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Western New York
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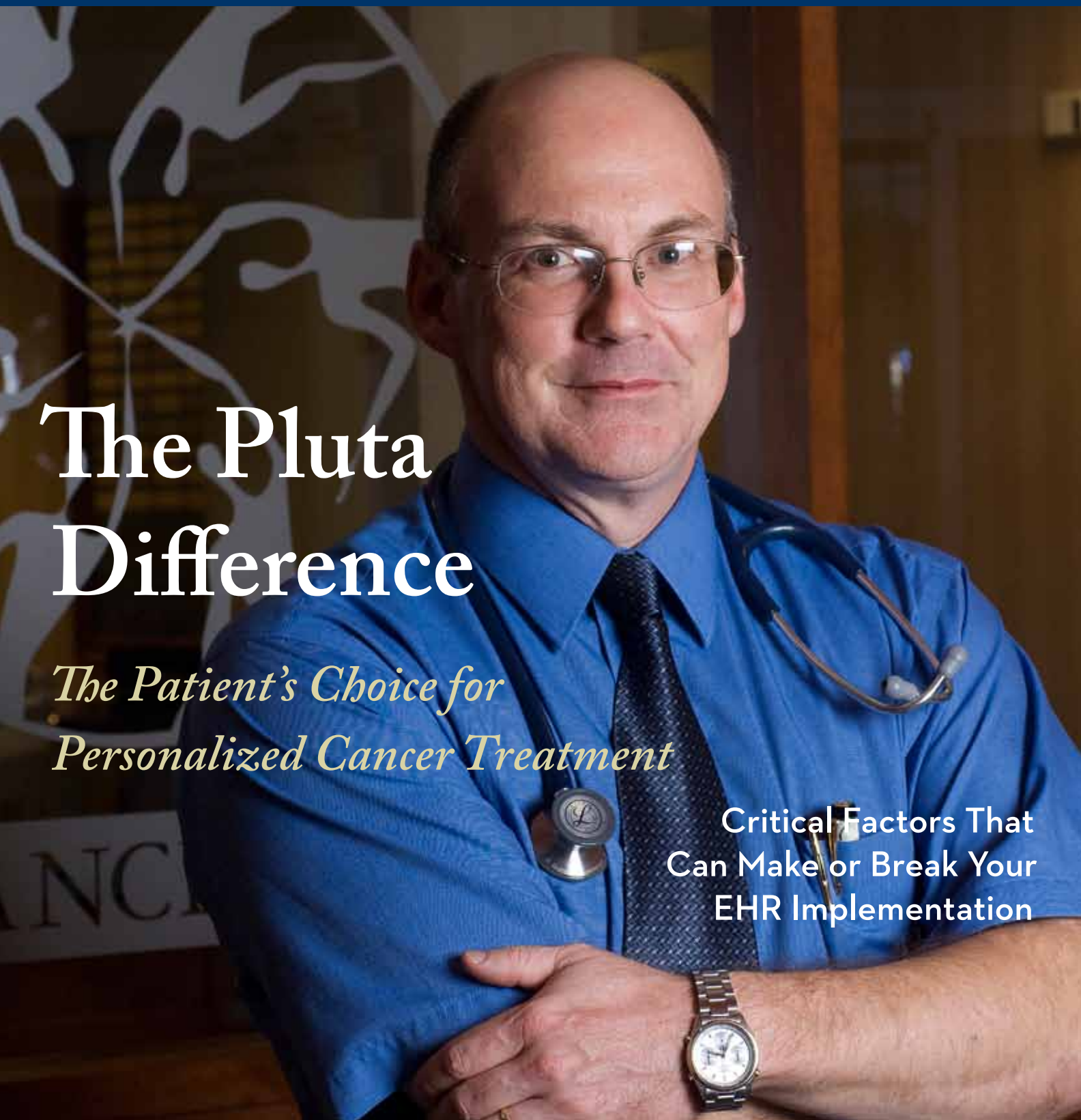

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Contents

Front row L to R: Sandra McDonald, MD; Jan Dombrowski, MD, Pluta Medical Director; Jennifer Cadiz, MD.
Back row L to R: Marcia Krebs, MD, Brian Yirinec, MD.

Welcome to the October Issue of Western New York Physician

We've entered, what for many, is the busiest time of the year. Whether you're in private practice or employed by a healthcare provider or center, the 4th quarter commands attention – to wrap-up – to reflect upon our position – to plan for the year ahead.

With only two issues remaining in the year, I myself am well into the process of planning – which for me begins with the editorial calendar. My goal is to uncover unique and relevant topical angles, ones that are significant in our region and which may expand awareness of area resources or present alternative approaches – to patient care and the business of medicine. The feedback I've been receiving from readers, contributing authors and advertisers has been of extraordinary value, drawing my attention to what is most important – the concerns and interests of the reader. Thank you to all of those who took the time to convey their thoughts and ideas. I'd like to hear from even more readers so I hope you will join in the conversation and participate in a brief and confidential online survey. See page 14 for details. My hope is to make valued improvements to the magazine – and your feedback ensures that I deliver just that. Thank you in advance for taking the time to share.

This month we visit the **Pluta Cancer Center**, the region's only independent facility dedicated to comprehensive cancer treatment. *What is the Pluta difference?* Read on for a glimpse of the unique and very personal approach to caring for cancer patients.

The World Health Organization has recently declared the human papilloma virus (HPV) as the new leading cause of cancer of the oral cavity and oropharynageal tissues, particularly in young, white, females. Because this patient category doesn't fit the typical profile, these tumors can go dangerously unnoticed. Drs. John Coniglio and Steve Cannady illustrate one successful case emphasizing how early recognition, diagnosis and treatment allow for dramatic cure rates and minimal loss of functional morbidity.

Continue on to find the latest thinking on EHR evaluation – avoiding the pitfalls for a successful transition; financial perspective on how not responding to the unknown impending changes to the tax code can dramatically impair the legacy of your life's work; and considering the medical liability issues related to the waiving of co-pays. Many thanks to each of you who contribute to and support ***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 practice and their patients and your advertising support makes it possible to deliver the magazine to readers each month.

Regards,

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The Changing Face(s) of Oropharyngeal Carcinoma Treatment at:

The Rochester Head + Neck Center

Steven Cannady, MD

John Coniglio, MD, FACS

Steven Cannady, MD and John Coniglio, MD, FACS

HISTORY

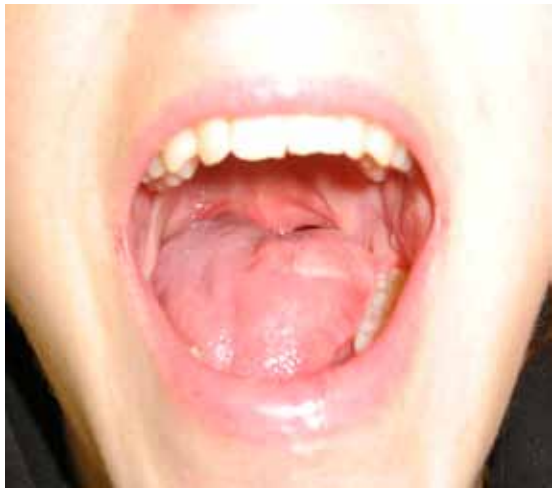
A 21-year old woman presented to RHNC with a 4-month history of progressive difficulty swallowing accompanied by left ear pain and 25 pound weight loss. She had no history of tobacco use and rarely drank alcohol. On examination there was a 3-4cm left posterolateral tongue base lesion (Figure 1). A transoral biopsy of the lesion confirmed a positive staining for p16 human papilloma virus (HPV within a pathologic squamous cell carcinoma). A Neck cat scan (CT) demonstrated the aforementioned lesion with a suspicious left neck node while a metastatic workup with chest CT was negative. The patient underwent a left transmandibular composite tongue base resection and neck dissection, with an anterolateral (ALT) thigh free microvascular reconstruction. Final pathology revealed all margins free of tumor and one metastatic lymph node. Radiation therapy was recommended and successfully completed. The patient is now 1- year post treatment with no visible surgical scarring, normal swallowing, speech, and tongue mobility (Figure 2).

BACKGROUND DEMOGRAPHICS AND EPIDEMIOLOGY:

Oropharynageal carcinoma (OPC) arises in the most posterior aspects of the oral cavity and upper pharynx; subsites include the base of tongue (posterior to the circumvallate papillae), the posterior pharynx, the soft palate, and the tonsil. Tumors arising in the OP often go unrecognized until they grow to sufficient size to be considered advanced stage. Squamous cell carcimoma (SCCA) accounts for >90% of OP tumors, however, lymphoma, minor salivary gland tumors, or metastatic lesions are all possible.

