

Western New York

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PHYSICIAN

THE LOCAL VOICE OF PRACTICE MANAGEMENT AND THE BUSINESS OF MEDICINE

Unity's Chief of Neurosurgery

Dr. Paul Maurer

A Master of Precision

**Are You Ready to be
a Meaningful User?**

**How Are You
Compensated?
"Show Me the Money"**





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Unity's Chief of Neurosurgery Dr. Paul Maurer *A Master of Precision*

Under the leadership of newly appointed Chief of Neurosurgery Dr. Paul Maurer, The Spine Center at Unity is poised to ride the wave of continued growth. Through Unity's pragmatic approach to patient care, a coordinated interdisciplinary team of experts on-site and a continuing collaboration with colleagues across health systems, patients in the community and beyond benefit.

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Welcome to Vol #3 of *Western New York Physician* where you will find informative stories and articles about and for physicians in western NY.

Our cover story spotlights Dr. Paul Maurer, the recently appointed Chief of Neurosurgery at The Spine Center at Unity Hospital. Although Dr. Maurer has been no stranger to Unity, this formal appointment allows this natural leader to guide The Spine Center through the next wave of growth.

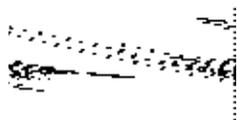
As we look at some of the unique health concerns facing women, hear from area experts on the latest options for preserving fertility after cancer treatment and how one interdisciplinary medical team focuses on treating, preventing and educating women about heart disease.

The practice management articles include an update from the folks at Innovative Solutions on the deadlines, requirements and implications of meaningful use; considerations for physician compensation models from Steven Terrigino, CPA; and the second installment in a series from the legal experts at Boylan Code on transitioning your medical practice.

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

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

Best,



To discuss a submission or learn about guidelines, please email the publisher -- Andrea Sperry @ WNYPhysician@gmail.com or communicate directly with us via the website:

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THE LOCAL VOICE OF
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THE BUSINESS OF MEDICINE

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Parenthood a Possibility after Cancer Treatment

Fertility preservation specialist an
important part of multidisciplinary team



Wendy S. Vitek, MD

Getting a cancer diagnosis can be heartbreaking. Learning that a treatment that can save your life might also dash your dream of having a family can compound that heartbreak to an indescribable degree.

Working in partnership with a reproductive endocrinologist, a woman may better understand the impact that her cancer treatment might have on her ovarian function and, consequently, her fertility. In many cases, a woman's oncologist will know if a particular treatment can impair her fertility. But adding a reproductive endocrinologist to her multidisciplinary care

team, for an independent assessment regarding her treatment's impact on her fertility, can round out that knowledge and help a woman understand her options.

A reproductive endocrinologist who specializes in fertility preservation can be a vital resource for women as they explore their options. While research continues in an effort to discover effective methods for preserving fertility, several alternatives involving tissue preservation prior to cancer treatment are currently offering hope to women.

OPTIONS FOR WOMEN

Embryo banking

Perhaps the most ideal option currently available, with this method, embryos are created, frozen, and thawed when needed. Ideally, if time and the woman's situation permits, she takes a 10-day course of fertilization medications to stimulate eggs for retrieval. This option has the highest success rate and is ideal for women who have partners (or access to sperm on short notice). When prompt cancer treatment is essential, this option may not be practical for women who do not have access to sperm. In that case, a woman needs to identify a sperm donor, which can be challenging and time-consuming in a situation where delay in treating her cancer may be detrimental to her recovery.

Oocyte banking

Oocyte or egg banking involves retrieving a woman's eggs and freezing them to be thawed and fertilized at a later date, a process considered experimental by the American Society of Reproductive Medicine. More study is needed to appropriately counsel women on the potential for its success in achieving pregnancy. A 2010 study (Cobo, et al) found no difference in pregnancy rates with fresh or frozen donor oocytes. Egg banking also carries with it the possibility of a woman preserving eggs and never using them to conceive, which raises obvious ethical dilemmas.

Ovarian cortical tissue banking

A relatively new and experimental method, with this process cortical tissue is removed through a surgical procedure. The tissue is preserved by freezing and then thawed and transplanted when the woman is ready to conceive. Conception would most likely require in vitro fertilization, though some cases of spontaneous pregnancies have been documented. Data on success rates is very limited and the procedure – as any surgery – poses risks for the woman. Additionally, if a woman has a cancer that could metastasize to the ovary, there are concerns that transplanting the tissue could reintroduce cancer. An alternative to transplantation would be to mature the oocytes from the cortical tissue in the lab. The mature oocytes could be fertilized to produce embryos. While this technology is not currently available, research is being conducted to make this possibility a viable option.

Not for women only

Fertility preservation isn't exclusive to women and has been offered to men for many years. For a man facing a cancer diagnosis, sperm banking is a time-tested way for the majority of men to preserve fertility. In addition, newer techniques for extracting sperm for freezing and storage may provide opportunities for the possibility of future fatherhood, although would require in vitro fertilization techniques for success.

Beyond the options, couples may also face financial challenges with respect to fertility preservation. While some health care plans cover at least a portion of the costs, many do not, or will not provide fertility treatment for a patient until an infertility diagnosis is in place. This can certainly add anxiety at a time when a woman should be focused on healing. The Strong Fertility Center sponsors events throughout the year aimed at and raising funds to help those who seek fertility preservation services but cannot otherwise afford it.

Without question, the first priority for those with a cancer diagnosis should always be to get the cancer treated. While it is best to seize the opportunity for fertility preservation before cancer treatment begins, it is not always possible and an individual risk assessment must be done. The best approach is a team approach, involving the patient, oncologist and reproductive endocrinologist.

GUIDELINES FOR FERTILITY PRESERVATION

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

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

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

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

ABOUT THE AUTHOR

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

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Vitamin D + TB Vaccine: Allies in Fight Against Bladder Cancer?

The tuberculosis vaccine is often used as a treatment for bladder cancer, and adding vitamin D might improve the vaccine's effectiveness, according to new research from the URMC presented at the American Urological Association annual meeting.

Yi-Fen Lee, PhD, associate professor of Urology at URMC, has conducted a pre-clinical study in a mouse model showing that a combination of vitamin D therapy and the Bacillus Calmette-Guerin (BCG) vaccine greatly improves bladder cancer survival. The next phase, an early clinical trial in patients, will begin soon as part of a collaborative research project between the URMC's James P. Wilmot Cancer Center and the Roswell Park Cancer Institute in Buffalo.

The connection between vitamin D and tuberculosis was established long ago, when ancient societies sent people with TB into the sunlight for therapy. Increasing vitamin D levels is known to wake up cells and trigger an immune response whenever infection or inflammation is present.

Also well-established is the use of the TB vaccine to treat several forms of bladder cancer. The vaccine works by pushing the body's immune system to fight the cancer cells. However, approximately 30 to 40 percent of people with bladder cancer who receive the vaccine do not respond to it.

Lee is investigating whether a lack of vitamin D in these patients might explain the poor response.

Prior studies have shown that BCG, the modified bacteria that causes TB, turns on a toll-like receptor signal that makes more vitamin D receptors and induces a key enzyme that converts to the most potent, bioactive form of vitamin D, or 1,25-hydroxyvitamin D3. So Lee thought it was likely that boosting the levels of vitamin D in the body would activate this process, enhancing the vaccine.

The mouse study involved four arms: a control group, a group that received vitamin D treatment alone, a group that received BCG treatment alone, and a fourth group that received the combination of vitamin D and the BCG vaccine. The latter (combination therapy) group was the only group in which 100 percent survived bladder cancer, Lee said.

"Vitamin D appears to be critical to the success of BCG immunotherapy," Lee said, although she does not advise taking high doses of vitamin D unless under medical supervision. "Just as importantly, though, we have shown the migration and signaling involved in establishing vitamin D

as a biomarker that can be easily measured."

The Elsa U. Pardee Foundation funded Lee's research. An estimated 73,500 new cases of bladder cancer will be diagnosed in the United States in 2012, and more than 14,000 deaths are likely to occur. Cigarette smoking is implicated in about half of all cases of bladder cancer in men and women.

Physician's Mindfulness Skills Can Improve Care for Patient and Provider

Training physicians in mindfulness meditation and communication skills can improve the quality of primary care for both practitioners and their patients, University of Rochester Medical Center researchers report in a study published online this week in the journal *Academic Medicine*.

As ways to improve primary care, the researchers also recommend promoting a sense of community among physicians and providing time to physicians for personal growth.

