere, his troubling heart congestion left many unanswered questions. Initially, the team treated him with various heart medications before ultimately proceeding with a pacemaker.

"I'm very active and love to go dancing, but my heart kept getting weaker," says Mr. Stott. "We came to the conclusion that a transplant was the way to go." With a supportive family and a positive attitude, Mr. Stott spent two months awaiting a donor. "Before the transplant, I would get very tired and short of breath," he says. "It's made quite a difference since. Once I got my strength back, I was right back on the dance floor."

Mr. Stott's experience with the Heart Transplant team speaks volumes about its management of a life-threatening condition. "The staff took great care of me," he says. "I hate staying in bed, so the nurses took me on walks outside as much as possible, which really helped my state of mind. Everything I needed, the staff responded to."

Almost a year post-transplant, Mr. Stott has revisited his transplant team regularly for monitoring. He walks on his treadmill at least 20 minutes twice a day, and in good weather, walks three to four miles daily, in addition to his twice-a-week dancing. Studies show that many heart transplant patients have lived 10 years or more with their new hearts, taking lifelong medications to help prevent the body from rejection.

Mr. Stott represents one of the fortunate few. Only about 2,000 heart transplants are performed in the United States annually. "We have a very select group," says Surgical Director Dr. H. Todd Massey, Director of the Artificial Heart Program at URMC. "with only about 50 approved patients awaiting transplant here at any given time." Nationally about 4,000 remain on the waiting list. The restrictions for transplant are stringent – most patients aren't considered good candidates after age 65 or if they have other serious medical conditions.

The toll on a patient's home life can also rule out transplant. The prospect of relocation to await transplant, with potential

loss of income and associated travel costs, can inhibit many patients from seeking a transplant. The average wait times have also increased, due to the aging of the average donor, distance the donated organs must travel, and available blood types. "Blood type definitely matters," says Dr. Massey. Fortunately despite the aging population, regional donation rates remain higher than the nation's, with the Finger Lakes Donor Recovery Network an active collaborator.

Surgeon H. Todd Massey, MD, center, and cardiologist Leway Chen, MD, MPH, at right, lead a large team of multidisciplinary experts dedicated to meeting the vast needs of people who suffer from heart failure. Also pictured are Nina Bentley, R.N., left, Megan Ayles, LMSW, Liubov "Luba" Fingerut, RN, and Eugene Storozynsky, MD, PhD.

The Program ensures that prospective transplant patients have options. "We prepare each patient by tapping all our available resources," adds Acting Program Administrator Lisa Guile Kotyra, CCRN, "from financial evaluation to counseling and dieticians who can work with patients on weight issues and smoking cessation. The team includes social workers, pharmacists, infectious disease, CMS and financial advisors. Harbor House, and the recently opened Golisano Hope Lodge and Hospitality House in Rochester, welcome patients and their families awaiting organ transplant.

Broadening Expertise, Critical Studies

In relatively short order, the Heart Failure and Transplant Program has expanded its offerings to accomplish a series of other "firsts." Its Cardiac Critical Care Transport Team of cardiac critical care nurses, respiratory therapists, perfusionists and physicians represents a unique life-saving service. Using a vehicle equipped with cutting-edge technology, the team assists patients being rushed to the URMC from outlying areas for the most comprehensive cardiac care.

Clinical studies of medical and surgical therapies offer patients the latest treatment options. For Dr. Chen, this commitment to cardiovascular research and outcomes has pushed the Program to the nation's forefront – being the first to test a new LAP (left atrial pressure) heart failure device that affords closer, daily monitoring. The technology aims to direct therapy more expeditiously and prevent worsening heart failure – potentially improving symptoms and reducing repeat hospitalization. As part of a feasibility trial, the URMC was the country's first to implant the technology in 2009, and the first to participate in the study's current phase.

Clinical VAD trials led to the implementation of the region's first HeartMate II device in 2004, and the innovative Jarvik 2000 in 2007. Where initially the Program lacked any mechanical support systems, more than 200 VADs have been implanted in the past seven years alone. A heart failure and transplant fellowship has also been created.

Hand- in- Hand Heart Health

"We draw expertise from a range of providers for multi-disciplinarian care," says Ms. Kotyra. "Whatever treatment option is chosen, we're always present as a team and as a patient advocate foremost." If the team determines the patient is not quite ill enough to warrant a transplant, co- management of care ensures that the best medications and procedures are in place to consistently monitor the condition to successfully postpone that final step.

Referring physicians and other regional hospitals remain critical to co-managing care. "We're always eager to work with other centers, whether other heart surgeons refer to us for bypass, VAD or both," says Dr. Massey. "At times, another heart center ultimately manages the patient's condition, and we offer

Dale Martin, RCVT, RDCS, studies echocardiograph images of a woman's heart.
Close monitoring of heart function and any changes is critical in providing comprehensive care.

any needed support. With more higher-risk surgery skills in our tool box, we've been able to educate our partnering physicians extensively on having mechanical support available in their own hospitals."

The team credits its referring doctors with knowing what to watch for when patients prove symptomatic of heart failure and other critical conditions, and for not referring patients too early or too late. "We work with our partners in the fashion they like," he says. With a hub and spoke system in place to support other institutions, the team has operated in every hospital in the region including Buffalo and Syracuse.

