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Western New York

PHYSICIAN

THE LOCAL VOICE OF PRACTICE MANAGEMENT AND THE BUSINESS OF MEDICINE

Rochester's Center for Urology

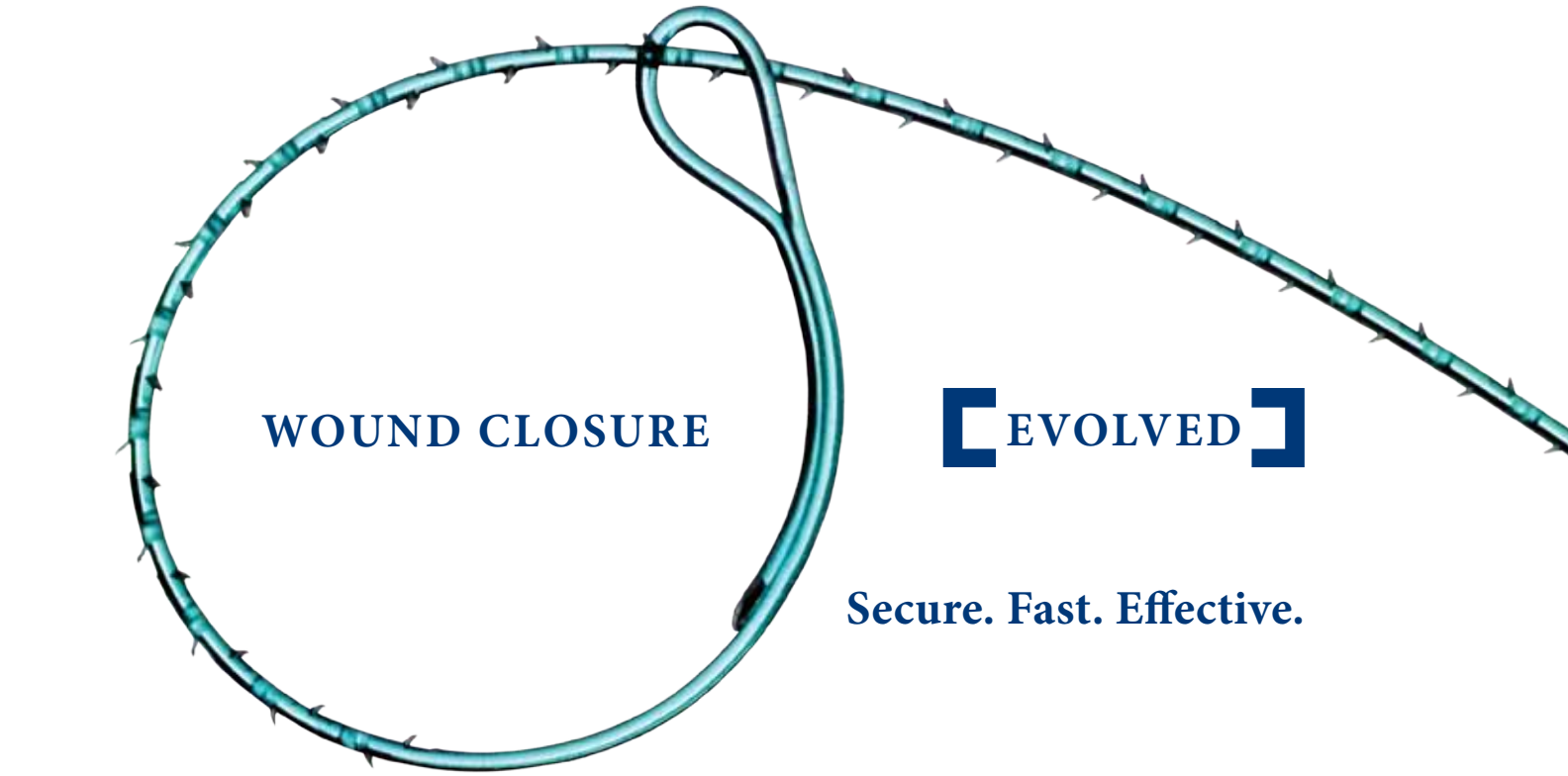
Tackling Critical Men's Health Issues Through Collaboration with Primary Care Colleagues

Age Management Medicine

A Proactive Approach to Healthcare and Aging

Avoiding Paralysis from Uncertainty

The Case for Proactive Retirement Planning



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2 Utilization of a Porcine Model to Demonstrate the Efficacy of an Absorbable Barbed Suture for Dermal Closure, UTSW, S. Brown

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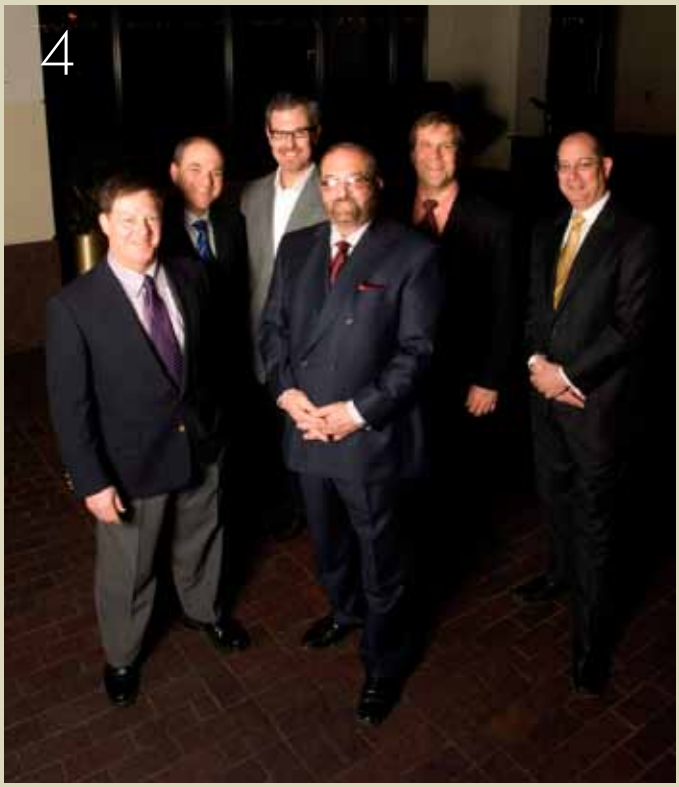