"Programs focused on personal awareness and self-development are only part of the solution," the researchers stated. "Our health care delivery systems must implement systematic change at the practice level to create an environment that supports mindful practice, encourages transparent and clear communication among clinicians, staff, patients, and families, and reduces professional isolation."

Medical education can better support self-awareness programs for trainees while also promoting role models—preceptors and attending physicians—who exemplify mindful practice in action, they wrote.

The *Academic Medicine* article, which will be published in the journal's June print edition, is a follow-up to a study by the researchers published in the *Journal of the American Medical Association* in 2009. That study found that mindfulness meditation and communication training can alleviate the psychological distress and burnout experienced by many physicians and can improve their well-being.

Seventy physicians from the Rochester, N.Y., area were involved in the initial study. The physicians participated in training that involved eight intensive weekly sessions that were 2 ½ hours long, an all-day session and a maintenance phase of 10 monthly 2 ½-hour sessions. For the new report, the researchers conducted in-depth interviews with 20 of the physicians who participated in the mindfulness training program.

The findings in the new study include:

- For 75 percent of the physicians, sharing personal experiences from medical practice with colleagues was one of the most meaningful outcomes of the program.
 - A nonjudgmental atmosphere helped participants feel emotionally safe enough to pause, reflect, and disclose their complex and profound experiences, which, in turn, provided reassurance that they were not alone in their feelings.
 - Sixty percent reported that learning mindfulness skills improved their capacity to listen more attentively and respond more effectively to others at work and home.
 - More than half of the participants acknowledged having increased self-awareness and better ability to respond non-judgmentally during personal or professional conversations.
 - Seventy percent placed a high value on the mindfulness course having an organized, structured, and well-defined curriculum that designated time and space to pause and reflect—not something they would ordinarily consider permissible.
 - Participants also described the personal struggles they have with devoting time and energy toward self-care despite acknowledging its importance.
- The researchers have developed and implemented required mindful practice curricula for medical students and residents at the University of Rochester School of Medicine and Dentistry. They also are studying the effects of an intensive, four-day residential course for physicians.

The authors of the article are: Howard Beckman, MD, clinical professor of Medicine and Family Medicine at the Medical Center and director of strategic innovation at Finger Lakes Health systems Agency; Melissa Wendland, associate director of research and planning at the Finger Lakes Health systems Agency; Christopher Mooney, MA, senior information analyst in the Office of Curriculum and Assessment University of Rochester School of Medicine and Dentistry; Michael S. Krasner, MD, associate professor of Clinical Medicine at the Medical Center; Timothy Quill, MD, director of the Center for Ethics, Humanities, and Palliative Care at the Medical Center; Anthony Suchman, MD, clinical professor of Medicine at the Medical Center; and Ronald Epstein, MD, professor of Family Medicine at the Medical Center and director of the Center for Communication and Disparities Research at the School of Medicine and Dentistry.

Epstein and Krasner conduct mindfulness meditation and communication training programs. The research was supported by the Physicians Foundation.

Unity's Chief of Neurosurgery Dr. Paul Maurer

A MASTER OF PRECISION

By Julie Van Benthuisen

When neurosurgeon Dr. Paul Maurer was a teenager, he earned his small paychecks mopping the operating room floors of Rochester General Hospital. While his fascination with surgery was borne within those hospital walls during high school, his professional journey would take him as far away as Saudi Arabia during the Gulf War to the west coasts of San Francisco and Seattle before returning to his hometown as a rising star in his field.

Inspired by a neurosurgeon at Walter Reed Army Medical Hospital in Washington, DC, after medical school, Dr. Maurer joined the army. "The military has always been another big interest for me," he says. "My time serving in the 101st and 82nd Airborne was the single most developmentally important time for me. I thoroughly loved it, and am extraordinarily appreciative of that opportunity." It was also during those early years in the military that Dr. Maurer developed an interest in wound ballistics and marksmanship.

A strong sense of family and community eventually brought Dr. Maurer back to Western New York. "From that time, I've always operated in every hospital here in town," he says. He has performed complicated spinal procedures on patients as notable as New York State congresswoman Louise Slaughter and media mogul Ted Turner.

His achievements speak for themselves, having been consistently ranked as one of the top 1% volume neurosurgeons in the country for the past 15 years. He performs more than 14 operations a week and 400 brain and spinal cord neurosurgeries each year. "The more you do, the better you get," he says. Early last year, Dr. Maurer's status was again elevated when he was appointed Unity Hospital's Chief of Neurosurgery and Surgical Director of the Unity Spine Center.



Calling Unity Home

“I’ve always loved Unity,” says Dr. Maurer, who serves patients at Unity and Strong on a monthly rotation. “Becoming Unity’s Chief of Neurosurgery was a nice opportunity to have more of a leadership role in the program while still maintaining relationships with my colleagues at other area hospitals. All of the neurosurgeons in the city and all of the hospitals have maintained a close collaborative relationship.”

Dr. Maurer often operates on injured NFL and NHL athletes, performing their surgeries at various Rochester hospitals. He appreciates the workability of Rochester, which he affectionately refers to as “The Roc.” He notes the nimble size and high level of efficiency at Unity.

A collaborative, community-wide focus has enabled Dr. Maurer and other area neurosurgeons to thrive in the Western New York region, he says. With 14 neurosurgeons supporting all area hospitals, patients have total access to every available neurosurgery skill without duplicating efforts and technology to keep costs down. “There has always been a community of people here to take care of patients. We can cover each other even though we might have a different home base. All of the local neurosurgeons cover multiple hospitals and it is a strong suit of the citywide neurosurgeon program.”

He commends hospital administration across Rochester for supporting this kind of strong collaboration. Even though it was Dr. Maurer who performed the fragile surgery on Rochester police officer Anthony DiPonzio when he was shot in the back of the head in the line of duty in 2009, he is the first to recognize the team of medical professionals from across the region’s health systems that came together to save the critically-injured man’s life. DiPonzio’s remarkable recovery has been well publicized, including throwing out the first pitch on the Red Wings’ opening day only months after his surgery. Dr. Maurer’s lectures on ballistics and explosive trauma have been extremely beneficial to other organizations both regionally and nationwide, including the U.S. Air Marshall’s Service, the FBI and numerous police agencies.

Patients Find New Lives

With more than 8,000 surgeries performed during his illustrious career, Dr. Maurer could write a book about the broad array of patient experiences – from the notable politicians and athletes to celebrities like Ted Turner, who was flown into Rochester in 1998 when he required emergency spinal surgery. Despite the sometimes heady operations he has performed, he remains most humbled and honored when helping to improve the lives of the everyday patients he’s worked with over the years.

“There has always been a community of people here to take care of patients. We can cover each other even though we might have a different home base. All of the local neurosurgeons cover multiple hospitals and it is a strong suit of the citywide neurosurgeon program.”



Kelly Kogut, 49, of Pittsford, suffered from chronic back pain for 30 years – tracing her injury back to the track field in 9th grade when she was only 14. “I was just running, and all of a sudden I had this horrible, crippling pain,” she says. “By that night, I couldn’t stand up and was home from school for a

really just a Bandaid to the problem.” Despite her ongoing suffering, Ms. Kogut remained an avid exerciser. It wasn’t until she was performing some rotation exercises that she finally reached her breaking point. “I was beyond pain.” When she returned to her pain management doctor, she managed to joke,



“Unfortunately, technology does not replace good judgment. We don’t accept patients who we know we can’t help, so we take a conservative approach to care.”

week.” Her doctor told her it was just muscle spasms, but week after week, her back throbbed like a toothache. As she moved through adulthood, her doctors continued to attribute the pain to muscle spasms, never once ordering an MRI or referring her to a specialist. “Sometimes moving a certain way would just tweak my back.”

Even Mrs. Kogut’s chiropractor over a decade’s time never manipulated her spine, only focusing on stimulation, deep tissue and traction. “I was just one of those people who slipped through the cracks,” she says. “Because I was never on heavy medication and have a high threshold for pain, I just assumed it was what the doctors told me.” For the last seven years before she met Dr. Maurer, she visited a pain management physician, undergoing nearly two dozen epidurals for pain relief. “It was

“Have I earned an MRI yet?” Her very first spine Xrays at the age of 46 revealed severe spondylosis, a fractured S1, an L5 in two pieces with the disc between them gone, two herniated discs, and two crushed L2 and L4 facet joints. It was at this point that Ms. Kogut was finally referred to two area neurosurgeons.