"By accommodating both doctors AND patients, particularly those in outlying areas, we assure patients receive the personal touch they need. We understand our patients' potential emotional and financial hardships, and recognize the added stress of distance."

Recognizing the nation's rising aging and obese populations, the team strives to remain at the forefront through education. "While our goal is always to not have patients with heart disease," says Dr. Massey, "the reality is sometimes it simply can't be prevented due to genetics or virus. Teaching patients about the path of preventable disease through improved exercise and diet remains tantamount. "Education truly empowers people."

Horizon of Challenges & Opportunities

By practicing evidence-based medicine, the URMC's Program in Heart Failure and Transplant has incorporated cutting edge procedures and technology now emulated elsewhere. "In just 10 years, other nationally-recognized institutions are applying these practices based on what we've accomplished," says Dr. Chen.

Investigative research on regeneration heart therapy has become a key area of focus moving forward. "Advanced research is enabling doctors to study heart failure in amazing ways, looking at 'sick' hearts as a whole and identifying markers for fixing them," he says. "Before long, we'll be able to actually take a patient's existing heart and make it better."

"Advanced research is enabling doctors to study heart failure in amazing ways"

Dr. Massey cites new, even more sophisticated mechanical assist devices on the horizon – essentially 'hearts on a shelf' that will be completely implantable before long and significantly improve patients' quality of life. Despite the advancements on the horizon, the team knows it needs to maintain that highest level of care regardless of the patient's condition. "We take great care of those who unfortunately reach a point where they can't be helped."

With ongoing support from many, the URMC's Program in Heart Failure and Transplantation has successfully brought a much-needed cardiac service to the Western New York region. "Not long ago, heart failure was considered a lethal condition," says Dr. Chen. "Through sophisticated therapies at our disposal and ongoing research, we're helping to extend life."

Giving New Hope The Colorectal Physiology Center

Jenny Speranza, MD, FACS, FASCRS

The Colorectal Physiology center at Highland Hospital is a new full service facility offering diagnosis and management of troubling bowel disorders. It is the only specialty center of its kind within 450 miles. Here we provide state of the art imaging and technology for the evaluation of colon, rectal, and anal disorders. Unfortunately, patients who suffer from these disorders often feel shame and embarrassment. Many have given up and lost hope.

The CPC is a unique resource where patients can undergo consultation, diagnosis, and management in one convenient location. This truly provides a comprehensive setting where patients can feel comfortable and familiar with their surroundings during all phases of their treatment. We provide many non-surgical treatments including dietary counseling and Pelvic Floor Muscle Stimulation and Biofeedback. We have a dedicated team to offer supportive counseling to patients for the often isolating and stigmatizing effects of these disorders. In addition, we offer the most advanced surgical interventions currently available by surgeons who are specialists in colon and rectal surgery.

> *"Bowel disorders encompass a wide array of disease processes."*

Bowel disorders encompass a wide array of disease processes. Such disorders include fecal incontinence, obstructed defecation, rectal prolapse, constipation, pelvic floor dysfunction, and pelvic pain syndromes. Unfortunately, many patients do not seek help even from their doctors as they feel humiliation and isolation. Many times the symptoms of these disorders are stumbled upon by the practitioner who then must probe to get more information. Up to 12 percent of the population suffers from some degree of incontinence. The actual incidence is underreported because of the social stigma of this disorder. Many individuals will not even share the details of their condition with their loved ones or family.

Many of these disorders are multifactorial and need a team approach for management. With the referrals from primary care physicians, gastroenterologists, gynecologists, and others, the CPC can help to diagnose and manage these life altering conditions. Injury to the sphincter complex during childbirth is one such factor. Nearly 25 percent of vaginal deliveries will result in some damage to the anal sphincter. Irritable Bowel Syndrome and Inflammatory Bowel Disease can also contribute significantly to bowel disorders. Proper management of these conditions is crucial to improving patients' lives.

The CPC offers the latest technology available to help diagnose and treat defecatory disorders. 3-D Endoanal/Endorectal Ultrasound is the newest and one of the best modalities to evaluate the sphincter complex. This gives precise and detailed images to measure any defects and plan possible repairs. Endoanal Manometry comprises a group of tests to evaluate the pressures, sensitivities and function of the anal musculature. It can help aid in the diagnosis of pelvic floor dyssynergy, rectal spasm, levator spasm, and other defecatory disorders. Pelvic Floor Muscle Stimulation and Biofeedback are proven ways to non-invasively treat mild fecal incontinence, pelvic pain syndromes and help strengthen the pelvic floor.

The Physiology center is overseen by Dr. Jenny Speranza, who is board certified in General Surgery as well as Colon and Rec-

tal Surgery. She has been involved with and the director of the center since its inception, which is a partnership between URMC's Department of Colorectal Surgery and Highland Hospital. She treats the full spectrum of colorectal disease and takes a special interest in treating patients with these complex and troubling defecatory disorders. Ashley Mallory is a certified Family Nurse Practitioner, has been specially trained in pelvic floor muscle stimulation and biofeedback. She is one of the only NP in the northeastern United States who performs these specialized treatments. Mary Rae Lodato is a Registered Nurse who helps counsel and teach patients life altering skills to help improve their quality of life. In addition, we have staff who are trained to help educate the patients regarding dietary and behavior modification techniques to maximize results. The CPC team is compassionate and attuned to the sensitive issues surrounding these difficult problems. The center offers a warm and caring atmosphere where patients are encouraged to speak freely and openly about their conditions.