From L to R: Paul L. DiMarco, MD, Gregory J. Oleyourryk, MD
Louis H. Eichel, MD, seated at piano Abraham A. Glazer, MD F.A.C.S.
John R. Valvo, MD F.A.C.S, Frederick W. Tonetti, MD.

Dr. Cavallaro and patient, Arnie Rothschild meet regularly to review his progress and blood work.

Welcome to the Premier Issue of Western New York Physician

We're pleased to introduce the newest resource for physicians and healthcare leaders in Western NY. Published monthly, Western New York Physician is dedicated to being the local voice of practice management and the business of medicine for the medical community – from Buffalo to Rochester and its many outlying areas within a 10 county radius.

Each month promises to deliver engaging and relevant clinical and business articles from local experts – people you know, sources you can trust, leaders in their fields with keen insight into healthcare in our region.

This month's cover story takes an in-depth look at men's health. Meet the highly-trained physicians at Rochester's Center for Urology as they discuss the most pressing health issues facing men today.

Join us next month as we learn more about one of the region's finest spinal surgeons – Dr. M. Gordon Whitbeck. His comprehensive, collaborative approach with supporting providers in radiology, pain management and physical therapy translates into high patient satisfaction and success rates.

May marks Melanoma Skin Cancer Detection Month. Although Melanoma remains the most serious form of skin cancer, it's highly curable when detected and treated in its early stages. As we begin to take our lives outdoors here in western NY, it is especially important to remind patients of the keys to prevention and the importance of early screening.

Moving forward, we invite you to share your clinical and practice expertise with your medical colleagues through Western New York Physician. Our comprehensive stories provide referring physicians in our region a more in-depth look at the resources available to their practice and their patients – creating a relevant and personal dialogue between providers and a better understanding of all disciplines of medicine.

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Western New York
PHYSICIAN

THE LOCAL VOICE OF PRACTICE MANAGEMENT AND THE BUSINESS OF MEDICINE

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Rochester's Center for Urology

Tackling Critical Men's Health Issues Through Collaboration with Primary Care Colleagues

Julie Van Benthuysen

Every day, doctors at Rochester's Center for Urology treat patients with the most pressing medical issues facing American men today. From prostate cancer to erectile dysfunction, this team of seasoned urologists incorporates the latest research, technology and therapies to help diagnose and treat a broad range of conditions and diseases. Despite the field's dramatic advancements, including groundbreaking robotic surgery, these doctors recognize that successful outcomes require a close partnership with primary care colleagues. With offices in Irondequoit, Greece, and Brockport, The Center for Urology's six physicians pride themselves on prompt evaluation, state-of-the-art patient care, and concise communication with referring health care providers.

Dr. John Valvo, Director or Robotic Surgery at Rochester General Hospital (RGH), has been at the forefront of men's health issues for decades. For most men, he says, a visit to their PCP or urologist doesn't occur until symptoms present themselves. "As gatekeepers, PCPs need to be acutely aware of urinary tract and reproductive system issues, as early treatment usually leads to the best possible outcomes." Doctors conducting a thorough review of each patient's health history upfront can identify certain risk factors and treat him before conditions worsen.

"Urologists have the unique opportunity to help integrate male health care. Many of the disease processes we evaluate and treat have significant crossover into general male health."

Dr. John Garneau, a local Internist in private practice, collaborates with The Center for Urology. "Our relationship is extremely important," he says. "My job is to diagnose, treat and decide the need for early referral in situations beyond my expertise."

Dr. Garneau and other proactive PCPs perform screening exams and blood tests based on the preventative and diagnostic aspects of men's health. He educates patients on the need for a referral, expectations for potential procedures or interventions performed and the necessary follow-up. "Confidence in the specialist and the ability to directly communicate makes a tremendous difference in patient satisfaction and overall outcomes."

Because in men, the urinary and reproductive tracts are so closely linked, disorders of one often affect the other. "Urologists have the unique opportunity to help integrate male health care. Many of the disease processes we evaluate and treat have significant crossover into general male health," says Dr. Valvo.

He cites six key conditions that continue to dominate men's health:

IMPOTENCE • UROLITHIASIS

LOWER URINARY TRACT SYMPTOMS (LUTS) • HYPOGONADISM

PROSTATE CANCER • URINARY INCONTINENCE

Impotence

Five years ago, male sexual dysfunction affected 150 million men and is predicted to reach 322 million worldwide by 2025 – more than doubling in two decades. Affected groups span all ages, nationalities and cultures. The universal impact of male sexual dysfunction has resulted in 30 years of intense investigations with a greater understanding of the normal pathophysiology of male sexual function.

John R. Valvo, MD, FACS
Director of Robotic Surgery at RGH

SIGNS + SYMPTOMS = DIAGNOSIS

Despite its widespread prevalence, male sexual dysfunction is still often undiagnosed and untreated due to the patient's reluctance to discuss it and the PCP's lack of dialogue and routine screening. Disorders of male sexual function can be sub-classified into disorders of desire, erectile, ejaculatory and orgasmic function, and failure of detumenscence (priapism). The most common complaint is Erectile Dysfunction (ED).