Dissatisfied with the first neurosurgeon, who essentially recommended she do nothing and hope the spine would just fuse together over time, she met with Dr. Maurer. “He said, ‘Well, this is going to be a short conversation. Your upper and lower spine aren’t actually connected properly. I don’t know how you are walking right now.’” He immediately walked her through a procedure of inserting rods and screws into her spine. Despite the risks, she felt immediately at ease under his care. “Before I

went into surgery, I grabbed his hand and asked, 'Are you sure?'" He said, "If I wasn't confident, you wouldn't be going in."

Mrs. Kogut expected to be bedridden for at least a month post-surgery, but was walking within five days. Six months later, she considered herself a new person, literally standing an inch and half taller. "Post-surgery pain was nothing compared to what I experienced for 30 years."

Since it was determined that Ms. Kogut's spinal condition was hereditary, a congenital weakness in that part of her spine, all three of her adult children underwent MRIs shortly afterwards. It was determined that her son, Zachary, who had been

suffering from back pain for almost a year, had actually broken his L5 while running – a result of the same condition. Five months after his mother, Zachary underwent spine surgery with Dr. Maurer and he is now pain free. "My son's tall and his extra weight had put so much compression on his spine that Dr. Maurer said it would only progress to a much worse state without surgery," says Mrs. Kogut. Her daughter Emily, who does not have the condition, recently underwent surgery with Dr. Maurer when she broke her tailbone and herniated a disc during a fall. "Dr. Maurer has been a hero to my family."



Dr. Maurer works in tandem with Dr. Mary Dombovy, Unity Spine Center's Medical Director for Physical Medicine and Rehabilitation, who also stresses the importance of continuity in patient care.

Belief in Continuum of Care

In short order, Unity's Spine Center has undergone a major evolution, and under Dr. Maurer's leadership is poised for continued growth. "We often face more complex decision making here," he says. "Our hallmark is that we take a solid, honest approach to every spine issue, the way it should be."

Despite the great strides in medicine in recent years, he recognizes that some conditions cannot be fixed. "Unfortunately, technology does not replace good judgment. We don't accept patients who we know we can't help, so we take a conservative approach to care." For patients with brain aneurysms, for example, he says 80% of the time they no longer need open surgery and can undergo a procedure that enables them to go home without formal surgery.

"While there's good care in other cities, there can also be horrible care in other cities. We don't have that variability here – we're very consistent," he says. "It's actually a good place to be a sick patient."

Dr. Maurer works in tandem with Dr. Mary Dombovy, Unity Spine Center's Medical Director for Physical Medicine and Rehabilitation, who also stresses the importance of continuity in patient care. "Things can go bad when there's a hand off that occurs, so having an interdisciplinary approach is very important," says Dr. Dombovy, who is responsible for coordinating all clinical neuroscience patient care.

Staff at the Spine Center takes a holistic view of each patient, with a surgical team reviewing each case individually to determine the best course of action – whether it's surgical or non-surgical – with an ongoing management program. Each patient is assigned a nurse navigator, who coordinates the efforts of the entire care team—creating a treatment plan, making appointments, and following up to be sure treatment is effective. "Our key focus is customer service," she says. "It should be utmost in what you do."

After two weeks of intensive care after his emergency surgery, officer DiPonzio was transferred to Unity Hospital in 2010. "Unity came highly recommended," says Joanne DiPonzio, Anthony's mother. "They have the most advanced rehab facilities available. Dr. Dombovy was wonderful, and the therapists were very good to him. They pushed hard enough and he's happy with the progress he's made. The Unity staff even set up a small hospitality room because we had so many family, friends and fellow officers coming to visit, but Anthony needed to stay quiet and rest."

Unity Spine Center offers a comprehensive array of services --

from state-of-the-art diagnostic tools like CT, MRI, injections, and diagnostics to a full range of treatment options. In addition to total care coordination, the Center's comprehensive services include neurology/psychiatry, neurosurgery, orthopaedic spine surgery, physical therapy, high-tech imaging, pain injections, and ongoing spine care programs for those whose conditions require it, from degenerative joint disease to spinal tumors and trauma.

"It's a combination of good staff, technology and medicine," adds Dr. Maurer. He's especially proud of the longevity of his own staff. His secretary and Nurse Practitioner have been with him since his early days in Rochester. "We take care of each other." Dr. Dombovy agrees. "Dr. Maurer is a great person to work with," she says. "Despite how busy he is, he really cares about his patients and it's very important to him that he always delivers great service." She especially appreciates the "curbside care" they can deliver together. "I'm always just down the hall if he needs me to weigh in on something."

**"It's a combination
of good staff, technology
and medicine."**

Tapping into Greatest Needs

In his relatively new role as Chief of Neurosurgery, Dr. Maurer plans to continue focusing on patients across New York State, noting the region's aging population and the need to be as cost-effective as possible moving forward. "To succeed, our health care delivery system needs high quality care at a reasonable price," he says. "We have good people in a moderate place, and we have a realistic cost to be sustained. While the treasury will not enlarge, our population will." He aims to maintain a vibrant, quality recruiting effort. "It's challenging, but we've always managed to do it because our viability and sensibility here has made it possible."

Dementia has become a key area of focus. "We used to have those services in town 5 to 10 years ago," adds Dr. Dombovy, "but there's a real gap in care, so we're looking at the community's need and how we can provide the right service where dementia is concerned." She also cites a heightened focus on stroke, the nation's leading cause of disability. "We want to work on stroke care to improve outcomes for our patients."

A continuing collaboration with colleagues across health systems will only help to make that possible. "Rochester care is astonishingly good in every field," says Dr. Maurer. "If everyone works together, you get the power of everyone's skills," he says. ***"We're competing FOR the community, rather than competing against each other."***

Women and Heart Disease

TODAY'S WOMEN ARE BUSIER THAN EVER.

They're juggling responsibilities for their family, work, household chores and volunteer responsibilities at school, desperately trying to keep all the "balls in the air." Add an aging or unwell parent, car trouble or tension at work and it's obvious that many women are harried and stressed out.

They are so busy taking care of their family that they don't have time to take care of themselves. It's no wonder women are surprised by a diagnosis of cardiovascular disease.

Unfortunately, the first encounter with the cardiologist for many of these women is after they've already suffered a heart attack. The problem is that they often don't realize the gravity of their situation, ignoring the symptoms while continuing to go about their routine, delaying medical care.

In the United States, there are 42 million women living with some form of cardiovascular disease. Heart disease is the number one killer of women and one third of all deaths in American women over the age of 20 are caused by cardiovascular disease. More than 200,000 women die each year from heart attacks – five times as many women as breast cancer.

Research shows that despite major education campaigns by the American Heart Association and its Go Red for Women effort, many people still don't recognize that men and women experience heart attacks differently.

It's well known that men feel pressure or a squeezing pain in the center of the chest, which may spread to the neck, shoulder or jaw along with lightheadedness, fainting, sweating, nausea or shortness of breath.

Women sometimes experience those symptoms. However, research published in the medical journal, *Circulation*, showed that during a heart attack, 43 percent of 515 women studied had no "acute chest pain... a 'hallmark symptom in men.'" Instead, they felt arm, shoulder or neck pain, fatigue and nausea, which can easily be mistaken as a stomach bug or another minor ailment.

While heart disease can be hereditary, there is a preventable component. Lifestyle choices can help reduce your risk:

- **Don't smoke.** Tobacco use increases the risk of death from heart disease by 2 to 3 times.
- **Get plenty of exercise to strengthen your heart.**
- **Eat a plant-based diet to ensure quality nutrition.**
- **Monitor your blood pressure and cholesterol levels.**
- **Diabetes doubles your risk of a heart attack.**

The unique challenges that women with heart disease encounter prompted the University of Rochester Medical Center to create the Women's Heart Program within its Heart and Vascular Center. The program focuses on prevention, helping to identify risk factors early to avoid heart disease and its complications.

A multidisciplinary team of experts provides comprehensive care to women at risk of developing heart disease and to help restore good health to women with heart disease. The team is made of many women who understand the daily challenges women face, and they're able to provide advanced care and practical tips for lifestyle changes to improve their health and high quality lives.

Hanna Mieszczanska, MD, is director of the Women's Heart Program and an associate professor of Cardiology at the University of Rochester Medical Center. In addition, her research interests focus on women's health and metabolic syndrome in women. A native of Poland, she joined URM in 2002. For specialty care at the Women's Heart Program at the University of Rochester Medical Center, call (585) 341-7791.