Historically, tobacco abuse and alcohol consumption have led to peak incidence in the 6th to 7th decade of life in men greater than women. Alcohol and tobacco, when abused in conjunction, lead to a multiplicative effect resulting in a 50-fold relative risk increase over those that do not use these products. More recently recognized is a subset of patients that develop OPC from HPV. This newly recognized group of patients are unique from traditional OPC patients in that they are often nonsmokers who rarely drink alcohol, and are more likely to be young, white, and female. Epidemiologic studies indicate that HPV patients tend to present with similar symptoms to traditional patients, however, HPV positive patients clearly develop tumors that raise a different set of questions and concerns. In fact, after cervical cancer, HPV OPC is the second most common virally induced tumor. People that test postivie for HPV-16 in the oropharynx are 14 times more likely to develop OPC than non-carriers. A Scandanavian study published in 2006 showed that husbands of women that developed cervical cancer were more likely to develop tongue or tonsillar carcinoma. Additional recent epidemiologic data led the World Health Organization (WHO) to declare that HPV is the new leading cause for cancer of the oral cavity and OP. The increase in this type of cancer recognized in the last ten years in 22-40 year old patients with no smoking or drinking history has made it a reality to suppose that OPC is in part a sexually transmitted disease. Indeed, patients with HPV OPC tend to report more sexual partners, and unprotected sex-

ual contacts. To the contrary, nearly 80% of the general population are carriers for HPV when tested with sensitive techniques, with over 120 strains currently known. Thus, it is important to distinguish benign from cancer inducting strains such as HPV 16, and realize that multiple factors induce OPC. When taken together, the changing face of OPC patients has prompted research into how to approach these patients differently given the long life ahead of them assuming they can be cured. Efforts have focused on less invasive surgical approaches such as transoral robotic surgery, transoral laser surgery, and free flap reconstruction of surgical defects to improve patients abilities to maintain normal swallowing and speech despite major surgery. What has become more clear over the past two years is that surgery, as part of an overall approach in OPC, improves overall survival, and trends towards better disease specific survival. All this recent information has helped shape a changing approach at the RHNC to treatment for OPC.



White or red discoloration in the oral cavity or OP for longer than 14 days should be evaluated by a physician. Leukoplakia and erythroplakia are precancerous conditions that require close monitoring at a minimum, with transoral biopsy as the gold standard for diagnosis. Advances in cancer screening techniques such as autoflourescent light may help detect earlier cancers than ever before and play a role in at risk individuals. Early cancers can be easily removed transorally and reconstructed with minimal functional morbidity and high cure rates (90%). Often adjuvant therapy such as radiation can be avoided. HPV patients, as a subset, have better outcomes overall when compared with tobacco induced counterparts. Recent phase III data showed a 58% reduction in death for HPV OPC patients compared with others.

More advanced tumors that involve adjacent bone such as mandible, or musculature of the oropharynx may lead to progressive ear pain, pain with swallowing, dyphagia, trismus (from mastication muscle involvement), oral fetor, and lymph node involvement. Stage III and IV cancers can be managed with chemoradiation administered concurrently or surgery followed by radiation therapy.

Unfortunately, chemoradiation follow up data reveal up to a 14% rate of severe long term complications such as jaw necrosis or feeding tube dependence. A recent 25-year review of tonsillar cancer treatment for advanced tumors showed improved survival when surgery was incorporated into the treatment plan. In another study, 38% of patients were able to avoid radiation alltogether when surgery was used as an upfront approach. Thus, our approach has shifted in recent years to offer surgery when possible for most tumors. Assuming surgery affords best outcomes, research has also supported reconstruction with free tissue transfer from the forearm, thigh, abdomen, or even back to recreate a pharynx, tongue, palate, or tonsillar fossa. Even for advanced tumors, other centers, as well as ours, have had excellent functional outcomes with >90 percent of patients swallowing without the need for feeding tube, and the remaining 10% using a feeding tube but also swallowing some. In addition, the ability to bring vascularized tissue to the defect allows the resection to be wider improving local and regional control of disease.

Advances in our understanding of OPC, and HPV OPC bring new excitement to treatment of these diseases. The last 50 years have been disappointing for lack of improvement in survival for OPC. The greatest advances have been in our abilities to reconstruct, and maintain function with reconstruction. The next 50 years promise to allow us to employ less invasive approaches through the mouth with laser and robotic surgery, while continuing to refine the reconstructive techniques that allow patients to speak and swallow despite large tumors of the throat.

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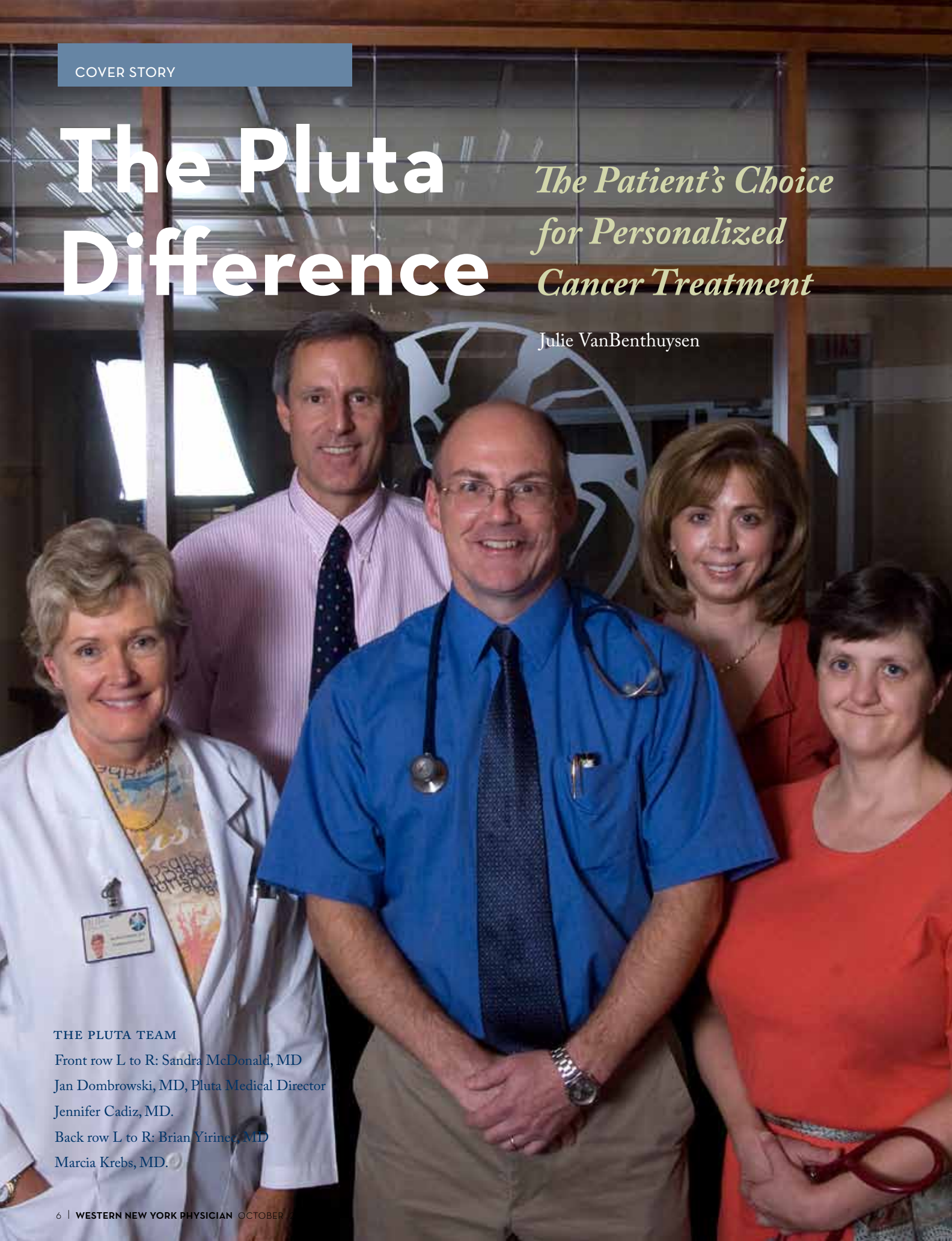
The Patient's Choice for Personalized Cancer Treatment

Julie VanBenthuysen



THE PLUTA TEAM
Front row L to R: Sandra McDonald, MD
Jan Dombrowski, MD, Pluta Medical Director
Jennifer Cadiz, MD.
Back row L to R: Brian Yiriner, MD
Marcia Krebs, MD.

CANCER SURVIVOR Joan Zummo was diagnosed with lymphoma six months after her husband Joe began chemotherapy for his own cancer. Despite the extraordinary ordeal over the course of one year, Joan recalls the experience with gratitude – giving thanks to the attentive physicians and staff at Pluta Cancer Center. Joe Zummo ultimately lost his life to cancer, but his wife of many years recently paid him tribute at Pluta's annual Emerald Ball fundraiser, sharing stories about what she calls "The Pluta Difference." From nurse Kitty who made Joe laugh, to the countless "extra miles" staff went to ease Joe's discomfort in his final days, Joan insists that only Pluta could have gotten her through the dual cancer treatments – and through the grief later on.