A clear medical and sexual history is paramount to understanding patients with ED. *"It's critical for patients to feel in control and provide complete explanations to the questions asked,"* says **Dr. Valvo**. *"It's the doctor's responsibility to listen, check blood pressure, perform a thorough cardiovascular exam and order pertinent lab studies including lipid studies."* Avoiding judgment and initiating discussion of sensitive topics helps facilitate conversation about sexual problems to determine if they're predominantly psychological or organic. Assessing partner participation and defining the patient's realistic expectations are also important before discussing treatment options. Doctors often need to educate men on anatomy and physiology so they fully understand their condition. *"An informed patient is an empowered patient."*

Research strongly suggests ED may be the precursor to heart disease, with symptoms generally appearing about five years prior to a cardiac event. *"Younger patients in their 40s and 50s with ED may have health issues smoldering below the surface, including the effects of smoking,"* he says. Diabetes should also be considered as this condition can also cause ED.

TREATMENT

Thirty years ago, treatments were predominantly based on the theory that psychological origins caused ED. *"That's changed considerably,"* says Dr. Valvo. Psychological causes of ED actually account for less than 10-15% of cases – often handled effectively through referral to a certified sexual therapist or marriage counselor specializing in sexual therapy.

Treatment alternatives for organic causes have also changed and must be tailored to each patient's needs. Options include oral medications like PDE-5 inhibitors, vasoactive medications delivered via intra-urethral suppository or direct penile injection, and non-invasive alternatives like vacuum systems or penile rings. If these alternatives prove unsatisfactory, penile prostheses can be implanted with a very high patient/partner satisfaction rate.

Treatment Options for ED

Psychogenic: Certified Sex Therapist • Certified Marriage/Sex Therapist
Empirical Trial of Vasoactive Medication
Organic: Vasoactive Medications • Penile Prosthesis
Intraurethral Suppositories • Vacuum Device • Penile Rings

Urolithiasis

Approximately 12% of all men develop kidney stones resulting in two million annual doctor visits. First time stone patients will often present to their PCP or ER. This represents an opportunity to diagnose and initiate early treatment to offer patients some relief while they undergo further urologic evaluation.

Greg J. Oleyourryk, MD
Director of RGH's Lithotripsy Services

SIGNS + SYMPTOMS = DIAGNOSIS

"An acute kidney stone event can wreak havoc on a man's workday," says **Dr. Oleyourryk**, *"For first time stone formers, it's critical that PCPs know when to refer to a specialist."* By ordering proper X-rays, blood work and urine studies, doctors can determine stone size, location, composition and possible UTI. Generally, patients with small stones (under 5 mm) can be managed conservatively with gentle hydration, pain medication, anti-emetics, and a low dose alpha blocker (to relax the ureters). For larger stones or stones in the setting of infection, a urologist's immediate evaluation is recommended.

TREATMENT

Kidney stone treatment has three major components–alleviation of symptoms, stone removal and stone prevention. As mentioned, symptom alleviation can be accomplished with hydration, pain medication, anti-emetics, and alpha blockers. Surgical stone treatment is generally minimally invasive. Options consist of shock wave lithotripsy (SWL) or endoscopic lithotripsy via ureteroscopy with laser. In rare cases, direct endoscopic removal via large bore nephrostomy tube or real surgery is necessary.

After treatment, prevention is essential. Using 24-hour urine collection and serum studies, 95% of patients can make dietary changes or take medication to lower lithogenic urine.

The alpha-blocker Flomax is used as medical therapy for passing stones, decreasing the need for surgical intervention of smaller stones. Changing patient diet is also key. *"Lowering a patient's calcium is not necessarily the answer,"* says Dr. Oleyourryk. *"Lowering oxalates found in red meats, drinking more clear liquids and avoiding soda, coffee and especially iced tea helps eliminate future stones."*

Lower Urinary Tract Symptoms (LUTS)

Fortunately, growing public awareness has helped the average male understand that the prostate gland slowly grows as he ages. Benign prostatic hyperplasia (BPH), a condition that affects the prostate gland, is found between the bladder and the urethra. As the prostate enlarges, it may press on the urethra and slow the force and flow of urine.

Paul L. DiMarco, MD
Director of the Urology Residency Program at RGH

SIGNS + SYMPTOMS = DIAGNOSIS

Dr. DiMarco typically sees patients once they begin experiencing a frequency to urinate with some discomfort. Many assume their lower urinary problem is related to prostate enlargement, but other factors exist, like infection, over-active bladder and cancer.

"It's critical that patients tell their PCPs about any of these symptoms to determine which tests to use." After taking a complete patient history, a rectal exam is performed to feel the back of the prostate gland and determine any irregularities. A urine sample and blood test can indicate signs of infection or the potential for prostate cancer. An ultrasound or prostate biopsy can also help in the diagnosis. *"As a hormone-dependent growth, it's extremely difficult to prevent the prostate from growing without medication. Family history also plays a role in patients possibly predisposed to increased prostate growth."*

Not everyone with LUTS needs treatment, particularly if it's diet-related (like too much caffeine or taking in fluids). *"Our goal is to treat before significant symptoms present themselves or immediately after they arrive,"* says Dr. DiMarco. Most symptoms of BPH start gradually, like the need to urinate more often during the night. Other symptoms are difficulty starting the urine flow and dribbling after urination ends. These symptoms may be caused by factors besides BPH, possibly indicative of more serious conditions like bladder infection or cancer.