Hanna Mieszczanska, MD

On a daily basis, we're inundated with numbers. Here's a few you should remember:

Total cholesterol:

less than 200 milligrams per deciliter (mg/dL)

LDL, or "bad" cholesterol

Optimal: less than 100 mg/dL

Near optimal: 100-129 mg/dL

Borderline high: 130-159 mg/dL

High: 160-189 mg/dL

Very high: 190 mg/dL and higher

HDL, or "good" cholesterol: 50 mg/dL or higher

Triglycerides: less than 150 mg/dL

Blood pressure: less than 120/80 mmHg

Fasting glucose: less than 100 mg/dL

Body Mass Index (BMI): less than 25

Waist circumference: less than 35 inches



THE HEADACHE MANAGEMENT CENTER

Rochester's First For Chronic Sufferers

By Julie Van Benthuisen

Approximately 28 million Americans suffer from migraines, translating to roughly 18% of women and 6% of men. Considered a chronic neurologic disorder, migraines cause episodic attacks of moderate to severe pain with associated symptoms including sensitivity to light and sound, nausea, cognitive dysfunction and fatigue.

About 3% of migraine sufferers develop chronic migraines, experiencing 15 or more days of headache monthly. Chronic migraine sufferers experience far more disability and depression and utilize the health care system at much higher rates than those with episodic migraines. The ability to function at work or home and over a lifetime can take a significant toll on a person's quality of life.

Fortunately, effective treatments do exist for patients with migraines and other chronic headache disorders. The rising need has become the impetus for Unity Health System's new Headache Management Center, spearheaded by Dr. Catherine Lavigne. "There has become a huge need for headache management, particularly for migraines," says Dr. Lavigne. "We felt it was very important to expand our expertise to create a specific program for patients, offering Rochester's only Headache Center."

While migraines have always been common, the condition remains underdiagnosed and thus undertreated. In fact, nearly half of all migraine suffer-

ers are never diagnosed. Despite the millions of sufferers, only about half are ever diagnosed and the majority never seek medical care. Only about 4% of those who actually do seek medical care consult with headache and pain specialists. "We're hoping the Center will encourage more patients to seek treatment earlier and more aggressively."

Understanding Chronic Headaches

The Center treats all chronic headaches, including migraines, cluster headaches and post-traumatic headaches. Its main objective is to diagnosis and treat patients with chronic and difficult to treat headache disorders and to educate PCPs on how to diagnosis and treat patients with less frequent headache types.

"Primary Care doctors have a lot on their plate, and headaches tend to get lumped into visits for other issues and move to the bottom of the list," she says. "We want to change that by helping to better educate physicians in what to look for."

The key is identifying the factors that contribute to migraines. Only recently has the underlying pathophysiology begun to be understood. "Our understanding has radically changed in the last 20 years. It used to be considered a disorder of blood vessels, but migraines aren't vascular headaches and patients' personalities don't make them more susceptible." Today, mi-

graines are considered a brain disorder whereby various parts of the brain are either oversensitive or do not dampen sensory input. This results in a cascade of events that cause all the symptoms one sees with a migraine. Some sufferers also experience auras which can cause visual, sensory or language disturbances that typically occur prior to the headache.

Migraine triggers include stress, lack of sleep, changes in hormone levels and strong smells. Barometric pressure changes, particularly problematic in this region due to our variable weather patterns, also trigger migraines.

"There's a lot of disability and needless suffering," she adds. "People push through but they can't really function right." Approximately 50% of migraine



sufferers miss two workdays monthly. Employers lose more than \$13 billion annually due to lost work days. "As a nation, we need to do a better job educating the population about chronic headaches.

Treatments Work

"The most effective approach is early intervention," says Dr. Lavigne. "It's so important to take medications while the pain is mild." The treatment of choice for most is triptans, which are much more effective than NSAIDs. Triptans come in pills, melt-tabs, nasal sprays and injections, so patients have options. In fact, it's often best to combine a triptan with an NSAID. Some can make patients tired or disoriented, however, and if taken more than ten days monthly, can actually worsen migraines.

Unfortunately, as a migraine progresses, it becomes more refractory to treatment. Many patients wait too long to see if their headache will turn into a migraine. "It's like an avalanche. Skiers see one starting, and while their watching and thinking about how to avoid it, the avalanche buries them."

Once the headache is full blown, most triptans and NSAIDs don't work well. Allodynia, a type of sensory impairment where a normally unpainful stimulus causes pain, doesn't respond to this combined treatment. "For these patients, even their hair hurts. They can't even put on a hat due to over sensitization."

Patients with more than 4-6 migraines monthly should begin with preventive medications, typically anti-depressants and seizure and blood pressure medications. Botox, now FDA-approved for chronic migraines, has also proven to be very effective. However, she discourages the use of opioids or Fioricet as they often cause worsening of migraines over time.

Family physician Dr. Melanie Conolly at Spencerport's Unity Family Medi-

cine knows the challenges of finding the right treatment options. "I see many patients with difficult to control migraines," she says. "In the past, neurologists would prescribe a medication and expect patients to follow up with their PCP, so there was a lot of back and forth when a medication didn't work." Collaborating with Dr. Lavigne has changed that. "She's very proactive and thorough. If something doesn't work, she tries the next thing. It's a lifelong condition, but for many, all of a sudden, they are actually MANAGING their headache."

Promoting Prevention

Dr. Lavigne supports preventative measures for avoiding chronic headaches altogether. With stress a big player, techniques like biofeedback, yoga, vitamin/herbal supplements and acupuncture can be powerful alternatives. "While we refer out for a more holistic approach, we hope over time to integrate those options into our new Center."

She is also hopeful that insurance companies will begin to support these alternatives by working together to negotiate better terms for her patients. "People pay what they can afford, and brand name triptans are very expensive." Currently only two generics exist, costing up to \$200 monthly. Injections can run between \$600 and \$800 monthly. "Money is not a small player in treating migraines successfully," she says, "especially

for the uninsured or those with a high deductible, so I always start my patients on a generic form."

The Center of the Future

Seeing patients as far away as Watertown and Ithaca, Dr. Lavigne plans to recruit another headache specialist and a mid-level provider for streamlining patient care. Down the road, the Center plans to expand its focus on the comorbidity of migraine sufferers with anxiety and depression, with a continued mission of outreach and education to PCPs.

"There ARE effective treatments out there. Between neurologists, headache specialists and PCPs, we can make a difference for patients suffering from migraines."



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Emergencies & HIPAA Security

Q: *Does HIPAA have any rules regarding my electronic medical records or other security issues in the event of an environmental emergency at my office?*

A: Yes, the HIPAA Security Rule has standards on that topic. HIPAA requires that you “establish (and implement as needed) procedures for obtaining necessary electronic protected health information (EPHI) during an emergency.” Specifically, you must determine what types of situations would require emergency access to an information system or application that contains EPHI. Procedures must be established beforehand to guide your staff on possible ways to gain access to needed EPHI in, for example, a situation where electrical power has been severely damaged or rendered inoperative due to a natural or manmade disaster, such as a tornado or a fire.

You must also have a contingency plan that includes, at the least, a data backup plan, a disaster recovery plan, and an emergency mode operation plan. You should conduct a risk assessment to determine just how extensive these plans need to be and whether there are other measures that you should take in the case of an emergency that affects your EPHI.

Kern Augustine Conroy & Schoppmann, PC, Attorneys to Health Professionals. For more than 30 years the firm’s practice has been solely devoted to the representation of health care professionals. The authors may be contacted at 800.445.0954 or via email – info@DrLaw.com. For more information log on to www.DrLaw.com



Medical Practice Transition Planning

Estate Planning Considerations

By Carol S. Maue, Esq., Jennifer N. Weidner, Esq. & Paul S. Fusco, Esq.



Jennifer N. Weidner, Esq.

IN OUR LAST ARTICLE, we explained how thoughtfully-prepared buy-sell agreements can be instrumental in planning for the eventual transfer of your practice. Buy-sell agreements are contracts you create during your lifetime with others in your practice to govern in the event that one of you wishes to voluntarily leave the practice, becomes disabled, loses one's license to practice medicine or otherwise engages in conduct that triggers a buy-out, or wishes to retire and sell his or her interest in the practice to other partners or members of the practice or to the legal entity formed to conduct the practice. The buy-sell agreement may also be drafted to govern the transfer of a practice from a deceased owner's estate to his or her surviving partners or to the practice legal entity.

While best practices dictate the preparation of a definitive buy-sell agreement, if for some reason you have not planned for the transfer of your practice by executing a proper buy-sell agreement with your partners during your lifetime, or if you practice solo, you may wish to include provisions in your Will directing your Executor – the individual or corporation you designate to handle the affairs of your Estate – how to handle the sale or transfer of your practice if you should die while still owning an interest in the practice.