The CPC is a new and innovative concept in treating challenging problems associated with defecatory disorders. It is truly a one of a kind entity in the region which will fill and unmet need for patients suffering from these afflicting conditions. The center is open five days a week and is conveniently located at Highland Hospital. Our goal is to improve patients' quality of life and restore hope.

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Is Your Patient **Depressed?**

Assessing Depression in Primary Care Practices

Rory Houghtalen, MD

Michael McGrath, MD

Major Depressive Disorder (MDD) is a very common illness-as many as 25% of women and 15% of men will have an episode of MDD in their lifetime. It is poised to become the second leading cause of disability in the US by 2020 according to the World Health Organization.

MDD is easier to diagnose when a patient announces depressed mood, but less obvious if the presenting complaint is fatigue, headache, back pain or a sexual complaint. A 2003 study found that at least half of MDD cases go undiagnosed. Recent public health campaigns to improve the recognition of MDD in medical settings have focused on screening starting with a two-question probe: "During the past month, have you often been bothered by... Little interest or pleasure in doing things? Feeling down, depressed or hopeless?" A positive response is followed by administration of a self-report screening tool called the PHQ-9 that can also be used to measure the response to treatment. The PHQ-9 helps gather information about other cardinal symptoms of depression including sleep and appetite/weight disturbance, loss of energy/motivation, problems with concentration/memory, negative thinking, hopelessness, suicidal ideation and psychomotor change. The McArthur Foundation Initiative Depression in Primary Care provides a curriculum and tools to screen for and treat depression (including the PHQ-9) at this website: www.depression-primarycare.org. Before concluding that MDD is the cause of symptoms, it is important to rule out common medical mimics (for example thyroid disease) guided by patient risk factors and characteristics.

While assessing for depression do not be afraid to ask about suicidal ideation. This does not create suicide risk where it did not previously exist. It is often helpful to normalize the experience for the patient. For example, one can say some thing like, "Many people who are feeling as you describe are also having thoughts about death or suicide. Has this been happening to you?" If a patient admits to suicidal ideation, it is important to tease out whether it is passive or active in nature. There is a big difference between someone wishing to be dead and having a plan to hang oneself. Many patients are relieved to share that they have had such thoughts and that help is available. Firearms are the most common means of suicide and should be removed from the home of any person diagnosed with depression until the illness is clearly in remission. Emergency room behavioral health specialists are often helpful in difficult situations when deciding about a safe level of care.

Depressed mood exists on a continuum from feeling blue over a lost opportunity at one end and hopelessness leading to suicidal ideation on the other. Some depressions are so intense that the sufferer cannot function and as many as 15% may include psychotic features. Treatment recommendations will vary depending on the severity of the episode, the type of depression, whether the episode is a recurrence or a first episode and the presence of co-occurring psychiatric and medical problems. There are five treatment options: psychotherapy, medication, combined medication and psychotherapy, light therapy (for uncomplicated seasonal depression) and technologies including ECT and Vagal Nerve Stimulation that are generally reserved for cases refractory to treatment.

In the US, we tend to over-utilize antidepressant medication and under-utilize depression specific psychotherapies such as

cognitive behavioral therapy (CBT) and Interpersonal Psychotherapy (IPT) because of practice habits, an inadequate supply of trained therapists and insurance and other systemic obstacles to psychotherapy. In fact, most cases of MDD with mild to moderate symptom severity will respond to psychotherapy, especially in a first episode. Antidepressant medications are generally effective and although a particular patient may not respond to a particular medication, there is usually a medication that will eventually help. The Sequential Treatment Alternatives for Resistant Depression (STAR*D) study showed that an initial antidepressant treatment has a 50% chance of producing a response and a 30% chance of achieving remission; roughly 75% of patients can expect to recover even if several treatment trials are required.

Many uncomplicated depressive episodes are successfully treated in a primary care practice. Referral to a specialist is indicated when two adequate (optimal dose and duration -which is more like 6-8 weeks than the 4 most of us have been taught) antidepressant trials have failed, if suicidal ideation or psychosis is present, if a bipolar depression is suspected, and/or a notable decrease in social functioning is persisting during treatment. When prescribing antidepressants it is helpful to advise the patient that a positive medication effect can take from two weeks to two months to emerge and that physical symptoms may improve before the mood lifts. Often times treating insomnia during antidepressant initiation is helpful when the antidepressant itself does not have hypnotic properties. Trazodone is one good choice for insomnia as it tends not to have important interactions at low doses, is not habit forming and does not disrupt sleep after longer-term use. Warn men about priapism when using Trazodone, which is not common at low doses, but can occur.

When referring a patient for specialty treatment it is helpful to make it clear to the behavioral health provider that you would like to receive a report on evaluation findings, any medication prescribed or changed and ongoing feedback about how your patient is responding. You will help the behavioral health provider by similarly providing updates on health status and medication changes you make during the course of treatment.