TREATMENT

Once it's determined that symptoms are caused by a benign prostate gland, treatment can be recommended. The urologist may suggest waiting to see if milder symptoms improve on their own. If symptoms worsen, options include minimally invasive treatment, like medications or using heat to destroy part of the obstructing prostate tissue pressing on the urethra. Minimally invasive procedures can often be done in an outpatient setting.

Treatments, both medical and procedural, can have sexual side effects such as ED and ejaculation issues (like dry ejaculation). Patients need to be made aware of these ahead of time as these potential side effects can play a role in the decision-making process. Medical therapy may not work for everyone prompting the possible need for more invasive options.

Surgery is considered the most effective treatment for men with strong symptoms persisting after other treatments are tried. This is typically done through the urethra using lasers or electrocautery, leaving no scars. Surgery does have risks – bleeding, infection or impotence – but these risks are generally small. A small percentage of patients who have had surgery may also need it again within a 10-year period.

Hypogonadism

Low testosterone (Hypogonadism) affects approximately 4 million American men, yet only 5% of candidates receive treatment. Beginning at age 40 testosterone levels begin to fall at about 1% annually.

Fredrick W. Tonetti, MD
Senior Partner at Center for Urology

SIGNS + SYMPTOMS = DIAGNOSIS

Loss of libido is the most common symptom prompting men to seek attention for a low testosterone level. "Testosterone is what makes men MEN," says **Dr. Tonetti,** who also specializes in noninvasive prostate cancer treatments. *"Any man who complains of erectile dysfunction should also be evaluated for a low testosterone through a simple blood test."*

He says that while many doctors may dismiss the symptoms of hypogonadism as part of the natural aging process, they can often be reversed with a simple treatment of supplemental testosterone with minimal risk and side effects. Patients should undergo evaluation to rule out other causes for hypogonadism, such as a pituitary tumor.

TREATMENT

The loss from hypogonadism is a decrease in drive, but several options exist for restoring testosterone levels – including oral agents, gels (like Androgel), patches, and injections. While many men have supplemented testosterone levels to improve vigor, oral agents can cause liver problems due to metabolites causing toxicity and are generally avoided by urologists. Topical patches can cause rashes, and gels can be absorbed in women if contacted with their skin. With injectables, a high peak and low level may occur causing mood swings. Recently in Europe, an oral form is being used which doesn't appear to have the liver toxicity issues and a depot form is now available for biannual delivery.

Testosterone replacement therapy can also improve mood, cognition, energy, muscle mass, bone density, red blood cell counts and an overall sense of well being. Other side effects of therapy can include increased dreams, aggressive behavior, oily skin and baldness.

Until recently, it was generally agreed that prostate cancer survivors shouldn't be treated with testosterone replacement therapy; however, recent studies show no increased risk for disease recurrence and clear benefits. Patients on testosterone replacement therapy need to be monitored periodically with blood work, such as PSA and liver function tests.

Prostate Cancer

The American Cancer Society estimates 192,000 men were diagnosed with cancer last year. Prostate cancer is the second leading cancer in men, killing about 27,000 in 2009. For almost 20 years, the combined use of prostate specific antigen (PSA) testing and digital rectal exam (DRE) has been the recommended method for prostate cancer screening.

Louis H. Eichel, MD

SIGNS + SYMPTOMS = DIAGNOSIS

Dr. Eichel, a local leader in advanced laparoscopic and robotic urological surgery, is an advocate for PSA screening for appropriately chosen patients.

In the last six months, both the American Cancer Society (ACS) and American Urological Association (AUA) issued updated guidelines for screening prostate cancer. They agree and disagree on some key points.

"Both agree that prior to PSA screening, physicians and patients should discuss the test's rationale," says Dr. Eichel. *"As a general rule, any patient with a life expectancy beyond 10 years is eligible. Physicians are obligated to discuss the test's benefits and risks."* The potential benefit is early detection of clinically significant prostate cancer (likely to cause morbidity or death). The potential risk of screening is the detection of clinically insignificant prostate cancer (unlikely to cause morbidity or death). The over-treatment of clinically insignificant prostate cancer can lead to significant patient morbidity including urinary incontinence, irritative urinary symptoms, and ED.

Previously, the ACS recommended yearly prostate cancer screening (PSA and DRE) for most men starting at age 50, and for men with a strong family history and African Americans (at higher risk) starting at age 45. Referral to an urologist was recommended for men with a PSA > 4.0 ng/mL.

The new ACS guidelines don't specify an age but recommend that men who choose to be tested should be screened annually if their level of prostate-specific antigen, or PSA, is 2.5 ng/mL or higher. Men whose PSA is under that threshold can be safely screened every two years. Men with a PSA level of 4.0 ng/mL or higher should consider further evaluation such as biopsy. These new guidelines also suggest physicians stop recommending yearly rectal exams.

"There are some real discrepancies between the new ACS and AUA guidelines," says Dr. Eichel. The new AUA guidelines recommend that all men who choose to undergo screening should have a baseline PSA test and DRE done at age 40. Physicians should then use various parameters such as age, change in PSA over time (PSA velocity), % free PSA, ethnicity, and family history to determine the appropriate screening interval. If baseline PSA is above the age related reference range or if the PSA rises by 0.7 ng/dl in one year, referral should be made for further workup and possible biopsy. The AUA also strongly recommends yearly DRE be performed to screen for prostate nodules and rule out other diseases like rectal cancer and other benign disorders.