For example, you can indicate which individuals (either a specific person or a class of persons, such as those who are your partners at your death) shall have the first right to purchase your practice and under what terms. You can direct the methodology to be used by your Executor to determine the value of your practice and thus the purchase price. You can direct the method of payment from the purchasing party, such as a cash purchase, or partly in cash and partly with a promissory note payable over time in installments to the beneficiaries of your

Estate. If promissory notes are contemplated, it is also important to ensure as part of your plan that there are other liquid assets available that will immediately pass to the beneficiaries of your Estate to provide for their benefit. Life insurance is one important – and (depending on your health and age when the policy is purchased) relatively inexpensive way to ensure the ready availability of liquid assets to support your beneficiaries, typically your family, at your death. You can also provide your Executor with specific powers in your Will to carry on the administration of the practice during the period of Estate administration until the practice is sold or otherwise transferred.

Ideally, your business attorney and your estate planning attorney should work as a team. When you meet with your attorneys, they are likely to ask you for very detailed information regarding the individuals you wish to designate to benefit from your Estate, and also very detailed information regarding the value of your assets and the nature of the accounts in your Estate (for example, whether they are retirement assets with beneficiary designations or non-retirement brokerage accounts).

Such information is always treated by your legal counsel as extremely confidential. The reason for the level of detail required is that the legal recommendations that will be made are based directly on the information you provide. If the value of your Estate is near or above the estate tax exclusion thresholds, then your attorney will advise you that estate planning advice is required to minimize taxes to the extent possible and to ensure that beneficiary designations on retirement accounts and insurance policies tie in squarely with the terms of your Will. Most people do not realize that accounts and policies with beneficiary designations do not pass under the terms of your Will; rather, the designations govern,



“Ideally, your business attorney and your estate planning attorney should work as a team”

and therefore the attorney will need to advise you accordingly to ensure that the assets flow out as you wish. For example, if you establish trusts for young beneficiaries under your Will, a beneficiary or contingent beneficiary designation will need to refer to those trusts if the beneficiary is under a specified age.

Your attorneys will also be likely to ask you for information about your family, even if they are not your intended beneficiaries. That is because state law provides certain family members with the right to review your Will when it is being submitted for probate after your death, to give them an opportunity to pass on the Will's validity and the competency of the Executor you have nominated.

Once you have provided the necessary information to your attorneys, you should have an in-person consultation to discuss

your objectives and legal counsel's recommendations. This is the time to bring up any questions you have about the transfer of your practice after your death, to have your existing buy-sell agreement reviewed, or if you don't have one, to consider having one prepared and executed and to determine whether you should include any provisions relating to the transfer under your Will. If you are married, your spouse should also attend the meeting so that your attorneys can ensure that the recommendations made fit both of your needs. Once you and your legal advisors have a comfort level with the recommendations, they can draft the legal documents and agreements required, including your Wills and other documents relating to your advanced directives, such as Powers of Attorney, Health Care Proxies and Living Wills. Your legal counsel should always

provide you with draft documents to review, and give you time to ask any questions or make any changes before you meet again to formally execute the documents. You must keep in mind that the documents must be fully executed in the exact manner mandated by New York law for them to have the intended legal effect. Unexecuted drafts and Wills that are not properly witnessed are not regarded as valid estate planning documents.

The relationship you have with your attorneys should be a cooperative one. Owing to the nature of the information shared and the discussions that occur, you will need skilled business and estate planning legal counsel with whom you are compatible and whom you view as your trusted advisors. The quality of the recommendations you receive (and thus your resulting estate plan) is dependent both on the skill-set and the level of communication you share with your legal advisors.

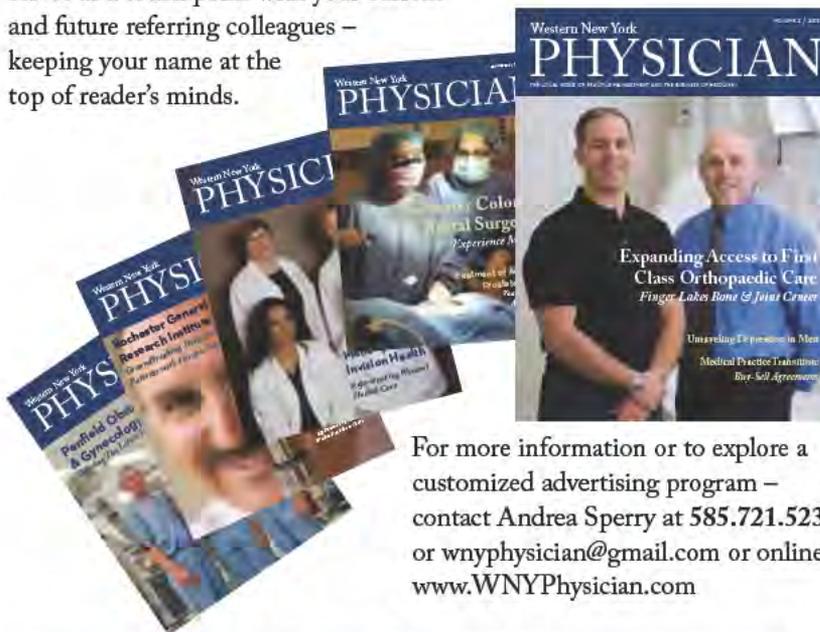
In our upcoming articles, we will present you with a case-study of an individual in the medical field who navigates her way through the business and estate planning processes relating to her medical practice.

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ARE YOU READY TO BE A Meaningful User?

Nicole Hirt and Elizabeth Amato Fleck

Physicians and administrators know all too well that today's health care environment is changing on a day-to-day basis. Understanding and planning for the government programs and initiatives that need to be implemented are a full time job on their own. As challenging as it may be, ignoring the implementation of said programs will soon start to affect your practice and your bottom line, if they haven't already. You may already be impacted by negative payment adjustments for your Medicare B claims if you didn't meet the Medicare eRx Incentive program measures. On a positive note, maybe you are seeing an increase in payments if you have met the criteria to be considered a Patient Centered Medical Home. Regardless of which programs may be affecting your bottom line, reaching Meaningful Use by the end of 2012 is essential in order to receive the full incentive amount through the CMS EHR Incentive Program. Unfortunately, if the measures are not met by 2015, Medicare negative payment adjustments are inevitable for your practice.

If your practice chooses to participate in the Meaningful Use Incentive Program, it will essentially guide your overall strategic plan for EHR optimization for the next four years. Meaningful Use (MU) is a Medicare and Medicaid EHR Incentive Program allowing providers to attest to "meaningful" use of certified electronic health records system (certified by the government or its designees as acceptable for meeting MU). What exactly does "meaningful" use mean? According to CMS, it means that you have successfully measured and met a set of core objectives and a set of menu objectives, to prove that you are optimizing the utilization of your electronic health record system. These objectives were determined by CMS and will change slightly throughout the three stages of Meaningful Use. Eligible professionals have up to \$44,000 available to them in incentive payment over five years under the Medicare incentive program and up to a \$63,750 in incentive payment available over six years with the Medicaid incentive program. The Medicaid Incentive Program is run by the states and has much stricter guidelines in order to qualify than the Medicare Incentive Program. Eligible professionals may only participate in one of the incentive programs, not both.

How successful is this Meaningful Use program to date? According to CMS, over 150,000 Medicare eligible providers and 78,000 Medicaid eligible providers have registered for participation in the programs. Over 3,500 eligible hospitals have also registered as of April 2012. This may seem like a minimal amount when considering all the providers and hospitals within the United States but there was little to no incentive to attest before 2012, as the total incentive outlays did not change. As of 2013, incentive payments begin to decrease for Stage 1 attestation. CMS

has reported that as of April 2012, over \$2.6 billion in Medicare incentive payments and over \$2.3 billion in Medicaid incentive payments have been issued. To break those payments down to the provider level, approximately 56,214 Medicare eligible providers, 35,040 Medicaid eligible professionals, and 2,843 eligible hospitals have received payments. Over \$217 million has been paid within New York State alone.

To be sure that you will receive the full incentive allowed, there are important dates that you will need to remember in 2012.

July 3, 2012 the last day Medicare eligible hospitals can begin their 90-day reporting period.

September 30, 2012 the reporting year ends for eligible hospitals and critical access hospitals.

October 3, 2012 (Most important if you practice within an office setting). The last day to begin your meaningful use 90-day reporting period for the Medicare incentive.

February 28, 2013 the last day for eligible professionals to register and attest in order to receive an incentive payment for 2012.