Joan's story captures the essence of Pluta Cancer Center, the region's first and only independent facility dedicated to comprehensive cancer treatment. Pluta maintains a medical approach based on using the most sophisticated technologies and treatments with warmth and compassion. "It's our belief that cancer care should revolve around a patient's life, not just the diagnosis," says Dr. Jan Dombrowski, Pluta's Medical Director and one of its two Radiation Oncologists.

That belief was instilled 35 years ago when the Pluta family provided a grant to the former Genesee Hospital to support a dedicated cancer center within the institution. When the hospital closed its doors in 2001, the Pluta family's commitment and heartfelt persistence to keeping cancer care front and center enabled the facility to remain open until a new, free- standing facility could be built.

"We knew we could accomplish everything we were already doing, but in an outpatient setting with the latest in cancer treatment equipment and patient comfort foremost in our minds," says Dr. Dombrowski.

A Welcoming "Home"

When then Medical Director Dr. Sandra McDonald and the Pluta family began to develop the new home for the Center, they took great pains to design a facility that would best suit patients in a non-threatening alternative to the institutional feel often associated with cancer treatment. Nearly all Pluta staff at Genesee Hospital joined the new facility, and the vast majority of that staff remains with the practice today, a testament to their commitment to the vision of the Pluta family.

Located conveniently in Henrietta, NY, the Center welcomes patients from the moment they enter the inviting lobby featuring comfortable seating areas with a fireplace view. The entire facility's layout spans a single floor, reflecting a recent trend in design that allows patients and staff to remain safely "above ground" for radiation treatments, in far more appealing rooms complete with colorful, hand-painted walls.

courtesy of Pluta Cancer Center

Pluta's linear accelerator provides state-of-the-art treatment in an environment designed for patient comfort.

Prominently displayed on the main reception wall is a large bell; it is a tradition for patients to "ring the bell" after their final radiation or chemotherapy treatment in celebration with Pluta staff. The bell, handcrafted and donated by a local fireman in appreciation for his completed treatment, symbolizes the special relationships forged at Pluta between patients and staff.

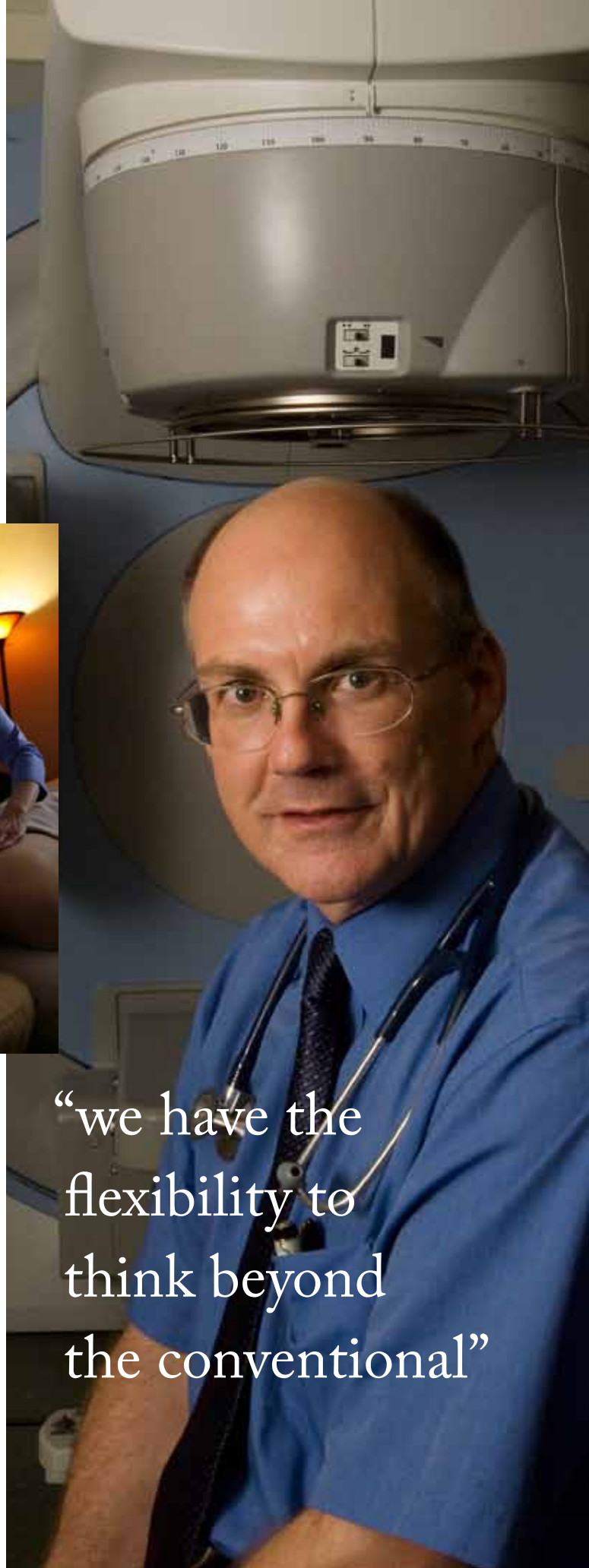
Where Everyone Knows Your Name

Recalling her time at Pluta, Joan Zummo talks warmly of the personal touch she felt on a daily basis, and of similar experiences she witnessed with other patients. On her husband's first day at Pluta, she says, his photograph was taken so that every staff member from that moment forward would know who he was. When nurse Marty approached Joe in the lobby that first day, she was able to greet him by name. "As I followed them down the hall, Marty took his hand," says Joan. "I knew then that Pluta was a different kind of place and that we were in the right place."

With five physicians on staff, Pluta manages more than 13,000 patient treatments and welcomes 900 new patients each year, including more than 5,000 patient follow-ups. Despite the busy pace, Pluta's top priority remains its patients' emotional and physical well-being. Pluta staff includes a social worker, massage therapist, and registered dietitian, tending to the non- clinical needs of each patient. Other patient benefits include yoga, tai chi, cooking classes and support groups. Social Worker Susan Nelson, who has been with Pluta for nearly 15 years, also serves as Director of Complementary Services. "These resources enable our patients and their caregivers a greater quality of life during treatment and recovery," she says.

Courtesy of Dixon Schwabl

Licensed massage therapist Jean Van Etten, who joined the practice in 2003, has been a welcomed resource for Pluta patients, says Dr. Dombrowski. "Jean has been well embraced and utilized by our patients since we introduced the service seven years ago." The same holds true for registered dietitian Jennifer Swartz. "We found early on that we needed a dietitian, especially for our head and neck cancer patients," he says. "Then we expanded the counseling to include patients with GI, lung, abdominal and gynecological diseases." Dr. Dombrowski recognizes that with the inclusion of these proven beneficial services, patients feel like they've been given a safe haven at Pluta.



Patients Choose

Dr. Dombrowski also defines the Pluta Difference in terms of access – access to the latest treatments and state-of-the-art equipment, and consistent access to physicians. "As an independent practice, we've always stayed committed to our doctors being responsible for the continuity of care which is why a patient will see the same physician throughout the treatment," Dombrowski says.

This accessible approach was crystallized for Joan Zummo, who watched regularly as two female patients drove more than 100 miles one way each day during the worst of the winter months to be treated at Pluta, despite one of them having a cancer treatment center just around the corner from her home.

"We recognize that patients can choose where they receive their cancer treatment," says Dr. Dombrowski. "As an independent center, we have the flexibility to think beyond the conventional, to see new patients within 72 hours, and to work with all area physicians and health care systems without being affiliated with any one."

Ongoing patient surveys consistently show a 99% satisfaction rate with the Pluta experience, with many citing the opportunity to experience something completely different. "Patients are more intelligent about care these days," says Dr. Dombrowski. "They want to be as educated as possible," he says, "and they want to know right off the bat what they can do to maintain some control over the situation."

Commitment to Latest Treatments

Pluta staff strives to maintain a niche in the community for people who want modern, up-to-date treatment in an environment that supports them body, mind and spirit. For instance, Pluta was the first cancer center in the Rochester region to perform accelerated partial breast radiotherapy. "We can offer women an alternative to a mastectomy, particularly those living in outlying areas," says Dr. Dombrowski.

Pluta provides radiation and chemotherapy on site. The radiation department includes two leading-edge dual energy linear accelerators capable of delivering Intensity Modulated Radiation Therapy (IMRT) treatment and utilizing the latest in image guidance (IGRT) to accurately target tumors. The Center also has a High Dose Rate (HDR) brachytherapy unit that allows staff to treat specific malignancies in the breast with technologies such as MammoSite, as well as certain gynecological and soft tissue tumors.

The medical oncology department utilizes state-of-the-art protocols and actively participates in clinical trials. Chemotherapy is administered in a setting designed for patient comfort with lounge chairs, personal TVs and wireless Internet.