Both organizations agree patients with high risk prostate cancer should be offered treatment. Patients with clinically insignificant prostate cancer should be followed closely over time while life expectancy is over 10 years, as some may convert to a more aggressive form of the disease and require treatment. Active monitoring of clinically insignificant prostate cancer requires serial PSA tests at regular intervals and may also require periodic repeat prostate biopsies. "*For now, physicians are encouraged to evaluate each patient based on individual risk factors and arrange for appropriate urologic follow-up."*

Age-Specific Reference Ranges for Serum PSA[111]

Reference Range

Age Range	Asian-Americans	African-Americans	Whites
40-49 yr	0-2.0 ng/mL	0-2.0 ng/mL	0-2.5 ng/mL
50-59 yr	0-3.0 ng/mL	0-4.0 ng/mL	0-3.5 ng/mL
60-69 yr	0-4.0 ng/mL	0-4.5 ng/mL	0-4.5 ng/mL
70-79 yr	0-5.0 ng/mL	0-5.5 ng/mL	0-6.5 ng/mL

Urinary Incontinence

Urinary Incontinence is an under-reported, under-diagnosed, and under-treated condition generally considered to be a normal part of aging. It affects 200 million people worldwide. Male incontinence can occur following surgical procedures on the bladder, rectum and prostate or from other conditions like overactive bladder, Parkinson's Disease, Multiple Sclerosis, and other neurologic disorders.

Abraham A. Glazer, MD, FACS

SIGNS + SYMPTOMS = DIAGNOSIS

Three types of urinary incontinence exist. Stress incontinence is leakage with cough, sneeze, and increases in abdominal pressure. This can occur after radical prostatectomy or TURP procedures. Urge incontinence is leakage with a feeling of a sudden urge to urinate. This can occur with BPH or anything that irritates the inside of the bladder. Overflow incontinence is caused by incomplete emptying of the bladder, also seen in some patients with BPH.

Dr. Glazer, fellowship trained in treating urinary incontinence, says that a detailed history and physical exam are an essential first step. Patients should be asked about onset and duration of incontinence, intake of caffeine, nicotine and fluid (particularly "brown" liquids like coffee, tea and soda), any concomitant diseases (particularly neurologic) and any prior surgery. *"A detailed genitourinary and neurologic exam should be performed including DRE."* Additional testing including urinalysis, urine cytology, bladder ultrasound for post-void residual volume, cystoscopy, and urodynamic evaluation may also be necessary."

TREATMENT

Treatment for incontinence varies depending on the cause. For men who leak with physical activity following prostate surgery, non-invasive treatment options are typically explored first. *"Normally we suggest a regimen of Kegel exercises for the pelvic floor/urinary sphincter."* If patients have trouble mastering these exercises, a trial of pelvic floor rehabilitation using a probe and machine in the urologist's office can be very helpful.

If exercises prove ineffective, invasive therapy may be necessary. For mild stress incontinence, urologists may inject a bulking agent around the bladder neck. For moderate incontinence, a sub urethral sling of mesh can be implanted, and for severe incontinence a complete artificial urinary sphincter can be installed. Male slings have been shown to have a 50% cure rate; artificial urinary sphincters have a 90% success rate.

"Some men simply suffer from over active bladder," says Dr. Glazer. Anticholinergic medication has been the mainstay of treatment for OAB for many years. *"When treating a patient for OAB it's always important to seek out the underlying cause as larger disorders may present with Urinary Incontinence."*

Some men suffer from "overflow" incontinence due to poor bladder contractility, often caused by longstanding bladder outlet obstruction from BPH or surgical denervation following pelvic surgery. Generally, the bladder doesn't recover well even after correction of obstruction and patients with conditions must either learn intermittent catheterization or have an indwelling Foley or suprapubic catheter.

"Through continued collaboration, our patients win."

Men's Health Moving Forward

Dr. Garneau is encouraged that awareness of men's health issues has been expanding far beyond the prostate in recent years. "ED is no longer taboo. It also allows for earlier screening, detection and treatment of other male-specific diseases." Consequently, testosterone discussions on issues beyond ED are an essential part of a man's history and physical exam and now screening recommendations exist for osteoporosis in age-specific males."

Dr. Valvo insists that it's only through consistent PCP partnership that men's health issues can be effectively addressed. "Through continued collaboration, our patients win."

Age Management Medicine

A Proactive Approach to Healthcare and Aging

Dr. Charles Cavallaro

Julie Van Benthuysen

As we age, we expect our bodies to begin their natural process of decline, slowly penetrating our lives from middle age on. Yet extensive research and what are now time-tested therapies continue to prove differently – that with the right approach, we can "square the curve" and actually stave off the decline of aging. A progressive local physician affiliated with the Cenegenics Medical Institute, is setting his patients on a guided course of Age Management Medicine that defies conventional thinking. Through the proper combination of nutrition, supplementation, exercise and if medically indicated, hormone replacement therapy, today's savvy patients can now take control of their health and their aging process.

Charles Cavallaro, D.O., a veteran emergency department physician affiliated with Rochester General Hospital, has been promoting a level of proactive healthcare that is providing an improved quality of life for his patients. "The practice of Age Management Medicine is a proven, evidence-based viable option for patients. It's a detailed health program specific to their individual needs."

Four years ago, Dr Cavallaro discovered Cenegenics after taking over a private concierge medical practice. Several patients were already participating in the Age Management regimen.

"I was skeptical at first," he says, "but I needed to learn what it was all about so I could care for my patients." Dr. Cavallaro enrolled at the Institute and became certified to practice Age Management Medicine. During his training, Dr. Cavallaro signed on as a Cenegenics patient. As an active professional in his mid 40's, he was frustrated with his own health status, noting a general lack of energy, low libido and an inability to lose weight. "My blood work showed I was headed down a path I was not willing to travel." Within six weeks on his own individualized program, Dr. Cavallaro saw dramatic results in how he looked and felt. "My weight, blood pressure, glucose and insulin levels all dropped off. From that point on, I embraced the science behind Cenegenics wholeheartedly. I was shown a new way to practice medicine that provides a focused level of care as it empowers the patient to control their own health destiny."