The most important date of all is the day that you decide to take the necessary steps to become a meaningful user of electronic health records, not only to receive an incentive payment, but to provide quality, efficient care to your patients.

For you to achieve meaningful use Stage I by the end of 2012, you must begin the process now if you have not already. The selection itself, of a certified EHR system, can be extremely cumbersome and confusing, let alone the implementation, training, and optimization of the system. If you have already selected and implemented an EHR system, you are now tasked with determining how to functionally achieve each of the core measures within your system. You must also choose five additional menu items that best suit your practice. Achieving meaningful use is not only changing the way providers practice medicine but the many areas of work flow and structure in an office will change (some greatly, some minimally) from check-in to check-out. That being said, there are a variety of resources available to assist providers and administrators in the MU planning, attestation, workflow redesign, and optimization processes. Providers are encouraged to partner with a reputable and experienced resource team that will assist in reaching Meaningful Use.

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How are You Compensated?



Steven M. Terrigno, CPA

“Show me the money” ~ Jerry Maguire

“SHOW ME THE MONEY” IS ONE OF THE MOST MEMORABLE quotes from the 1996 movie Jerry Maguire. This month’s article focuses on compensation plans and making sure valuable partners and/or prospective partners are seeing the money.

If you are in a partnership, hopefully you can answer the above question, “how are you compensated” with some degree of certainty. Medical practices employ different methodologies in allocating income amongst their partner group. Most of these allocation models have been in place since the inception of the practice and continue to be employed. However, while you may know the theory behind your practice’s allocation model, do you deem it to be fair and equitable? The allocation of income not only has to be fair and equitable, it must be perceived to be such in order to ensure its success.

Physician practices should assess their compensation models from time to time. Events triggering a review of a practice’s existing compensation arrangement may be: partners expressing dissatisfaction with the current arrangement, prior to the admission of a new partner, or aligning compensation with a strategic plan to be implemented, just to name a few. Ideally, the window of opportunity to review compensation is prior to any of the above events happening! Additionally, merely a long passage of time may be a good reason to revisit the current model. Perhaps what worked then, is no longer the best methodology, as your practice mix has evolved.

Building or perhaps reviewing an existing compensation plan is a very time consuming process. Hence, there must

be a firm guarantee from the partner group, to commit both time and resources to get the job done. Keep in mind, the ultimate goal is to have a plan that is both fair and equitable. Additionally, it must be understandable and relatively simple to administer.

What makes a plan fair and equitable? Ideally, it is one that is tested over the course of time, but most importantly, the partners perceive it to be functional. Reviewing a compensation model takes into account many factors, both tangible and intangible. Generally, the simpler the model, the better it will work. I see a variety of compensation models and each work well for the particular practice they are being used in. While there are many plans, some of those most commonly used types are as follows:

.....

1 EQUAL ALLOCATION

Net income is divided equally amongst the partner group.

2 PRODUCTIVITY BASED

Net income is divided by each physician’s productivity.

3 COST ACCOUNTING MODEL

Each physician is considered as an individual profit center. Each partner is directly allocated their revenue and a proportionate share of expenses. Generally, fixed expenses under this arrangement are divided equally and variable expenses are split based upon productivity.

.....

Each practices' model has to be reviewed independently. What works for one practice or specialty, may not necessarily be a good fit for another practice. While you may use one of the above plans, or have a combination of them, there are some points or questions often overlooked with respect to compensation plans.

"compensation can include not only the income allocation but other perks as well"

First, how does your practice define productivity? Productivity can be measured in a variety of ways. Some practices use a percentage of gross cash receipts, charges or relative value units. Others use hours worked with varying weights given to types of hours (i.e. administrative vs. patient service hours vs. continuing education hours). If the allocation of your income is based upon one of these factors, it is key to know if they are accurately being accounted for and ultimately if you, in particular, are being allocated your fair share.

Next, is consideration given to the office managing partner or other partners with significant administrative responsibilities? These responsibilities within a practice consume additional necessary time. Accordingly, the cost to the person in this role is the foregone opportunity of not seeing patients. This responsibility should be rewarded rather than penalized, as the ultimate success of the practice centers around these functions, especially the managing partner. Often times this position goes uncompensated. Consideration should be given for a stipend for this role.

Intangible factors are another consideration often overlooked. Examples of intangible factors may be a practice with partners who generate numerous referrals, especially for the newer partners in the group. This may be based upon their reputation or specialized qualifications.

Perhaps tracking who and where patients are generated can lead to an additional allocation of income.

Lastly, compensation can include not only the income allocation but other perks as well. For example, one partner may be covered under the company's health insurance plan while another gets that coverage elsewhere. Equalization of these perks should be achieved in some manner when devising the compensation package.

Regardless of the plan you have in place, it is imperative that its functionality is appropriate for your practice. Moreover, the accounting for the allocation should be reviewed regularly by your accountant for propriety. Ultimately, a plan must be equitable and those that have to abide by it must agree to and trust the methodology behind it. If a change in a compensation plan becomes eminent, the practice may be at a point of addressing the issue too late. It is better to be proactive with this aspect of your practice as the ultimate rewards of a properly designed compensation model will be... everyone seeing the money!

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,

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What is My Liability?

Medical Staff Credentialing Pitfalls

Issue

The credentialing of providers for appointment to an entity's medical staff is a procedural legal minefield with potential regulatory and liability implications for **(1)** the credentialing entity; **(2)** those serving on the evaluation committee(s); and, **(3)** the provider submitting the credentialing application.

CREDENTIALING IS THE PROCEDURE WHEREBY THE healthcare entity formally determines whether a prospective licensed healthcare provider meets the minimum criteria which demonstrate his or her competence for admission to the medical staff. Healthcare entities which credential providers include, for example, managed care (MCO) and provider (PPO) organizations, insurers, hospitals, and medical groups. Hospitals are entrusted with a legal duty which they owe to the public which requires them to follow a defined process whereby the credentials of each member of the medical staff are evaluated prospectively, and then continuously thereafter during the biennial reappointment process. During credentialing, the healthcare entity is responsible for verifying a provider's education, training, certification, licensure, and prior history through a process of primary source verification, which requires that original sources be contacted directly. The legal standards to which hospitals are held are that of due diligence and reasonable care. In the event that an entity fails to meet these legal standards and allows a substandard provider onto their staff, and patient harm



James E. Szalados, MD, MBA, Esq.

results, the entity can be held liable to injured parties under the legal theory of 'negligent credentialing.'

Federal and state health benefit program regulations also impose regulatory requirements on hospitals and MCOs which benefit from governmental health program funds to assess and monitor the competence of physicians. CMS requires compliance with Joint Commission (JC) and NCQA accreditation guidelines for privileging and credentialing as a Conditions of Participation. Thus, in addition to civil legal liability, entities which do not adhere to a strict and effective credentialing process may also face (1) exclusion from federal and state funded programs; (2) loss of commercial payer contracts; and, (3) loss of JC accreditation.

JC Standards require that the medical staff be organized under a set of bylaws, rules and regulations in order to provide a framework in which the duties and functions of the staff may be performed effectively. Since hospitals administer their credentialing processes through committees of the medical staff and the Board of Directors, there is a potential individual liability to members of the respective committees. There are three key legal issues associated with credentialing duties: (1) the confidentiality of credentialing and peer review information; (2) restraint of trade issues, and (3) scope of immunity. The Health Care Quality Improvement Act (HCQIA) confers procedural confidentiality and limited immunity for members of a professional review body except in cases of alleged civil rights violation, antitrust cases, and alleged violations of Americans with Disabilities Act (ADA) and the Age Discrimination in Employment Act (ADEA) statutes. In addition, credentialing decisions are increasingly complicated by economic and quasi-economic pressures ("economic credentialing") such as (1) DRG profile, (2) average length of stay, (3) pay for performance data, and (4) economic performance. The AMA continues strongly oppose privileging or credentialing decisions based on economic factors.