Co-Authored by: Michael McGrath, M.D., Chair, Unity Behavioral Health, Unity Health System Rory Houghtalen, M.D., Medical Director, Education and Ambulatory Service, Unity Behavioral Health.

2011 Editorial Calendar April–September

APRIL
Top 10 Men's Health Issues
Sports Medicine: Treating the Sports Injury

MAY
Top 10 Women's Health Issues
Sleep Disorders
Digestive Diseases
Stress and the Impact on Health

JUNE
Ophthalmology / Imaging
Medical Technology • Dermatology

JULY
Sexual Health / Telemedicine
Wound Care

AUGUST
Pediatrics / Mental Health
Orthopaedics

SEPTEMBER
Chronic Diseases
Prostate Cancer Awareness

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 Technology & the Future of Medicine
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.

What is My Liability?

My Bad Outcome is Presented at Peer Review Conference

James E. Szalados, MD, MBA, Esq.

Issue

The scenario is familiar to every physician: a complication occurs during the medical management of a patient and the case is reviewed at a 'mortality and morbidity (M&M),' 'quality assurance,' 'root cause,' or a clinical 'peer review' conference.

The rationale behind a the M&M conference is that in order to best ensure that hospital medical staff provide the highest possible quality of patient care, the medical staff must be able independently and freely engage in objective, nonjudgmental review of adverse outcomes and commit to practice changes, develop process changes, and engage in further learning. The M&M conference evolved into an integral part of continuous physician education following the 1910 Flexner Report and gradually evolved into a forum for attending and resident physician education and a facet of continuous clinical quality improvement. New York CLS Public Health Law § 2805-j(1)(a) mandates hospital based quality assurance programs.

Discovery, or disclosure, refers to the pre-trial phase in a lawsuit during which each party, through the process and law of civil procedure, may obtain evidence from the opposing party though depositions, interrogatories, and documents. NY Civil Practice Law and Rules relating to disclosure state, that all matters relevant to a civil proceeding are discoverable unless they are privileged, or are somehow legally protected. The burden of proof to show that a privilege does indeed apply will legally fall on the party who is asserting that privilege.

In general, Peer Review is protected under statutory privilege; however, NY PHL § 2805-m(2) carves out a clear exception to the Peer Review privilege, stating that

> Notwithstanding any other provisions of law, none of the records,documentation or committee actions or records …nor any incident reporting requirements… shall be subject to disclosure …except as hereinafter provided …. No person in attendance at a meeting of any such committee shall be required to testify as to what transpired thereat. …. *The prohibition relating to discovery of testimony shall not apply to the statements made by any person in attendance at such a meeting who is a party to an action or proceeding the subject matter of which was reviewed at such meeting.* [Italics added for emphasis]

Thus, a reasonable interpretation of the NY statute would suggest that the discussions which occur at an M&M conference are privileged and not subject to discovery by plaintiff's counsel; with the exception of statements made by the physician whose case is the subject of the discussion. Arguably then, the statements of the physician whose case is being reviewed may represent an admission of liability and be used against that physician at trial. Although such liability is naturally counter-intuitive to physicians who are likely hoping to engage in free dialogue with the intention of group learning and improving quality of care, the reality is that there is a statutory vulnerability inherent in M&M conferences.

The evidentiary vulnerability of the M&M conference has not been exploited by plaintiff's attorneys, possibly because the proceedings of such conferences are rarely documented. One could imagine that if minutes are not formalized, the conferences not taped or videotaped, and there is no hostile intent in the room, a plaintiff's attorney would find it difficult to establish exactly what was said at the M&M conference and by whom.

In conclusion, physicians should be aware of the hidden danger in disclosures they may make during M&M conferences. Table 1 outlines some potential risk minimization strategies for physicians, departments, and hospitals to consider during M&M discussions.

Table 1: Risk Minimization Strategies to Protect Confidentiality of Clinical Peer Review

- Clinical cases for review at M&M conferences should not be presented by parties involved in the case.
- M&M conferences should not be taped or videotaped. Minutes of M&M conferences should be general and quotations omitted.
- Consideration should be given to having an attorney take minutes at M&M conference in order to potentially best afford attorney-client privilege as a further potential obstacle to discovery.
- M&M conferences should be held as closed peer meetings with close attention to identification of attendees present.

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.

Promoting Communication Between the Referring and the Consulting Physicians

The Risk

Lack of communication between providers can result in a delay in diagnosis or treatment, the failure to act upon abnormal test results or findings, and the duplication of the prescription of, or failure to prescribe, appropriate medications or order diagnostic testing. A lack of clearly defined roles and responsibilities for all physicians may impede your ability to provide and promote safe and effective patient care.

Recommendations

1. Referring physicians should develop a method for determining whether a consultation has been completed and if a written report has been received.

2. As a matter of standard office policy, all consultation reports must be reviewed by a provider, initialed, and dated prior to being filed in the patient's medical record.

3. Office follow-up procedures should permit easy identification of a patient's noncompliance with the recommendation for a referral, such as when a written report has not been received from the consultant.

4. If a patient has been non-compliant in obtaining the recommended referral/consultation, follow-up with the patient is necessary. Your discussion with the patient should include reinforcement of the necessity and reason for the referral/consultation, as well as documentation in the patient's medical record of all attempts to contact the patient and obtain compliance.