Medical Science and Natural Aging

One of the central and more controversial factors of Age Management Medicine is hormone optimization. Extensive studies reveal that declining hormone levels in both men and women contribute to a litany of symptoms including diminished libido, waning energy, decreased lean muscle mass, increased body fat, loss of bone density leading to osteoporosis, reduction in skin tone and elasticity, memory lapses, cardiovascular concerns, depression, sleeplessness, irritability and mood swings, as well as immune dysfunction, brain cell injury, arterial wall damage, and blood-sugar problems.

This slow, steady deterioration in our health becomes undeniable, both physically and mentally as we continue to age. "The body's hormone receptors don't lose their ability to respond to hormone messages. Instead these receptors are waiting anxiously to be filled," explains Dr. Cavallaro. "By restoring hormone levels, along with healthier lifestyles choices, patients can truly turn the tide on their aging process."

The Cenegenics approach starts with a comprehensive seven-hour Executive Health Evaluation to establish a patient's physical, metabolic and hormonal baseline. Included is a two-hour nutrition consult and a detailed explanation of the exact nature of any imbalance in the patient's profile.

Dr. Cavallaro and patient, Arnie Rothschild meet regularly to review his progress and blood work.

Dr. Cavallaro integrates a three-pronged synergistic program for each patient. This includes nutraceutical supplementation (pharmaceutical-grade vitamins with essential fatty acids and antioxidants) with a sound low-glycemic diet to boost the immune system and reduce weight. Secondly, the program provides a tailored exercise program (cardio and weight resistance) geared to rebuilding muscle mass and bone strength and lowering heart disease risk. Finally, if the intensive blood evaluation of a patient reveals diminished levels; bio-identical hormone optimization is offered. "The goal is to bring the levels back to a safe but elevated range within the normal laboratory parameters." Patients are monitored regularly and have their blood work reviewed every three to six months. An ongoing collaboration between Dr. Cavallaro and the patients' primary care doctor creates a dynamic opportunity to proactively manage and monitor any health related issues that may arise as the patient naturally ages.

"Essentially, I take a snapshot of where patients are today, then, initiate a playback of their last 20 years. I can then map out the road that lies ahead and provide them with the information to take them forward in the right direction." With careful guidance, Dr. Cavallaro demonstrates how an individualized health regimen will help them take control of the situation and improve their health and lifestyle dramatically.

"Aging is inevitable, but how we age is not."

Dr. Cavallaro generally sees two factions of patients – those in their 50s and 60s who've essentially coasted through life but suddenly find that while they're doing nothing different, their health and weight are sliding in the wrong direction. The other group includes the athletic type who has suddenly "hit the wall" as they enter into their 30s and 40s. In both scenarios, feeling old is not an option for these patients.

From a Patient's Perspective

Arnie Rothschild, a 63-year old former athlete who harness races in his spare time, suffered from arthritis, chronic hip pain and weight gain despite his active lifestyle. "I was falling apart," he says. Tired of hearing from doctors that his symptoms were just a natural part of aging, Rothschild took the initiative by researching other options for his conditions. That research soon led him to Cenegenics and its local physician affiliate, Dr. Cavallaro.

Anticipating the need for hip replacement (he's since had two); Rothschild made the conscious decision to get himself back on track. He was stunned after the initial evaluation revealed his lack of upper body strength, despite regular workouts. Two years into his regimen, Rothschild considers himself a new man. He returned to work three days after hip surgery, and was back in the gym within three weeks, shocking his friends and co-workers. "I feel that I have a medical partner in Dr. Cavallaro," he says. "While I'm never going to play college baseball again, I'm stronger than I was in college, more flexible and less arthritic."

Rothschild maintains a Mediterranean diet and vitamin regimen and takes a low dose of testosterone and growth hormone injections regularly. He hasn't been sick in two years. "For the first time in my life I feel in control of my health, versus having to see a doctor every time I have a symptom."

Physicians who refer patients to Dr. Cavallaro recognize the viability of shifting the emphasis from a disease-driven medical approach to an innovative health-focused practice. He hopes that over time, more physicians will begin to embrace the idea of Age Management Medicine, becoming more educated and open to hormone replacement therapy as research continues to confirm its many benefits. Today's patient is much more engaged in managing their own healthcare. They come to their doctors seeking answers but in addition, need to be provided the tools to address their individualized concerns. Dr. Cavallaro understands that. "Patients have an increased willingness to invest their time and money to maintain the highest level of wellness possible. It's our role as physicians to direct our patients to viable medically sound options."

Cenegenics is affiliated with three medical schools, and with Centers and affiliates worldwide, holds an unprecedented proprietary position in the medical community-at-large. Created by physicians, managed by physicians and used personally by physicians and their families, Cenegenics maintains a very high patient retention rate. "Patients aren't willing to go off their regimen once they've personally experienced such positive results," says Dr. Cavallaro.

As a busy husband, father and physician, Dr. Cavallaro has always understood the value of preventive medicine. Despite a growing practice, his passion for the Emergency Room continues. "My knowledge of Age Management Medicine has only helped to round off the way I practice all medicine," he says. "After 20 years in the ER, I've seen the worst of the worst – patients who just don't know how to take care of themselves. Doctors have trained patients to take a pill, not change their lifestyle. Today, we now have the ability and responsibility to talk to them about nutrition and exercise and everything else that is available for them to take control of their health."

He sees it quite plainly. Age Management Medicine looks at a patient inside and out; giving the body back what is naturally lost as time passes. "Aging is inevitable," says Dr. Cavallaro, "but how we age is not."