Once credentialing bodies become aware of adverse quality of care issues there is a duty to terminate or limit that provider's

medical staff privileges, and, potentially, report that action to the State Board of Health (OPMC) and/or the National Practitioner Data Bank (NPDB). Three categories of information must be reported to the NPDB: (1) malpractice payments made on

The legal standards
to which hospitals
are held are that of
due diligence and
reasonable care.

behalf of any licensed health care practitioner; (2) sanctions by licensure boards; and, (3) adverse credentialing actions which are (a) based on competence or professional conduct which affects conduct or could affect adversely the health or welfare of a patient or patients; (b) actions by a “professional review body” in the conduct of a “professional review activity”; (c) acceptance of a surrender of clinical privileges by a provider while he or she “is under an investigation by the entity relating to possible incompetence or improper professional conduct” or in return for not conducting such an investigation; or, (d) a professional society review action which adversely affects membership. Providers who are active members of a medical staff may appeal adverse credentialing decisions and invoke notice and due process hearing rights to a formal administrative review, a process which may be time and resource intensive to the healthcare entity, and in circumstances, to the members of the credentialing committees. There are two types of due process: (1) substantive due process requires that a decision be neither arbitrary nor capricious; and (2) procedural due process requires that a practitioner receive a fair hearing, including a right to notice of the facts relied upon, a right to be heard, a right to present evidence and argument in opposition to the proposed action, a right to confront the accuser, and a right to be heard by an unbiased tribunal. Where a healthcare entity fails to adhere to a systematic approach in credentialing or peer review, an adversely-affected provider may make a claim of discrimination.

Finally, individual providers are at risk for liability and sanction at many points in the credentialing process. Providers must be accurate and complete in their credentialing applications since errors, mis-statements, or omissions can constitute ‘mis-

representation,’ which, can at best result in procedural delays, and in the worst case scenario, result in denial of privileges, civil charges, and even violations of the Federal False Claims Act where federal reimbursement is obtained under false pretenses. Moreover, denial by a hospital of an application for staff membership, denial of a request for additional privileges, or even an approval privileges that are more restrictive than requested, are each NPDB reportable actions, if the decisions are based on the physician’s competence or professional conduct.

In conclusion, the credentialing process represents the point of first formal contact between a provider and a healthcare entity; as such it represents great potential for legal liability to all parties involved. Providers should consult with an attorney experienced in healthcare law well before a contract or affiliation agreement is signed to ascertain that basic rights are not jeopardized or waived; hospitals and groups should seek expert advice in developing compliant policies and procedures, and, providers as well as hospitals should seek expert counsel in any dispute regarding adverse credentialing decisions.

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.

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U.S. News Ranks Golisano Children's Hospital Among Best in Four Programs

Golisano Children's Hospital at the University of Rochester Medical Center (URMC) is steadily moving up the list of US News & World Report's Best Children's Hospital rankings. The hospital has been listed among the nation's best hospitals for four pediatric specialties – gastroenterology, neonatology, orthopaedics and neurology/neurosurgery. The annual rankings will be published in the US News Best Hospitals 2013 guidebook in August, are based on data submitted by nearly 180 pediatric institutions nationwide.

"We are delighted that Golisano Children's Hospital has – again – been recognized nationally for the expert care for which we are already known regionally"

Each of the past four years, Golisano Children's Hospital has added a specialty to the US News rankings, starting in 2009 with orthopaedics, which ranked #38 this year. Neonatology ranked #26; Gastroenterology, which is new to the list this year, ranked #43, and Neurology and Neurosurgery ranked #44.

"We are delighted that Golisano Children's Hospital has – again – been recognized nationally for the expert care for which we are already known regionally," said Nina F. Schor, MD, PhD, chair of URMC's Department of Pediatrics and pediatrician-in-chief of Golisano Children's Hospital. "We are able to provide this top-notch care because of the collaboration among many departments within URMC, the Ronald McDonald House and the community. And because of those partnerships, we are a destination for pediatric care throughout upstate New York, which underscores, even more, the need for our new children's hospital."

Amar Munsiff, MD Joins the Medical and Dental Staff at Rochester General Hospital

Rochester General Hospital welcomes Amar Munsiff, MD to its Medical and Dental Staff. Dr. Munsiff is a Hospitalist, and is Board Certified in Internal Medicine. After attending New York Medical College, Valhalla, NY, he completed his residency at Montefiore Medical Center, Bronx, NY.



Amar Munsiff, MD

The Plastic Surgery Group of Rochester is Proud to Welcome



Emily H. Beers, MD

Dr. Beers earned her undergraduate degree from the University of Michigan and her medical degree from the Ohio State College of Medicine. She subsequently completed a general surgical residency and a plastic surgery residency at the Rochester School of Medicine and Dentistry. She will begin accepting new patients on August 1, 2012. Appointments can be scheduled at (585) 922-5840.

Urgent Care Service Opening in Clifton Springs

FLH Medical, PC is pleased to announce the opening of their second Urgent Care location located in the Clifton Springs Professional Park in the Interlakes Orthopaedic Surgery Office and will provide on-site X-Ray services.

"We are pleased to be able to offer a much needed service. The community has requested more urgent care services in addition to our Geneva location. We recognize that people are very busy. Providing access

to care in the evening hours and weekends with shorter wait times to address unexpected medical concerns serves an important need. Additionally, Urgent Care is less expensive than going to the emergency room," explained Kurt Koczent, Administrator of FLH Medical, PC.

UNITY NEWS

Unity Health System is pleased to announce new roles and appointments for several of its longtime leaders.



Stewart Putnam

has been appointed president of Unity's Health Care Services Division.

Putnam has over 30 years of experience in health care administration and has held key leadership roles at St. Mary's and Unity since 1984, serving most recently as executive vice president/chief operating officer of Unity Hospital.

Prior to the creation of Unity Health System, Stewart served as president of St. Mary's Hospital. He was instrumental in establishing Unity's unique outreach programs for the vulnerable and underserved.

Putnam earned his bachelor's degree in Biological Health from Pennsylvania State University.



Michael Nazar, MD

has been appointed to senior vice president for Clinical Affairs of Unity Medical Group. Dr. Nazar has been with Unity since 1985, most recently as vice president of Primary

Care and Community Services for Unity Health System.

He received his MD from the University of Connecticut School of Medicine in 1982 and completed his residency in Family Medicine at the Highland Hospital, University of Rochester program in 1985. He is Board Certified in Family Medicine and Geriatric Medicine and a clinical associate professor of Family Medicine at the University of Rochester School of Medicine.



Joseph Salipante, MD

Dr. Joe Salipante has been appointed chief quality officer for Unity Health System. He previously served as vice president for Medical Affairs at Unity Hospital. Salipante joined St. Mary's

Hospital as a general internist in 1977 and became vice president for Medical Affairs at St. Mary's in 1990.

URMC NEWS

Yuhchyan Chen, MD, PhD, Named Fellow in Elite Leadership Program

Chair of Department of Radiation Oncology, Wilmot Cancer Center part of Global Class

Yuhchyan Chen, MD, PhD, Philip Rubin Professor and chair of Radiation Oncology



Yuhchyan Chen, MD, PhD

at the James P. Wilmot Cancer Center, has been accepted into the 2012-2013 class of Fellows for the Hedwig van Ameringen Executive Leadership in Academic Medicine® (ELAM) Program for Women at Drexel University College of Medicine. Chen was nominated for the honor by Mark B. Taubman, MD, dean of the University of Rochester School of Medicine and Dentistry.

"The selection of ELAM Fellows is a very competitive process and I am extremely honored to be chosen as a member of the newest class," said Chen. "I am excited about learning new skills and knowledge that better equip healthcare leaders to be both efficient and proficient in the rapidly changing healthcare environment. Radiation

Oncology is a medical specialty with evolving new technology, which can be costly. I hope to develop an analytical process and plan that will objectively assess the value and the impact of advanced technology on the cancer patient population in Upstate New York given our current and future economic challenges."

Chen is one of just 54 physician leaders selected for the 18th incoming class for ELAM®, the only program in the U.S. dedicated to preparing senior women faculty for positions of leadership at academic health centers. The program is designed to help participants foster a culture within their organizations that is more inclusive of different perspectives and responsive to societal needs and expectations. ELAM also aims to increase the diversity of women in leadership positions, and to continue to expand its reach beyond the US, welcoming participants from Canada, Europe and – this year – Saudi Arabia.

Chen joined the University of Rochester Medical Center in 1995, when she was appointed as assistant professor of Radiation Oncology. She began serving as acting chair of the department in December 2009 and was formally appointed chair and Philip Rubin Professor of the Department of Radiation Oncology at the Wilmot Cancer Center January 1, 2012.

New Pediatric Orthopaedic Surgeon Brings Hip Expertise to Region

U.S. News-ranked program expands at URMC's

Golisano Children's Hospital A new pediatric orthopaedic surgeon at Golisano Children's Hospital at the University of Rochester Medical Center brings with him highly specialized techniques for treating children and adolescents with complicated hip issues, such as dysplasia.