Thoughtful Truthfulness

Among the many things that Joan Zummo says impressed her about Pluta was the staff's "thoughtful truthfulness" – a kind and compassionate honesty delivered in a form each patient could handle. Her husband Joe never used the word cancer during his treatment, but referred to the "puppies" his surgery had left behind. When he learned his tumor count was going up, he said to Dr. Cadiz, "The puppies are growing and they are having a party." Without pause, says Joan, Dr. Cadiz replied, "Yes, Joe, the puppies are growing, but they are a long way from having a party." In those few words, she says, Dr. Cadiz told Joe the truth, reassured him and gave him hope, and she did it in the language he had chosen and was comfortable hearing."

Social worker Susan Nelson describes Pluta's services to a new patient.

Consistency, Connectivity

Clearly, treating cancer is only part of Pluta's mission. It's giving patients the most comprehensive experience despite Pluta's role as a tertiary provider, receiving them only after they've met with their Primary Care physician, undergone imaging work and seen a surgeon. "It's critical that we always communicate back to the patient's PCP," says Dr. Drombrowski. It'softentimes during cancer treatment, he says, that other medical issues like high blood pressure are detected that require consultation with their PCP. "We strive to work with other health care providers to ensure there's a strong partnership between patients and every practitioner along the way."

It's no surprise referrals to Pluta come largely from the word of mouth of satisfied patients and their families. Area PCPs and specialists who recognize Pluta's different approach continue to be very loyal to the practice. "Our referring doctors feel comfortable with what we do and have been supportive for a very long time," says Dr. Dombrowski.

Veteran urologist Dr. John Valvo, Chief of Urology at Rochester General Hospital, agrees. "The Pluta Cancer Center provides expert, compassionate care while always respecting the dignity of the individual," he says.

Community Give and Take

As a non-profit organization, Pluta relies on the quiet generosity of its many donors. Fundraising efforts include the Emerald Ball, now in its 11th year, an annual Tree of Hope event, a Mother's Day event at Red Wings games, high school basketball games and ladies' hockey tournaments. "Over the years, the community has been very supportive," says Dr. Dombrowski. "Collectively, Pluta has received a substantial amount in gifts toward our ongoing efforts to deliver to our patients the best possible treatment."

In keeping with its community-centric tradition, Pluta offers complimentary medication, food and transportation for patients with economic hardship and lunches for all patients undergoing extended chemotherapy sessions. Through Pluta's connection with the American Cancer Society, patients make use of the resources of Rochester-based Hope Lodge, one of only 30 facilities nationwide offering out-of-town patients a place to stay while undergoing cancer care.

As an online extension of its staff, care and environment, Pluta patients and their family and friends can also tap the Center's website, www.PlutaCancerCenter.org, to find a simplified yet comprehensive website to inform and help them cope with a cancer diagnosis.

Looking Ahead

The biggest change Dr. Dombrowski has seen over the past decade has been the decentralization of oncology care. "Prior to 2000, everything cancer-related was done within the hospital setting. The level of sophistication we can bring to bear in our own facility now is impressive." Dr. Dombrowski also cites the instantaneous access in this information age, which now makes available within days published reports on groundbreaking cancer treatments– representing an enormous information transfer and a complete change in the healthcare model.

Dr. Dombrowski and his fellow physicians also recognize the opportunities ahead with biological immunology and vaccine and targeted drug therapy. "As we continue to understand the critical role genetics plays in cancer, there will be far more individualization of therapy based on the patient's actual diagnosis," he says.

Even with all the exciting advancements on the horizon, says Dr. Dombrowski, Pluta remains committed to that gentler touch its staff provides to cancer patients. "The people at Pluta are its heart and soul," insists Joan Zummo. "My husband got to tell his story one last time, and the last days of his life were immeasurably more comfortable because of these people. That's the Pluta difference."

"Collectively, Pluta has received a substantial amount in gifts toward our ongoing efforts to deliver to our patients the best possible treatment."
~Dr. Jan Dombrowski

The Benefits of Massage for Oncology Patients

Kim Ross, LMT

Kim Ross, LMT

You may be aware clinical research is mounting in support of massage for people in compromised and stressful health situations. Most recently researchers at Cedars-Sinai Medical Center in Los Angeles recruited 53 healthy adults and randomly assigned 29 of them to a 45-minute session of deep-tissue Swedish massage and the other 24 to a session of light massage.

To their surprise, researchers found that a single session of massage caused biological changes. Although both groups benefitted, the differences may offer meaningful benefit to cancer patients in particular. The researchers found volunteers who received light massage experienced greater increases in oxytocin, a hormone associated with contentment and bigger decreases in adrenal corticotropin hormone, which stimulates the adrenal glands to release cortisol. Clearly, light touch massage is valuable to those with cancer for its ability to decrease hormones that hinder the healing process as well as its comforting effects.

Comfort-oriented massage (never deep pressure) or simple touch (meaning employing light holds instead of rubbing the skin) can be administered to people with cancer regardless of the severity of their condition. This is the approach of therapists with special training in oncology massage. These therapists have been trained to take a detailed health history at each massage session with their client and will modify their technique to work around side effects or complications of radiation, chemotherapy, surgery, and medications. Blood counts are considered in massage design, as well. They will reach out to the patient's physician if they are concerned about proceeding with a massage.

Where can you suggest your patients go for massage? Use Human Touch Initiative (HTI) as a resource. HTI is a local organization whose mission is to help those with cancer access massage with specially trained oncology massage therapists at low or no cost. Patients can visit www.HumanTouchInitiative.org for a list of qualified oncology massage providers in the area whether applying for HTI support or not.

Kim Ross, LMT, is the Executive Director of Human Touch Initiative. She is available for consult or to give talks regarding oncology massage.

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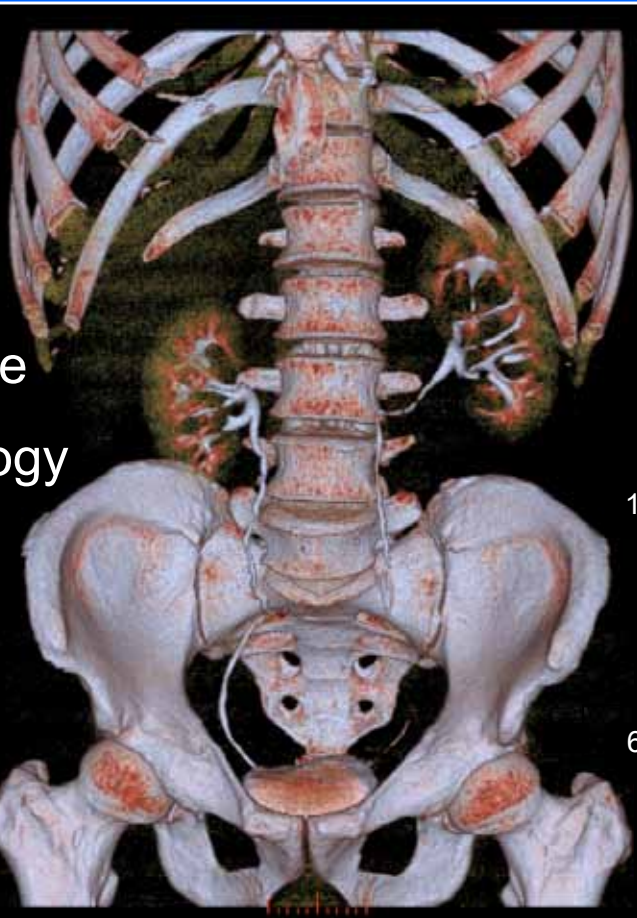

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Advances in CAT Scan

Michael Lechner, RT(R) (MR), CAPPM

Michael Lechner, RT(R) (MR), CAPPM

Since the introduction of Computer Axial Tomography (CAT scan, CT) by Godfrey Hounsfield and Allen Cormack in 1972, there have been many important advances in CT technology.

In the beginning, CT was not a practical clinical tool because it took too long to get an image. It wasn't until the early 1980s that the technology was efficient enough for clinical use. Even then, the systems took several minutes to produce a single image. A major advance was spiral CT which captured one slice, in one tube rotation. This combined with more powerful computers allowed for both rapid image acquisition and reconstruction.

In the 90's, Multislice scanners were a breakthrough in CT imaging. The technology added multiple detectors to rotate in tandem with the x-ray tube. This allowed for multiple slices of image data to be obtained in a single rotation of the x- ray tube. System configurations grew from 4 slice up to 32 slices. With the ability to obtain volumetric coverage with increased speed, these CT scanners allow users to capture whole organs in seconds.

"An important issue within radiology today is how to reduce the radiation dose during CT examinations without compromising image quality."

New 64,128 and 256 multislice detector CT scanners allow life saving imaging by capturing aortic dissection, pulmonary embolism and coronary artery disease in one single gated thoracic exam. These emergency studies are often called "triple rule outs." Other systems have the ability to dynamically obtain both anatomical and functional information in a single cine acquisition of the brain to allow immediate treatment during acute stroke evaluation. Coronary Artery Angiography (CCTA) can image the coronary arteries in less than 10 seconds and allow for great detail in evaluating calcifications, soft plaques and blockages. CTA Runoff studies can efficiently capture the blood vessels from the renal arteries to the toes without the need for interventional angiography.