5. If a written report from the consultant is not received in a timely manner, you should contact the consultant to determine whether a written report has been generated.

6. Consulting physicians should routinely send written reports to referring physicians in a timely manner. These reports should include:

- findings
- recommendations, including interventions, and the delineation of provider responsibility for treatment
- follow-up of abnormal test results, including incidental findings.

7. To promote effective communication, the consultant should contact the referring physician about any patients who fail to keep appointments. Medical record documentation should reflect the missed appointment, as well as notification of the referring physician.

8. Telephone conversations between referring and consulting physicians are important when clarification of the contents of a report is necessary. Timely contact must be made when an urgent or emergent clinical finding is identified. These conversations must also be documented in the patient's medical record.

Intelligent Asset Architecture for Producing Retirement Income

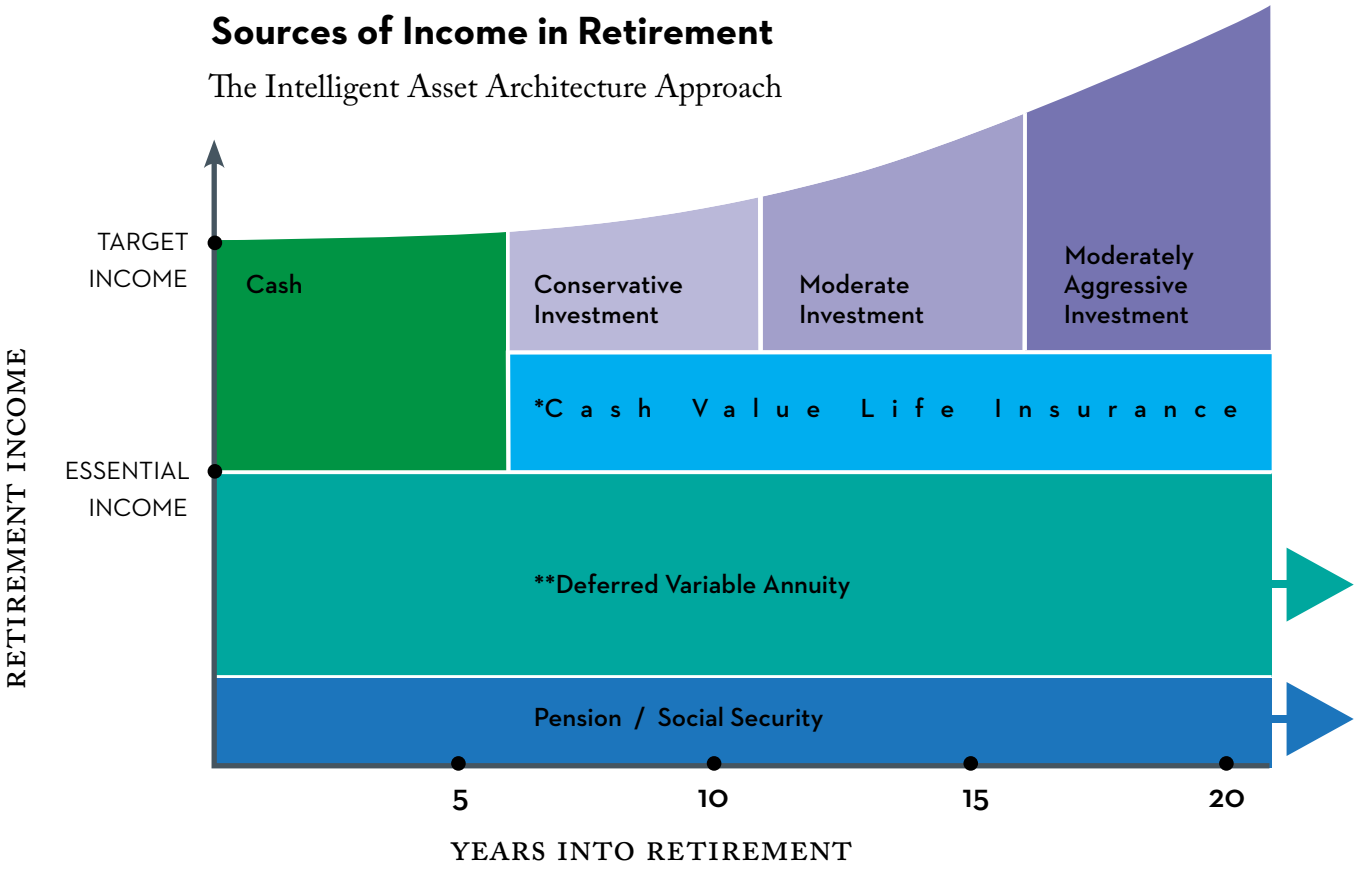
James M. Sperry, MBA

Physicians have been facing the perfect storm as it relates to preparing for retirement. Not only are reimbursements and compensation under pressure, but market volatility and the promise of higher taxes are all conspiring to hamstring physicians' ability to accumulate assets for retirement. Indeed, recent experience in the market and challenges in the broader economy have sharpened everyone's focus on their retirement prospects. This has not been lost on the financial services industry and the popular press, which have responded in characteristic fashion with memorable ads and a plethora of new titles in the bookstores. Surely you have seen ING's TV spot in which people are shown walking the streets carrying large orange numbers, each representing that individual's unique goal to save for retirement. The overt message is that if Bob and Mary successfully save their targeted $1,376,483, the orange number we see Bob lugging on his way to work that morning, then they will be all set for a comfortable retirement free of worries. While the spot is admittedly amusing, its very premise involves a fallacy that could cost you the comfortable retirement that you have worked to earn. That is, it ignores *how* they saved, which may have as much to do with one's ultimate retirement lifestyle than how *much* they saved! The emphasis in retirement planning is best placed on anticipating how to generate income rather than blindly accumulating assets. Thus, the average physician in our region (age 54) needs to be as laser-focused on where they are directing their retirement savings as they are on how much they are saving.