Dr. Cavallaro's Cenegenic's office is located near Bushnell's Basin, and can be reached by telephone at 585-624-8144. For more information regarding this fascinating program log onto his website at: www.cenegenics-drcavallaro.com.

Time to Develop an IT Roadmap

Federal Stimulus Funds—Catalyst for Change that Will Help Your Practice

Al Kinel

Al Kinel

You probably know that Federal Stimulus funds are available for practices and hospitals to deploy appropriate IT solutions. You may or may not know that doctors can get a maximum of $44,000 in funds from the federal economic stimulus package for adopting a certified EMR system that meets the government's standards. Funding from the Health Information Technology (HITECH) bill comes in the form of incentives through reimbursement increases for Medicare and Medicaid for those that meet defined requirements, and decreases for those that do not.

Requirements include implementing certified packages for electronic medical records (EMR), integration with local or statewide Healthcare Information Exchanges (RHIOs), moving towards "meaningful use" by modifying processes to leverage new capabilities, and submitting eligibility and claims digitally. These should not be considered stand-alone projects, but rather a series of modules and processes that establish a platform to elevate the capabilities of your practice.

This is a daunting set of initiatives even though you may have been contemplating moving in this direction for years. Maintaining your current processes and arsenal of tools may feel comfortable, but it will constrain your ability to continue to practice and get paid what you are accustomed to for your services. Should you finally proceed? While every primary care practice is a slightly different situation, the answer for most should be……YES.

The financial impact of ARRA on your practice or hospital can be significant, but that is not the only reason to finally take the plunge. There are several other reasons why you should begin now including:

- if deployed properly, new tools and processes will enhance your ability to deliver high quality service and lower risks of error
- you can lower administrative costs, and enhance your ability to submit claims and adjustments, thereby increasing cash flow
- system product risk has dissipated – leading products are replicating features, and certification has created a pool of adequate choices
- communication between specialists, hospitals, and patients can be improved through links to PHRs and access to information now available from the RHIO, making an EMR more valuable than 12 months ago
- there is funding for local resources to help primary care physician offices with major decisions that comprise this journey, and to assist in changes to attain the promised benefits

Once you have decided that you are at least going to give this change thoughtful consideration, the next question is…HOW? Like any complex problem, it is best to break it down into more manageable pieces:

Comprehend Incentives

All partners and managers should understand the program overview, objectives, requirements, process, and financials.

Assess Current IT Capability and Funding Impact

Assessment of current systems, capabilities, and related initiatives, and financial impacts of compliance. Gaps should be summarized for the following systems:

EMR ✦ CPOE
Meds Administration
Clinical Decision Support
Patient Communication
Eligibility and Claims Processing
Interoperability with RHIO

Produce IT Roadmap

Every practice should develop a roadmap with prioritized initiatives to provide the capabilities you want, taking into account financial requirements, constraints, and benefits. This IT Strategic Plan will guide your journey.

Program Management for Each Initiative

For each, you will need to define the objectives, requirements, select and negotiate with vendors, make key decisions (like conversion and business continuity), track critical issues and status, manage change, and communicate with all stakeholders.

Still a daunting set of tasks. The good news is that federal funds have been provided to the New York eHealth Collaborative (NYeC) for personnel within our area to do many of these for primary care, at VERY low rates. This will be similar to the service bureau role that Monroe County Medical Society (MCMS) has been playing. They will also work with vendors and the RHIO to help you implement the technology, interfaces, and process changes you need to be successful. Over the next 90 days the process of how to engage these resources to help you develop a plan to meet your needs will be communicated – stay tuned. In the meantime, get mentally ready for change.

Al Kinel is President of Strategic Interests, LLC, a firm dedicated to helping address client's strategic issues. Al brings significant expertise to help our community leverage technology to improve healthcare. Al has been a leader, a change agent, and driver of innovation for Xerox and Kodak Health Group/Carestream Health. Al has deep experience in healthcare information technology and he was the initiator of the RHIO in Rochester. His firm is available to help your practice understand the path that is in your best Strategic Interests. Visit his website at www.strategicinterests.com or e-mail Al at alk@strategicinterests.com.

Avoiding Paralysis from Uncertainty

The Case for Proactive Retirement Planning

James M. Sperry, MBA

James M. Sperry, MBA

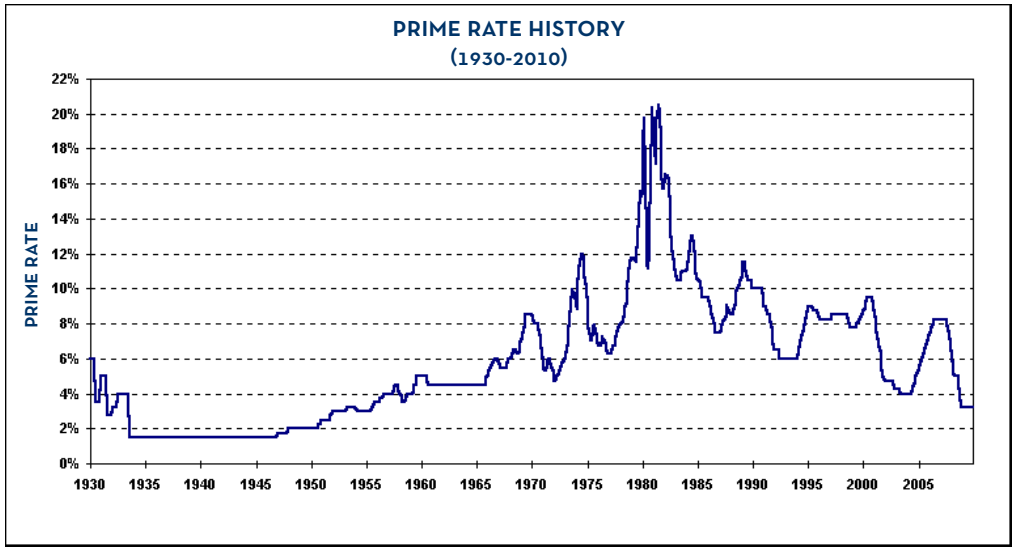
Uncertainty is synonymous with risk, something we manage continuously in our daily lives. Whether we are considering a vaccine for our children or evaluating an alternate route home during rush hour traffic, many of our everyday decisions involve some form of conscious or subconscious risk assessment. Managing risk is fundamental to every clinical decision physicians make. I believe that physicians as a group are masterful risk managers when in a clinical setting. They gather just enough information to evaluate the situation and assess various risks, and then they are decisive in their decision-making.