Dual energy CT integrates two detector and tube assemblies into one rotating gantry. Dual-energy CT techniques extract and compare data from x-ray photons in two distinct energy bands. This information can be used to distinguish between structures of similar composition such as CT contrast in the coronary arteries and coronary calcium. Both have similar densities and appearance but can be subtracted from one another to more accurately define stenosis.

An important issue within radiology today is how to reduce the radiation dose during CT examinations without compromising image quality. Generally, higher radiation doses result in higher-resolution images, while lower doses lead to increased image noise and blurrier images. Today, a powerful and computationally intensive software algorithm exists to lower radiation doses of a CT scan by up to 40-50% while still maintaining image quality.

So what lies ahead for CT imaging?

Spectral and multi energy imaging CT systems are in development to characterize diseases such as cancer. Spectral systems have the potential to draw data from dozens of separate energy levels, revealing information specific to certain clinical conditions, and can help to reduce or eliminate image artifacts.

One of the most important advances will be to further extend the dose reducing technologies currently available. The ALARA principle assumes that there is no "safe" dose of radiation. Under this assumption, the probability for harmful effects increases with increased radiation dose, no matter how small. Therefore, it is important to keep radiation doses to as low as is reasonably achievable. Specifically in examinations such as CT, it is vital to utilize the least amount of radiation to protect the patient yet not degrade image quality. Full model radiation dose reduction uses image processing algorithms that produce high-quality CT exams with multiple times less the radiation used under existing protocols. This is a computationally intensive technique which is not yet available in current CT scanners. CT is an extremely powerful diagnostic tool which is widely used throughout the world. However, as the use of CT has increased the concern over increased radiation exposure to patients has also increased. Whatever the advances are within the imaging realm of CT, lowering the radiation dose must be a key goal of all CT imaging manufacturers moving forward. University Medical Imaging, P.C. applies the most recent low dose technology available on the market, and will continue to evaluate advances in CT imaging technology moving forward.

***Michael Lechner**, RT (R) (MR) is the Practice Administrator at University Medical Imaging.*

What is My Liability?

Waiving Co-Pays: Courtesy or Liability?

James E. Szalados, MD, MBA, Esq.

James E. Szalados, MD, MBA, Esq.

Issue:

Your patient requests that you waive his co-payment obligation so that he might see you more frequently for his complicated and chronic medical condition. Physicians might altruistically hope to reduce the cost of medical care for certain patients by waiving co-payment requirements ('waiver of co-pay' or 'insurance only'). Under Health Care Reform, the actual dollar amount of co-pays is likely to increase, underscoring the need to understand the implications of routinely waiving co-pays. A co-pay refers to a cost-sharing obligation under which the insured is responsible for payment of the co-pay at the time when services are rendered. Physicians are not categorically prohibited from waiving fees in whole or in part; however it is critical to understand the circumstances in which it is inappropriate to do so. Legal liability for the waiver of co-pays has primarily stemmed from waivers granted that are not communicated to the relevant insurer; and, from waivers linked to the inducement of referrals, either in reality or simply in appearance.

Waiver of co-pay is different from a waiver of charges; waivers of co-pay have significant legal implications whereas under most circumstances a physician's waiver of all charges may be inconsequential as long as there is no underlying fraudulent intent (such as, concealment of medical information or incentivation of laboratory utilization) or effect.

There are two common circumstances under which providers might waive co-pays: first, for patients with economic hardship; and second, as professional courtesy to fellow physicians or their families. There are no special exceptions in the law which would allow professional courtesy to physicians or their families.

The American Medical Association Compliance Guide for Medical Practice states that "[t]he waiver of copayments and deductibles and the provision of free services, except in limited situations due to the patient's financial or medical indigence, may be viewed as a violation of law or a violation of the physician's participation agreements with insurance companies... However, a decision, in the exercise of business judgment, not to pursue the full legal remedies available to collect a debt would not constitute insurance fraud."[1]

Traditionally, physicians would discretionarily waive co-pays for patients with economic hardship. On one hand, physicians cannot deny services to patients who are unable to afford a co-pay. However, an unpaid prior co-pay may be construed as unpaid debt, and since physicians are not required to continue to provide elective care to patients with unreconciled outstanding debt following appropriate notice, the physician may then discharge a patient from their practice. On the other hand, providers may choose to continue to serve recipients who are unable to pay the co-pays but must inform insurers of the circumstances under which they are doing so.

Penalties for improper waivers of co-pays might range from insurers' denial of all related payments or even de-selection of an involved provider from an insurer's panel (sanctions); civil or criminal prosecution for breach of contract, fraud, or mail fraud; or criminal conspiracy under RICO. State licensing agencies may view such charges as cause for investigation or suspension of licensure. Prosecution under the federal False Claims Act can result in the imposition of civil, criminal, or civil monetary penalties and loss of participation in Medicare and Medicaid.

Private and governmental payers base their arguments against waivers of co-payments and/or co-insurance generally on three areas of law:

Waiver of Co-Pays as Insurance Fraud

Waiver of co-pays violates Federal and State Insurance Fraud laws. However, there are many simpler reasons that insurers would want discourage waivers of co-pays for patients. Insurers believe that co-pays discourage frequent and casual visits to physicians and impose a small but significant cost sharing on patients, this then limits insurer payouts for potentially unnecessary care. Also, insurers reimburse physician's claims based on a 'reasonable, usual and customary' standard; the insurers' reimbursement is calculated based on complex statistical analyses of the prevailing costs for similar services within a set geographic area. Routine waivers of co-pays may thus suggest to insurers that they are reimbursing charges at a higher amount than would otherwise be necessary.

The following example illustrates how waiver of a co-pay might be construed to be insurance fraud:

Where the customarily charge for an encounter or procedure is $100, and implicit in the reimbursement is an assumption that the provider will collect a 20% co-pay, the insurer would then reimburse the balance of $80. If, however, the provider waives the co-pay, that provider's apparent [discounted with respect to market value] charge for the encounter would really be $80, for which the insurer, after a 20% co-pay allowance, would be obligated to reimburse only $64.[2] In this particular example, submitting a claim to the insurance company for $100 would be considered an actionable fraudulent or even false claim. In this particular scenario, the 'knowingly' and 'materially false' elements of N.Y. law which statutorily defines insurance fraud[3] and imposes penalties for violations could be relatively easily demonstrated:

> A fraudulent health care insurance act (1) is committed by any person who, knowingly and with intent to defraud, presents, causes to be presented, or prepares with knowledge or belief that it will be presented to, or by, an insurer . . . or any agent thereof, any written statement or other physical evidence as part of, or in support of, . . . a claim for payment, services or other benefit pursuant to such policy, contract or plan, which he knows to: (a) contain materially false information concerning any material fact thereto . . . . or, (2) which he knows to: (a) contain materially false information concerning any material fact thereto; or (b) conceal, for the purpose of misleading, information concerning any fact material thereto... .

In a published opinion, the New York Insurance Department determined that if a provider waives a co-pay that would be otherwise applicable, liability for insurance fraud might be avoided if the insurer is made aware of the waiver.[4]

Waiver of Co-Pays as a Violation of Federal and State False Claims Acts:

Failure to collect co-pays for individuals covered by Medicare or Medicaid is a violation of the Federal False Claims Act, and the NY State False Claims Act. Additionally, if a practitioner waives otherwise required co-pays as a customary business practice, without the knowledge or consent of a private insurer, he or she may be guilty of insurance fraud that would reach the level of federal prosecutorial discretion under HIPAA. However, in the case of Medicare and/or Medicaid recipients, waivers may be specifically interpreted to represent the filing of a false claim[5] to the government and violation of federal and state fraud and abuse laws. The Patient Protection and Affordable Health Care Act of 2010 reinforces and strengthens existing False Claims Act legislation.

The Office of Inspector General (OIG) of the Department of Health and Human Services (DHHS) has determined that 'a routine waiver of co-pays and/or deductibles is equivalent to misstating charges to government programs and thereby constitutes a violation of the federal False Claims Act.'

The New York State False Claims Act[6] is patterned upon the federal False Claims Act and is enforced by the Office of the New York State Attorney General.

Waiver of Co-Pays as a Violation of Stark and Anti-Kickback Legislation:

Medicare Fraud and Abuse subsections, Stark, and Federal Antikickback[7] legislation each prohibit the use of any inducements that could influence a decision to refer patients, or which may affect a patient's decision to seek care. Specifically, the anti-kickback statute makes it a criminal offense to knowingly and willfully offer, pay, solicit, or receive any remuneration to induce or reward referrals of items or services reimbursable by Federal health care programs. For the purposes of the statute, "remu-

neration" includes a transfer of anything of value, in cash or in kind, directly or indirectly, overtly or overtly. The OIG has long held that providers who routinely wave Medicare copayments or deductibles for reasons unrelated to individualized, good-faith assessments of financial hardship, may be held liable under the anti-kickback statute.[8] Remuneration specifically includes the waiver of copayments and deductible amounts.[9] The OIG opines that waivers may represent inducements to Medicare beneficiaries resulting in self-referral to physicians for additional utilization of services; or, incentivation of patients to use one physician's practice over another.