P. Christopher Cook, MD, FRCS, associate professor of Orthopaedics, was recruited from Dartmouth-Hitchcock Medical Center to join the Division of Pediatric Orthopaedics in URMC's Department of Orthopaedics. Cook earned his MD from Memorial University of Newfoundland School of Medicine and trained at Children's Hospital of Boston. He previously



P. Christopher Cook, MD, FRCS

practiced both at Pittsburgh Children's Hospital and in Halifax.

"Dr. Cook has the perfect blend of expertise and personality to fit well into our practice," said James O. Sanders, chief of the Division of Pediatric Orthopaedics and professor of Orthopaedics and Pediatrics. "Our families are going to love his bedside manner and skills, and we're delighted to have someone of his caliber join our team."

Golisano Children's Hospital's pediatric orthopaedic services, under Sanders' direction, have expanded in both depth and breadth over the past several years, earning it a place on the US News & World Report rankings for three years in a row. The addition of Cook will reduce wait times for patients and will open up new opportunities for children and adolescents with hip issues.

"He's the final piece of our hip preservation program," said Brian Giordano, M.D., assistant professor of Orthopaedics who specializes in arthroscopic surgery of the hip. "Most smaller cities have to send children with complicated hip problems elsewhere. We're now one of only a handful of centers that can repair soft tissues and larger structural abnormalities in the hip at the same time."

Cook said that the hospital's progress in expanding pediatric orthopaedic services and the plans for a new children's hospital, including pediatric operating rooms, were among the reasons he was drawn to the University of Rochester. He has also spent much of his career teaching the next generation of orthopaedic surgeons and looks forward to sharing that responsibility with Sanders.

RGH NEWS

Robert Nesselbush Named President at RGH

Paula Tinch Chosen as Interim Chief Financial Officer

Mark C. Clement, president and CEO of Rochester General Health System (RGHS) announced several senior level appointments.

Robert Nesselbush, Chief Financial Officer at RGHS since 2007, has been named president of Rochester General Hospital (RGH). "Bob has been a key member of



Robert Nesselbush

the Executive Leadership Team and has similarly played an instrumental role in our health system's growing success and progress in recent years," said Clement. "As healthcare reform revolutionizes payment and delivery systems, Bob's strong financial leadership, coupled with his ability to manage complex clinical and system initiatives, makes him uniquely qualified to lead RGH – the flagship of our system."

"RGH is a proven leader in our region, with a well-earned national reputation for excellence in a variety of clinical areas"

Since joining the health system as Director of Financial Reporting and Accounting in 1993, Nesselbush has taken on varied and expanding leadership roles and responsi-

bilities at RGHS. He has led some of the system's most important initiatives, including the successful launch of Care Connect, the \$70 million electronic medical record system that went live in 2011 at Rochester General Hospital and other key health system locations.

"I am honored, and extremely excited, to accept this position," Nesselbush said. "RGH is a proven leader in our region, with a well-earned national reputation for excellence in a variety of clinical areas. I look forward to doing all I can to help RGH find new ways to serve our growing community of patients with clinical innovation and compassion."

With the appointment of Nesselbush as president of Rochester General Hospital, Clement also announced that Paula Tinch, Vice President and Controller/Finance, will serve as the system's interim Chief Financial Officer. "During Paula's more than four years with RGHS, she has emerged as a high-performing financial leader," said Clement. "She has contributed directly to our strong year-over-year financial successes – making her well prepared, and well suited, for this interim role."

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RGHS Announces Innovative Women's Health Programs

A number of recent announcements from Rochester General Health System (RGHS) underscore the health system's commitment to comprehensive women's health services.

Erich Van Dussen



Obstetrics Quality Through Standardization

RGHS is one of the first health systems in the United States to adopt an innovative international program, MORE^{OB}, designed to enhance the quality of obstetrical care through a system-wide standardization of clinical processes.

A patient-safety continuous improvement program, MORE^{OB} ("Managing Obstetrical Risk Efficiently") helps Obstetrics teams develop and adopt new process-driven practices that can improve the effectiveness of already highly functional teams, and streamline communications throughout an Obstetrics unit.

RGHS affiliates Rochester General Hospital and Newark-Wayne Community Hospital jointly implemented the MORE^{OB} program earlier this year. Adopting MORE^{OB} simultaneously at both RGHS hospital affiliates reinforces RGHS's commitment to both patient-safety innovation and the system-wide integration of clinical services.

The MORE^{OB} program includes three progressive modules, each lasting one year. During that time, a core team of RGHS program leaders will help the full Obstetrics teams of both hospitals improve on their current care models through highly collaborative workshops, drills and self-conducted audits.

Since its initial 2002 pilot installation in 33 Canadian hospitals, the program has grown to include more than 230 healthcare organizations in the United States and Canada. The American Congress of Obstetricians and Gynecologists contributed to the adaptation and development of MORE^{OB}'s clinical content for health systems in the United States.

"In the short term, the MORE^{OB} program will help drive consistency and standardization in our care processes to help our teams provide obstetrical care that's not only consistent in its

high quality, but consistent in the way that care is delivered to patients," said Abraham Lichtmacher, MD, Chief of OB/GYN Services. "And in the long term, the program will create an environment of heightened patient safety, with improved outcomes and higher efficiency. It's a true win/win for patients, team members, the health system and the community we all serve."

RGHS was invited to join this exciting new effort thanks to the health system's reputation for clinical innovation, Dr. Lichtmacher added, as well as a recognized dedication to the constant improvement of patient safety.

Robotic Surgery on the Rise

Few hospitals nationwide are as experienced at robotic gynecologic surgery as Rochester General, and minimally invasive

robotic gynecologic surgery – with benefits including reduced blood loss and post-operative pain, shorter hospital stays and faster recovery periods – has become the single largest surgical category performed using RGH's two da Vinci robotic surgical platforms.

The health system has become a national leader in robotic surgical techniques. In early June, an RGHS surgical team completed the hospital's 5,000th robotic surgical procedure since the technology was introduced at Rochester General in 2004. This high-volume milestone places RGHS in the top 1 percent of hospitals nationwide for robotic surgery. To meet increasing demand, RGHS will add a third robotic surgical platform this summer, while expanding and clinically integrating robotic surgical services to Newark-Wayne Community Hospital.

For more information about RGHS and its commitment to innovative women's health services, visit www.rochestergeneral.org/women.



Abraham Lichtmacher, MD
Chief of OB/GYN Services

“In the long term, the program will create an environment of heightened patient safety, with improved outcomes and higher efficiency.”

URMC Clinical Trial Tests New Regimen for Hypertension

Could less be more for mild high blood pressure?

Researchers at the URMC are testing whether different doses of an established blood pressure medication can provide the same benefits as a standard dose in people with mild hypertension, possibly with fewer side effects and at a lower cost. The newly launched clinical trial, funded with a \$1.9 million grant from the National Heart Lung and Blood Institute, is the first of its kind in the United States.

The study drug, carvedilol (brand name Coreg®), is FDA approved and widely used for the treatment of high blood pressure. What researchers hope to learn is how varying amounts of the medication, including doses lower than typically prescribed, affect patients with mild or stage 1 hypertension – a systolic pressure (top number) ranging from 140 to 160 mm Hg.

According to hypertension expert and study investigator John D. Bisognano, MD, PhD, people with this early form of the disease are often advised to try lifestyle changes, such as eating a healthier diet and exercising, for six months to a year before initiating drug therapy. For individuals implementing lifestyle modifications who are also considering medical treatment, the trial provides an opportunity to try a safe and effective drug that, even at varying doses, may help bring their blood pressure back to healthy levels.

"It is so ingrained in everyone's mind that we have to have a constant level of medication, but it is possible that if the drug level goes down, the brain may be able to make up for that," said Bisognano, director of Cardiology Outpatient Services who will run the trial with Francisco A. Tausk, MD, professor in the Departments of Dermatology and Psychiatry and Jan A. Moynihan, PhD, Engel Professor in Psychosocial Medicine, also in the Department of Psychiatry at the Medical Center. "We may be able to meet the medical need with less medication in this low-risk population and potentially decrease side effects in the process."

Such an outcome would be a huge step forward for the millions of Americans with mild hypertension who are limited in the amount or number of medications that they can take because of adverse side effects. It may also appeal to the growing number of Americans who are skeptical of or want to avoid standard pharmaceuticals, a culture change that Bisognano and other physicians have witnessed in their practices over the past few years.

According to the Centers for Disease Control and Prevention, nearly a third of the nation's adults struggle with high blood pressure, which increases the risk of heart disease and stroke and represents a significant economic burden to society, with \$54 billion spent on the condition in 2001 alone.

RGH Awarded Funding to Train New Physicians in Community Settings

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

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

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



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