Architecture for Producing Retirement Income

Not long ago, the conventional wisdom for retirement planning was to direct savings to investments (perhaps 70% stocks, 30% bonds for someone in his 40's) and gradually dial down the allocation to stocks (perhaps to 30% stocks, 70% bonds) as he approached his retirement. If bonds are yielding 4% and the retiree needs $100,000/yr in income to support his lifestyle, then his bond allocation itself needs to be $2,500,000 – his orange number (or part thereof). This is appealing for its simplicity, but it is terribly inefficient and quite risky. Yet, to my amazement, this type of approach remains the predominant methodology practiced by the largest investment managers today. Frankly, given the sophistication of financial tools available to the retail investor like you and me today, I think this kind of advice is irresponsible, at best.

In contrast, the architecture for retirement plans that we design and implement enables our clients to minimize taxes, guarantee lifetime income that they cannot outlive, reduce their exposure to market risk, maintain flexibility and control, and preserve their assets to secure their legacy after they die, all without the need to accumulate any more assets than they would have using the old conventional wisdom. This is accomplished through systematically building several asset classes which differ in their tax characteristics, potential for growth, downside protection, and capacity to generate income. Once in retirement, the retiree's lifestyle is supported by drawing income from each of the different asset classes in the right amounts at the right stages during retirement.



* Cash value in permanent life insurance grows tax-deferred and can be withdrawn tax-free.
**Deferred variable annuitites can now produce lifetime guaranteed income that increases with inflation (as measured by CPI).

Understanding the role of each asset class and the fact that certain asset classes cannot be funded overnight, you can start to appreciate why it is necessary to begin planning in advance into which asset classes you are directing your savings. To reinforce this point, let's examine one possible component of such a plan – a component that can generate tax-free income.

Consider a healthy 53-yr old physician with $500,000 in cash who is otherwise inclined to continue earning cash-like returns (e.g., a CD at 1%). By age 67, his account will grow to $547,473. If instead of reinvesting the interest, assume the same physician used it and the principal to fund a life insurance policy. By age 67, he would have $700,889 in cash value and assets – over $150,000 more. For retirement purposes, however, what is significant is that this cash value could generate, say, $50,000/yr in income that is tax- free, the only asset class (other than your ROTH IRA) that can do so. In addition, he would have established a $1,289,444 death benefit to protect his family and secure his legacy. The cash value in the life insurance can thus simultaneously serve as a powerful component in the overall architecture to his retirement income plan, while also protecting his family and securing his legacy.

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Ask Yourself...

1. If you are at least 45 years old and your advisor has not implemented a program for you to systematically build a diversity of asset classes that will generate income in retirement, minimize taxes, and optimally manage your market risk, you should ask yourself why.
2. If your advisor's firm is not a member of M Financial Group™, are you comfortable knowing that you are forgoing the most sophisticated advice available for protecting and growing wealth, and leaving money on the table while doing so...? There are only 125 or so M Group member firms in the US and Canada, so don't be surprised when you learn that your advisor's firm is not a member and therefore cannot offer you the same benefits and cost savings.

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

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Community Diabetes Collaborative

Unity Leverages $7 million of NY Funds to Connect Providers and Coordinate Care for Patients with Diabetes

Al Kinel, MBA

The Community Diabetes Collaborative is a program to establish new approaches and systems to improve outcomes for almost 3,000 patients with diabetes that are cared for by 19 Unity primary care physicians and a myriad of specialists and other providers within Unity and the community.

Innovative approaches to treat diabetes are desperately needed. The number of U.S. citizens with diabetes has reached 26 million. Diabetes affects 11.3 percent of U.S. residents over 20, according to the National Diabetes Fact Sheet for 2011.

Dr. KK Rajamani, Chief of Endocrinology, Unity Health System describes the clinical situation, "The need for timely, patient-centered care for the millions of patients with diabetes will continue to increase. Technologies that facilitate accurate and timely communication between doctors and with patients, as well as reminders of key actions to both, are urgently needed to improve diabetes care. Technology will enable those who have diabetes to manage the disease better, and prevent serious complications such as kidney failure, amputation, and blindness."

This program will implement EHRs, establish interoperability between providers so that authorized users can create a single-patient view of Unity patients including clinical information from non-Unity providers, establish communications, patient engagement, alerts and decision support for protocols and standard of care for diabetes, and enable the 6 Unity Medical Group practices to attain Level III status of the Patient-Centered Medical Home (PCMH) accreditation.