Nonetheless, the statute does contain certain exceptions to the definition of "remuneration" for waivers of co-pays that are not advertised, and are not routine, and there are granted to financially needy patients for which reasonable collection efforts have been made.

Conclusions: Strategies to Limit Liability:

In conclusion, the routine waiver of co-pays (or deductibles) exposed a physician's practice to multiple tiers of legal liability and every practice should carefully evaluate its policies regarding waivers of co-pays or charges to assure conformity with the law. This is an area where expert legal advice and guidance is vital to minimize liability. With respect to private insurers, a physician's decision to waive a co-pay should, at the very least, be communicated to the insurer. Patients insured at any level through a federally-funded funded program such as Medicare or Medicaid, may not be routinely granted a waiver of co-pay except under specific limited circumstances. There is no specific exception for waiver of co-pays as professional courtesy. Every medical practice must develop and maintain a formal written policy in place with established guidelines regarding waiver of co-pays, waiver of all professional charges, and guidelines for determining a given patient's financial hardship as part of the practice's Compliance Plan.

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.*

[1]Trites, PA. Compliance Guide for the Medical Practice: How to Attain and Maintain a Compliant Medical Practice. Chicago, Ill: American Medical Association; 2006.
[2]New York Insurance Department Opinion 08-04-04 (4/2/08). [3]N.Y. Penal Law § 176.05 Subsection (2)
[4]State of New York Insurance Department Opinions: 08-04-04 (4/2/08), citing State of New York Insurance Department Opinions: 00-12-06 (12/14/00) and 08-03-19 (3/27/08).
[5]Federal False Claims Act at 18 U.S.C. 287 and 1001, 31 U.S.C. 3729, and 42 CFR 1320a-7(a).
[6]NY State Fin. Law, ch 13 §§ 187-194 (2007).
[7]Federal Anti-Kickback Statute at 42 U.S.C. 1320a-7(b)(7).
[8]See Special Fraud Alert, 59 Fed Reg. 65,374 (Dec 19, 1994). [9]65 Fed. Reg. 24400, 24416 (April 26, 2000); See also OIG Advisory Opinion No. 01-11 (June 20, 2001).

Advertiser Index

Tri-County Family Medicine went live with our new EHR system on August 1. The benefits to the patients and practice are substantial but the implementation presented many challenges.

Fortunately, we were guided by EHR and IT experts who had the expertise to help ease the transition. To ensure a successful EHR implementation for any medical practice, I strongly suggest partnering with a firm that has extensive IT experience and skills but also thoroughly knows the software.

I don't know what we would have done if we didn't have Innovative Solutions Health IT in our corner every step of the way. They were fantastic and supportive.

Joyce E. Wheaton, Administrator
Tri-County Family Medicine Program, Inc.

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Critical Factors That Can Make or Break Your EHR Implementation

Elizabeth Amato Fleck, MSHA

Elizabeth Amato Fleck, MSHA

Many people today have personal computers, yet only a small percentage of them understand and utilize the full potential of this technology. The same can be said for Electronic Health Records (EHR). The Centers for Disease Control and Prevention reported in 2009 that 27% of physicians have a basic or fully functional EHR system. What's important to note is that "having" an EHR system is very different from "utilizing" the technology to its full potential. Physicians who fail to optimize their EHR are no different from people who use their personal computers for only the most basic functions. Each of them misses out on the real value of the technology they possess.

It's no secret why many medical practices under utilize their EHR technology. It's because it's not a simple process. In fact, it's quite complex but this should never be a deterrent to achieving the goal of full optimization. A successful EHR implementation renders benefits for providers, staff and patients including improved care coordination and communication, increased quality and safety and positively impacts return-on-investment. Unfortunately, not every EHR implementation is successful. We've assisted many practices through their EHR implementation and identified factors and conditions that, when present, facilitate successful implementation but when absent, inevitably leads to serious problems.

Critical Factors Relative to the EHR Process

Organizational Readiness

The transition to EHR is a monumental change. A common challenge physicians and administrators face is correctly communicating the nature of the changes before, during and after they happen. Practices that regularly inform their staff, providers and patients about the benefits of EHR including realistic timeframes involved are more likely to obtain a genuine buy-in from them during implementation. The fear of change and the unknown becomes manageable when everyone involved understands what's taking place now and in the future. We've also learned without such readiness and communication, practices may experience resentment, subversive sabotaging of the implementation and an unwillingness to change the way the practice operates. We've worked with practices that opted for a phased-in approach to implementation, gradually incorporating aspects of the EHR over a period of time which helps ease the transition phase.

Reliable Infrastructure

It's not uncommon for a practice to "ramp up" their IT infrastructure to accommodate EHR demands. They do so by working with trusted IT vendors that have medical practice experience. Such vendors can provide a pre-implementation "readiness" assessment to determine if network or hardware upgrades are necessary. Many practices stumble because of faulty IT infrastructure and then jump blindly into an EHR implementation, both serious errors easily avoided with proper planning.

Aligning with Local Stakeholders

Successful EHR implementations do not happen in a vacuum. Regional Health Information Organizations (RHIOs), medical societies, Regional Extension Centers (RECs), healthcare IT vendors and hospital systems are all valuable resources practices can connect with to ensure that they're leveraging all the field of health information technology has to offer. We have found

that physicians and administrators learn tips, tricks, and best practices from these stakeholders which are useful in their own implementations.

Commitment to Workflow Redesign

Workflow is a critical component in an EHR implementation. Successful implementations involve workflow analysis for every department or clinical area early on in the process. Failure to address workflow issues leads to challenges that make the transition to EHR more difficult. When we see practices that simply automate their processes from a paper environment into an electronic format, they experience more frustration, decreased productivity, and overall dissatisfaction with the EHR.

The critical factors aforementioned merely scratch the surface of what goes into EHR implementations. We encourage practices to talk to their peers, seek out trusted resources and align with partners that have a proven track record of EHR implementation success. Whether your practice is already implemented, plans to implement or is still considering the options, knowing what works for others will help steer your practice towards success.

Cracking the Code on Healthcare

Changes in healthcare technology, reimbursement, incentives, business models – what does it all mean and what can you do to succeed in the face of recently enacted healthcare reforms?

Cracking the Code on Healthcare offers you the opportunity to hear from nationally recognized thought leaders and participate in discussion forums on these topics. Plus view innovative technology demonstrations from a select group of EMR exhibitors. Choose to attend either the Friday morning session or a shortened Thursday evening session. Thursday evening is planned for physicians and office managers to participate in discussion forums on improving practice
productivity and profitability and view the technology fair.

The event will be held at:
Locust Hill Country Club on November 4th and 5th.
For information on registration, contact Linda Becker @ 585.738-7397 or visit www.healthcarebenefitsnetwork.com.

EDITORIAL OUTLOOK

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Special Focus: *Cervical Cancer*
Glaucoma
Obesity

FEBRUARY

Clinical Focus: ***Heart Disease–***
Advances in trends, treatment and rehabilitaiton

Preserving Your Legacy

Wealth Transfer 101

James M. Sperry, MBA

James M. Sperry, MBA

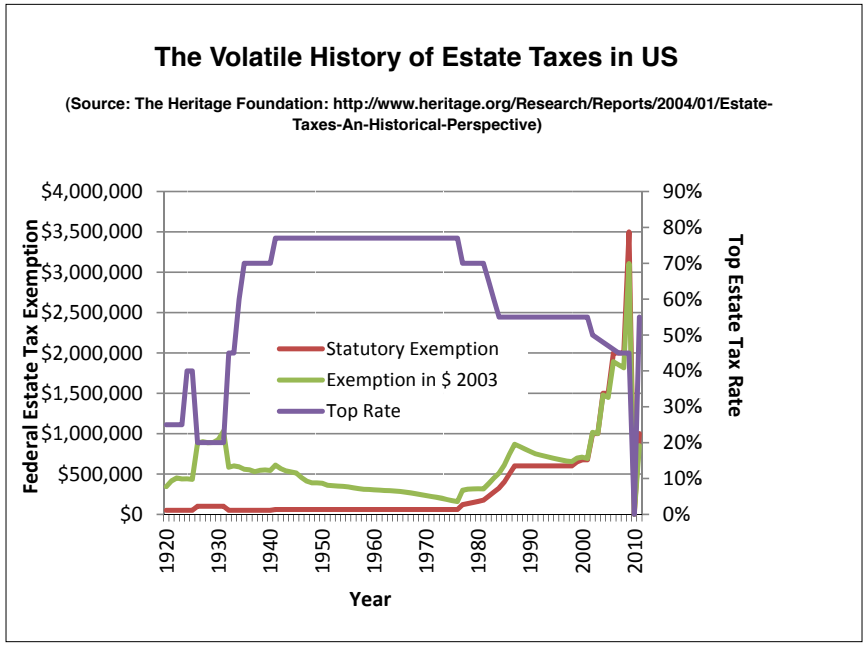
Many analysts and advisers complain that planning is now difficult, if not impossible, given the current uncertainty in the estate and other tax laws.1 I recently collaborated with an estate attorney on planning options for a healthy 80-year old widow with a $9 million estate. Her attorney confided in me, "I don't know how we can do any planning for this client when there is no estate tax this year." I was shocked and appalled.

I hope you are receiving much better advice than that, but I fear that such paralysis is not so uncommon. The truth is, even the most basic planning will enable you to protect and enhance the wealth that your hard work has earned. Further, in planning how to transfer your wealth, trying to forecast future estate tax exemptions should not be a priority because "guessing right" can be nearly impossible (see chart below) and there may be no cost to "guessing wrong." Basic planning can give you the flexibility to adjust to the ever-changing estate tax landscape. What is known is that those who do not plan stand to lose 50% or more of their wealth to taxes. So, why would you wait?

The Estate Tax Picture

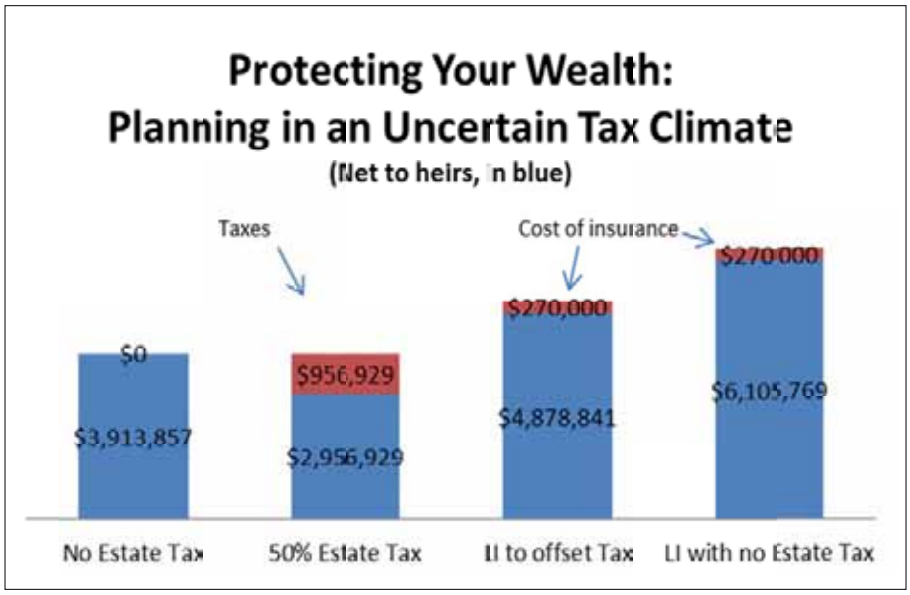
Taxing assets at death, a custom dating back to 700 B.C. Egypt, began in the US in 1797. So-called "death taxes" were used intermittently in the 1800's to supplement funding for wars. With top estate tax rates at 77% in the middle of the 20th century, estate taxes were levied to minimize excessive concentration of wealth, which endures as part of the justification today. The federal estate tax was repealed for 2010 through the Senate's failure to act by the close of 2009. Virtually everyone expects Congress to restore the estate tax for 2011 and beyond, but opinions on the level of exemption vary widely. This is what has confounded most advisers when it comes to designing a plan that is most protective of their clients' assets.

The federal estate tax exemption for 2011 will default to $1,000,000 with a top tax rate of 55% unless Congress enacts an alternative by the end of this year. Based on current proposals floating through Congress, the exemption is likely to be closer to $3,500,000 (c.f., H.R. 436, H.R. 498, S. 722), similar to that in 2009. Regardless of where Congress sets the exemption and how it evolves from that point forward, you can still take action today that will enhance the wealth you transfer, regardless of whether your estate is ultimately slammed with estate taxes or not. In fact, failure to plan may prove to be the most wealth-eroding decision you ever make in your career.



[1] "What Should You Do Now?" Charles Passy, *The Wall Street Journal*, page R4, September 20, 2010; and "What Should We Do with the Estate Tax," *The Wall Street Journal*, page R1, September 20, 2010.

The Case For Planning in Uncertainty — You Don't Need to 'Guess 'Right'



Consider a hypothetical couple, age 50, with a gross estate of $1,000,000. Assuming a modest 6% net growth (from appreciation and annual portfolio returns, as well as contributions to their retirement plans), their estate would grow to exceed $6,000,000 at their life expectancy of 81. Under current assumptions ($1,000,000 exemption per spouse), they would have over $4,000,000 of their assets exposed to estate and other taxes that could amount to over $2,000,000 (top estate tax rate of 55%). In a flash, over one third of their life's savings could evaporate. This picture could be different if there is no federal estate tax (but watch for state estate taxes – current exemption in NY State is only $1,000,000). What is the most efficient way to manage this given that we have no idea what their estate tax liability might be in 31 years? In other words, would their heirs be worse off if they do implement a basic plan but there is no estate tax applicable to their estate when that time comes?

Fearing possible loss of one-third of their life's savings, let's say the couple chooses to protect some of their assets using life insurance, which can be arranged to avoid estate and income taxes. One simple insurance plan for this hypothetical couple could produce over $2,000,000 in death benefit for only $15,000 in premiums each year until they retire at age 68. As shown, this would be extremely advantageous, even in the absence of any applicable estate tax at their deaths. Everything else being equal, it could enable the couple to transfer $2,200,000 more to their heirs tax-free. At that age, the internal rate of return on the premiums paid would be 9.25% after taxes!

"failure to plan may prove to be the most wealth-eroding decision you ever make in your career."

So, regardless of the estate tax picture, the basic plan using life insurance serves multiple purposes:

- Immediate liquidity when it is needed most
- Enhanced diversification to maximize risk-adjusted returns in their overall portfolio
- Guarantee of a legacy, regardless of the prevailing estate tax picture at the time
- Enables charitable gifting on qualified retirement assets to minimize income taxes

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Jim develops individualized protection, growth and transfer strategies for clients in diverse lines of business, including medicine. He earned his MBA from the Simon Business School at the University of Rochester (2002) and his Ph.D. in engineering from Duke University (1997). He moved his practice to Tompkins Financial Advisors recently to offer his clients greater depth of expertise in investment management, estate planning and wealth transfer, tax planning, and specialized services for business owners. You may reach Jim by phone **585-721-0068** or email **jsperry@ammfinancial.com.**

WHAT'S NEW IN Area Healthcare

Paul Barr, MD

Kristen O'Dwyer, MD

Two Oncologists, Scientists Join Wilmot Cancer Center Team

URMC adds two new physician/scientists to serve people with cancer and expand novel research programs at the James P. Wilmot Cancer Center.

"These new faculty members are very talented and will serve our patients well," says **Jonathan Friedberg, MD**, chief of **Hematology/Oncology** at the Wilmot Cancer Center. "These recruitments are a testimony to our ability to attract high quality clinicians and researchers to Rochester. Our new building, the University's focus on cancer and the growth of our research program over the past few years are clearly paying off. This is a very exciting time for the Wilmot Cancer Center."

Paul Barr, MD, assistant professor, joined the multidisciplinary lymphoma team from **Case Western Reserve University** where he was director of the lymphoma program. In 2007, Barr trained under **Richard I. Fisher, MD**, director of the Wilmot Cancer Center and an international expert in lymphoma.

Barr will also join the collaborative team of scientists working on the lymphoma **Specialized Program of Research Excellence** and will study new therapies for T-cell lymphomas. The program is an $11.5 million **National Cancer Institute**-funded research initiative to bring about better treatments and understanding of lymphomas, which has seen a puzzling increase in incidence over the past three decades.

"He brings experience in clinical research and will work to grow the efforts of the lymphoma program in developing clinical trials exploring novel agents," Friedberg says. "In addition, his expertise in chronic lymphocytic leukemia will support our clinical research portfolio in that disease."

He is a graduate of **Miami University in Ohio** and **Northeastern Ohio Universities College of Medicine** and completed residency and fellowship training at Case Western Reserve University.

Kristen O'Dwyer, MD, joined the multidisciplinary leukemia team and Jordan's laboratory. She recently completed fellowship training at **Memorial Sloan Kettering Cancer Center** and before that, residencies at **New York Presbyterian Hospital/ Weill Cornell Medical College** and the **National Cancer Institute.** She will be working on translational research in leukemia as well as myelodysplasia and myeloproliferative diseases.

O'Dwyer, a senior instructor, graduated from **Northwestern University and University of Iowa** before earning her medical degree from **University of Wisconsin School of Medicine and Public Health**.