Community Participants

- Hamilton Manor and Latta Road Nursing Homes
- Lifetime Care Home Health
- University Cardiovascular Associates
- Westside Podiatry
- Metro Footcare
- Nephrology Associates
- Borg and Ide Imaging
- Several Ophthalmology Practices
- ACM Laboratory

Unity Participants

- 6 Primary Care Practices
- Wound Care Center to open in 2011
- Diabetes Center
- Dialysis Centers
- Vascular Surgery
- Diagnostic Imaging
- Park Ridge & St. Mary's Hospitals
- Mental Health
- Long Term Care Facilities
- ACM Laboratory

Michael Nazar, MD and VP of Primary Care and Community Services for Unity Health describes the strategic relevance of the program, "Unity has established diabetes as a service line that delivers quality care for patients with diabetes and attains excellent outcomes today. We understand that continuing to improve outcomes and lower cost requires coordinating care

amongst a variety of providers within Unity and the community. A foundation for this coordination is the ability for all providers to access relevant clinical information and images, regardless of where it was generated."

Interoperability: True interoperability will be accomplished by ensuring all providers have an interoperable EHR, connecting the clinicians by leveraging the services of the RHIO, and then establishing effective interoperability by making relevant information available to authorized users in the format and at the time when it is most useful to help them diagnose and treat patients. The program is paying specific attention to the information needs of transitions of care, such as when a patient is referred to a specialist, is admitted to the hospital, or moves from the hospital to a long-term care facility or back home.

Decision Support: Once interoperability is accomplished, the program will deploy decision support tools to facilitate care including an information warehouse, reports, analytics, algorithms, and real-time access to actions required to improve outcomes. Examples will include reports and real-time queries that identify patients that are "outside normal limits" for labs such as HA1C and LDL, and tools to help clinicians to bring a patient that is "outside normal limits" to WNL.

Patient and Provider Engagement: Systems and process changes to enable patients to participate in their care, will include but are not limited to a Patient portal, automated contact (phone, e-mail, text), integrating home monitoring devices to the physician's EHR, education, and care manager engagement. This will also include tools to improve communications among providers such as referral management, subscription service, transition of care tool, etc.

This project aligns with the goal of the National Health Information Network (NHIN); to develop a secure, nationwide, interoperable health information infrastructure that connects providers, consumers, and others involved in healthcare. In fact, this project will accelerate efforts to operationalize the services and capabilities of the RHIO. The Rochester RHIO is one of the best well-aligned RHIOs in the nation, and it is helping providers to send results to referring physicians and to access clinical information for patients that have been seen by other physicians. To enable the desired functionality for this program, Unity will establish specific clinical workflows and systems based on existing and future RHIO capabilities.

Funding for this project is provided by Unity Health System, The Greater Rochester Healthcare Foundation, Rochester Regional Health Organization (RHIO), contributions of time and effort by a large number of community stakeholders, and over $7 million in funds from a grant from NY State DOH.

The vision of the program is to enable patients with diabetes to:

- experience improved quality of care - and life
- be identified and treated more rapidly for the disease and complications
- experience fewer/shorter hospital stays and better care if they should visit the ED
- undergo fewer tests, procedures and surgeries
- more rapidly return to normal glucose levels
- be more engaged in their care by:
  - receiving discharge summaries, care plans, test results, education, alerts and reminders
  - becoming more compliant with referrals and patient responsibilities
  - experiencing smoother transitions in care settings

John Glynn, VP and CIO of Unity articulates how this initiative aligns with the IT strategy of Unity. "For years Unity has invested in IT to help our providers, nurses, and administrative staff to improve outcomes while simultaneously reducing time, effort and cost. This project will accelerate the value we attain as we improve the tools we deliver to Unity employed and community physicians. This program will enable improved communications and satisfaction of all involved, and will serve as a platform for the future."

As a result of this initiative, Unity will have built an infrastructure with the interoperability, communications, decision support, and patient engagement systems to enable clinicians to collaborate to treat a multitude of chronic diseases, and to practice medicine for all episodes of care.

Al Kinel is President and founder of Strategic Interests, LLC, a consulting company dedicated to helping clients capture value from the strategic use of IT. Al and his network of colleagues bring significant expertise in the application of Healthcare Information Technology. Al is also the Program Manager of this innovative project on behalf of Unity.

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Is It Too Late for Our Practice to Adopt EHR?

Elizabeth Amato Fleck, MSHA

Erik Riffel

The speed at which EHR has impacted healthcare has left many smaller, independent physician practices feeling "left behind" in the race to keep up with advancing technology. Many practice administrators and physicians feel confused and unaware how to even begin the process let alone effectively disseminate the vast amount of information that comes across their desks. The reality is they need not worry because they have plenty of company. In fact, a recent report published by the President's Council of Advisors on Science and Technology (PCAST) stated, "Currently, almost 80 percent of physicians—the majority in small, independent practices—lack even rudimentary digital records."

EHRs are here to stay. Medical practices now considering adopting an EHR system are in an excellent position to benefit from their delayed entry into the market. Lessons learned from practices that embraced EHR early on, help assure that those implementing it now can expect higher levels of efficiency, security and economy. Beginning the process is no more complicated than understanding two basic factors that affect every practice.

THE FOUNDATION When constructing a new home, a strong foundation is critical to the long-term integrity of the structure. The first step in adopting EHR follows the same logic: build it right from the ground up, making sure the infra-structure is sound. Whether you are considering local (on site) or hosted (in which EHR is not on site), you begin by focusing on the security of your internet connection. The transfer of medical data can be costly, so you need to make sure it happens safe, sound and fast. The security of patient and business records is critical to the success of the practice and corrupt or lost data can violate HIPAA regulations. Proper routing and firewall protection secures against this happening. When data is entered into the system, it travels to a network switch where it is directed to the correct server for processing and dissemination to the correct user. The servers act as the main point of collection and distribution so information can be shared with those connected to the network. Hardware such as office desktops, laptops, tablets, printers, scanners and other peripheral devices also impact the flow of data so EHR software compatibility is a key element impacting system success.

PLANNING AND ASSESSMENT In EHR, one size does not fit all. Every practice is unique, so it's important to define exactly what a medical practice expects from its EHR system. Look past the obvious – eliminating lost charts, no longer needing to store paper records – and determine what other elements can help strengthen the practice. Once these are correctly identified, the process of matching system requirements to practice needs can begin. If this sounds complicated, relax. Many organizations, societies, and healthcare IT vendors have tools that have been developed to address needs assessments and many are free to the practice.

Once the needs assessment is completed, qualified vendors are selected to present information on their products offerings and eventually, conduct system demonstrations. The results of the needs assessment will be used by the practice during the vendor demonstration phase to gauge how well the EHR system functionality and usability aligns with the practice's needs and expectations. Without a solid needs assessment, it's easy to make the mistake of selecting the wrong system based upon reputation, misunderstanding or price.

EHR technology will continue to fast-forward, improving practice management and patient care. Administrators and physicians still considering EHR adoption now have the advantage of benefitting from what we have learned to date, making their entry into the medical information age a much smoother transition. There are numerous local resources qualified and experienced in health information technology and medical practices are encouraged to leverage them to their advantage.

Practice administrators and physicians considering EHR can find more answers to their questions at a free informational seminar on March 23rd in Rochester. For event details, visit www.innovativeehr.com/event.

Reach

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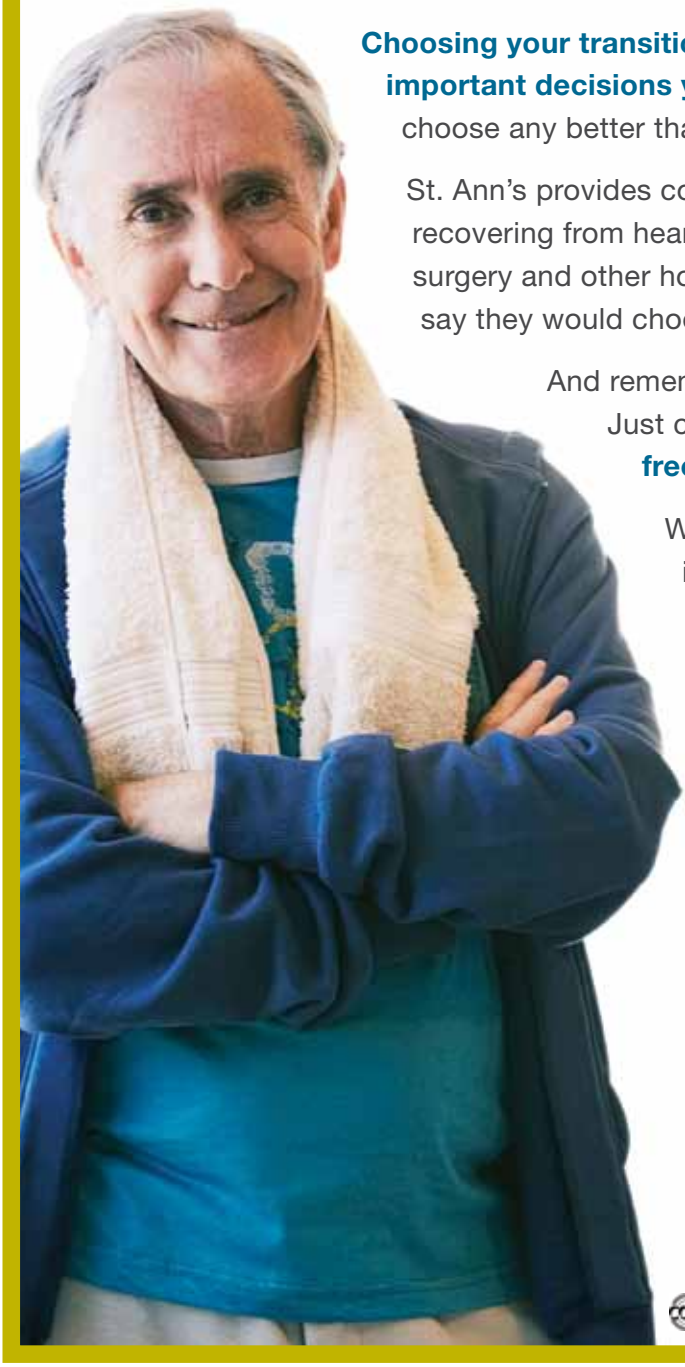

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