She received the **American Society of Clinical Oncology Cancer Foundation Young Investigator Award** and has published several research studies in major journals.

Bill Levine Cutting the Ribbon at the William and Mildred Levine Ranch

EquiCenter Horses Move to New William & Mildred Levine Ranch

The EquiCenter, a volunteer-based, not-for-profit therapeutic horse center that benefits people with disabilities, veterans and at-risk youth, is relocating its therapy horses to its new **William & Mildred Levine Ranch** in Mendon.

This expansion, made possible by William Levine's pledge of $1.5 million, is the next exciting step in the EquiCenter's journey to provide therapeutic equestrian services to more groups and individuals throughout the community in need waiting for EquiCenter services. To learn more or to become involved contact: info@equicenterny.org.

Camp Good Days and Special Times Presents Courage Award to Berk CEO Cited for Courage in the Face of Personal Adversity

Bradford Berk, MD

Camp Good Days and Special Times, Inc. recently honored URMC CEO Bradford C. Berk, MD, PhD with their first Courage Award, which was presented at Camp Good Days' Courage Bowl Game.

The Courage Award is a new award to be bestowed upon someone who has displayed great courage at a difficult time in his or her personal life.

Berk's determination and resolve was a critical factor in his selection as inaugural recipient of the award. In May 2009 Berk suffered a serious spinal injury as a result of a biking accident, which left him on a ventilator and paralyzed from the neck down. After the accident, Berk took a leave from his duties as CEO, resolving to focus his full attention and energies on his recovery. After three months in intensive inpatient rehabilitation, Berk's progress allowed him to resume his leadership role and research activities at the Medical Center in March 2010.

Berk's professional path also is indicative of great personal character. He was recruited to the Medical Center in 1998 as chief of Cardiology and director of the newly formed **Center for Cardiovascular Sciences at the Aab Institute for Biomedical Sciences.** A year later he was named chair of Medicine and then nine years later, CEO and senior vice president for health sciences. A continuously funded **National Institutes of Health** researcher for almost a quarter of a century, Berk continues to lead an active cardiovascular research program and has added a new dimension to his focus – using state-of-the-art genomic approaches to unravel the genes that regulate how blood vessels respond to stresses.

Scott A. Mooney, MD

Elyssa L. Pohl, MD

Eva M. Wall, MD, FACS

Geneva General Hospital and Soldiers & Sailors Memorial Hospital Medical Staffs Welcome New Physicians

Scott A. Mooney, MD has joined the medical staffs of **Geneva General and Soldiers & Sailors Memorial Hospitals**, specializing in the field of Interventional Radiology. Dr. Mooney earned his medical degree from the **New York Medical College in Valhalla, NY**. He completed his residency at the **University of Rochester Medical Center in Rochester, NY**. He is board certified in diagnostic radiology by the **American Board of Radiology**

Elyssa L. Pohl, MD.has joined the medical staff of **Geneva General Hospital**, specializing in the field of Anesthesiology. Dr. Pohl graduated with her medical degree from **SUNY Upstate Medical University in Syracuse, NY**. She completed her internship at **Mary Imogene Bassett Hospital in Cooperstown, NY** and her residency at **St. Lukes-Roosevelt Hospital Health Center in New York, NY**. Dr. Pohl will be working in the Surgical Services department at Geneva General Hospital.

Eva M. Wall, MD, FACS has joined the medical staff of **Geneva General Hospital**, specializing in the field of General Surgery. Dr. Wall is a graduate of **Johns Hopkins University in Baltimore**, received her medical degree from **George Washington University in Washington, DC**, completed her residency in surgery at **Geisinger Medical Center in Danville, PA** and a fellowship in **Surgical Critical Care at The Queen's Medical Center in Honolulu, HI**. After her residency, Dr. Wall was **Chief of Trauma Surgery at Rochester General Hospital.** Most recently, she was a member of the Surgical Hospitalist team at **The Everett Clinic in Everett, WA**. Dr. Wall is board certified by the **American Board of Surgery and Surgical Critical Care.**

Archives of Internal Medicine Focuses Spotlight on Rochester General Cardiac

Ronald Kirshner, MD

Prestigious Journal Reports on Significant Infection Reduction

The Archives of Internal Medicine, a publication of the American Medical Association, has published results of a study conducted at the **Rochester Heart Institute at Rochester General Hospital.**

The study examines the post-operative infection rates of methicillian-resistant Staphylococcus aureus (MRSA) in patients who underwent cardiac surgery at Rochester General Hospital.

In the study, postoperative wound infection rates were compared before and after the introduction of a new, comprehensive MRSA intervention program in 2007. The study found that 3 years following implementation of the new protocols at Rochester General MRSA infection rates were reduced to practically zero.

Ronald Kirshner MD/Chief of Cardiac Services at Rochester General, and a co-author of the study, credits the dramatic drop in infection rates to a "long journey of process improvement that actually began in the early 90's."

"Because of the way our Cardiac program is organized, we are able to make certain that every patient receives the same protocol every time. This form of implementation science has had a huge impact on our outcomes," said Kirshner.

"How much money will I need to retire?"

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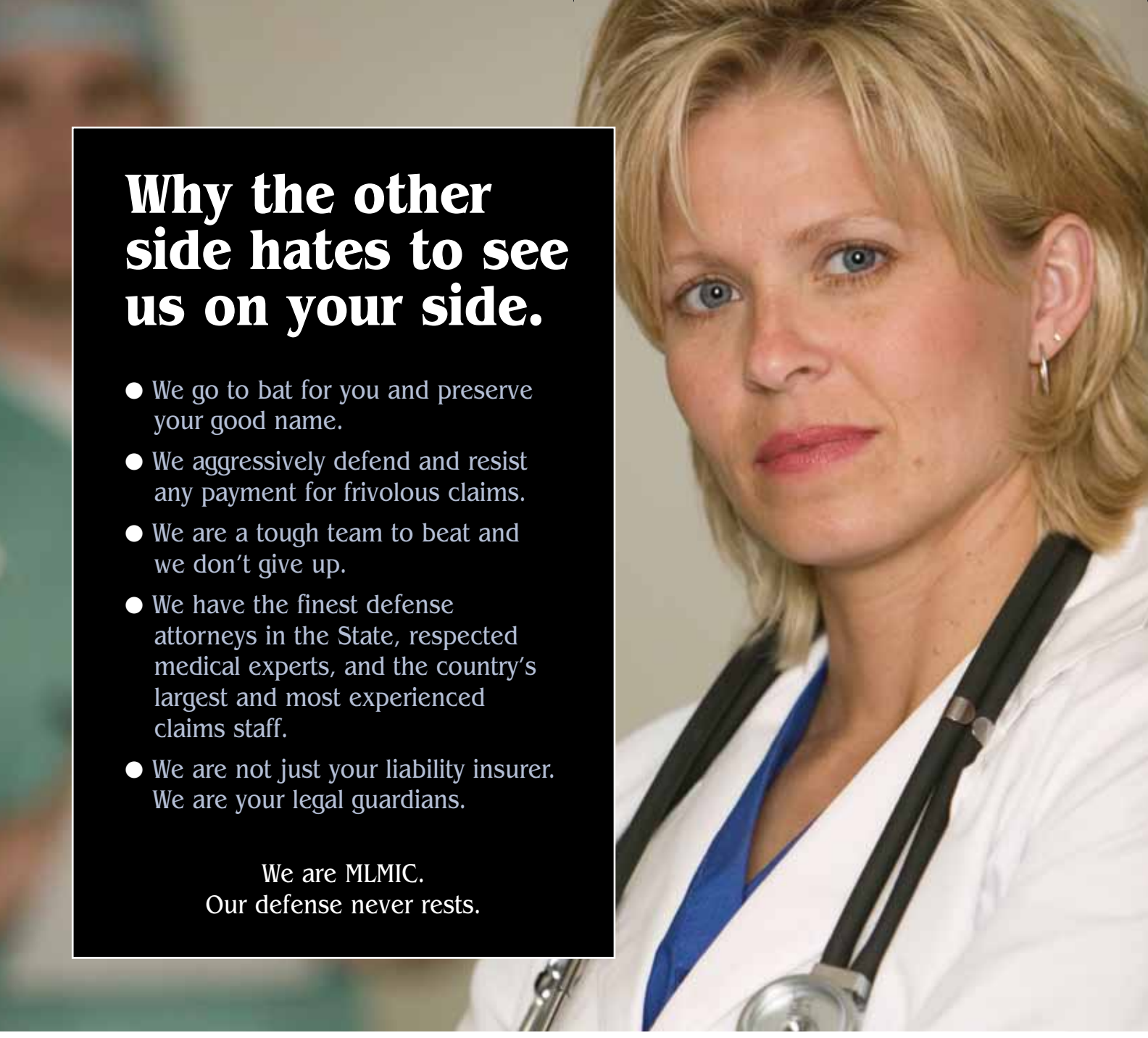

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