Yet the same physicians who are so decisive in the face of uncertainty with the clinical challenges of their patients may be paralyzed by other sources of uncertainty in their own lives. This may be especially true when that uncertainty relates to something about which they are not expert. In my practice, I have met many physicians who are 25+ years into their careers who have done virtually no concerted financial planning. Obviously, this is not because of a lack of either intelligence, responsibility to those who are dependent on them, or time. So ask yourself if the uncertainty inherent in the many factors affecting your future retirement are paralyzing you and preventing you from planning properly? To remove some of the mystery, it is worth examining several sources of risk in retirement so you can confirm that you have taken active steps to address them.

Market volatility and interest rate risk

The extreme market volatility of the past 2 years has caused many to question their prospects for retirement. Most physicians with whom I work store the majority of their accumulated wealth in investments, cash, and real estate. To the extent that one has substantial exposure to the market, one needs to be very clinical in quantifying and managing the amount of market risk they are assuming, especially as they near retirement. And avoiding market risk altogether is generally not optimal, since that often invites a greater set of risks. Instead, connect with a qualified financial advisor to learn how to measure the aggregate amount of risk in your overall portfolio and be deliberate and explicit in managing it.

In addition to extreme market volatility, we are also in a period of historic low interest rates.



Source: Federal Reserve Board
(Data points from 1930 to 1949 are based upon incomplete information and are best estimates.) Chart copyright 2010 MoneyCafe.com

Many people believe that rates will necessarily rise in the future. If rising interest rates mean that I earn more on my money, then where is the risk? Bond prices move inversely to interest rates. And since the conventional investing wisdom has been to increase one's allocation to bonds at the expense of equities to reduce market risk when nearing retirement, rising interest rates may put downward pressure on the value of the largest asset class in your portfolio at exactly the time when you can least afford it. So, managing this risk requires a diversified approach involving several income-producing asset classes, not just bonds. Finding the right mix of these income-producing asset classes and achieving a suitable level of market risk is fundamental to responsible retirement planning but is not typically within the skill set of the average investor.

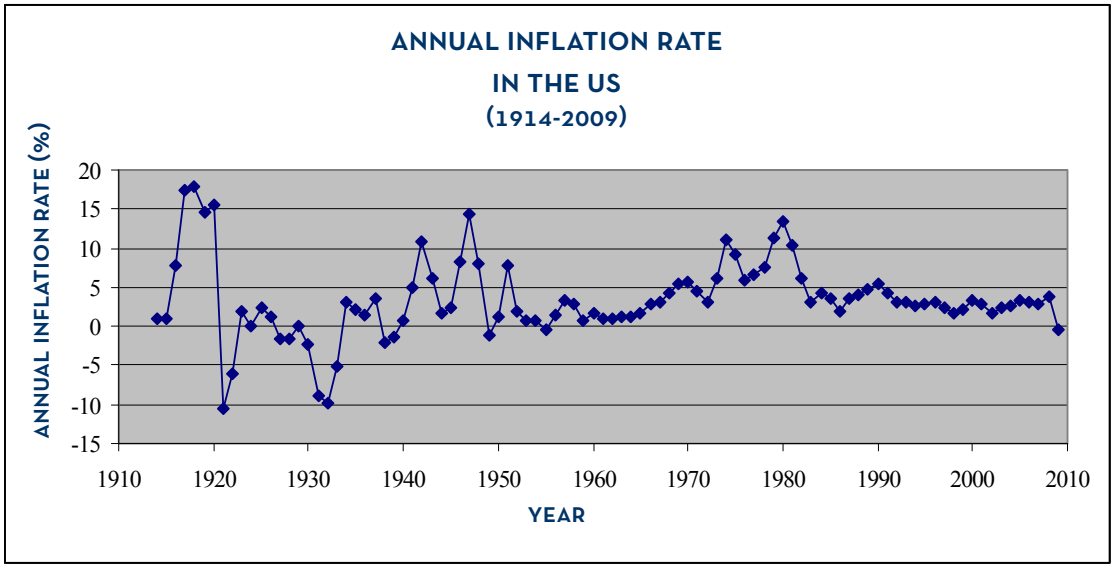
INFLATION

Given where inflation is now and the current level of government spending, few people doubt that inflation will rise substantially in the intermediate future. High inflation represents a perfect storm of trouble for retirees for several reasons. First, retirees live on fixed incomes, a large proportion of which may not increase with inflation. Second, once in retirement, retirees may not have the same flexibility or capacity to turn on other sources of income to offset the erosion of their purchasing power. Third, in a climate of rising prices, retires are disproportionately sensitive to those prices which tend to rise most quickly, notably health care, food, and fuel. Fortunately, individual investors now have tools available to help combat this issue. Consult your financial advisor.

LONG TERM CARE

Nothing jeopardizes retirement lifestyle more than a need to fund long term care (LTC). With parents in their 70's and 80's, many Rochester physicians have personal experience with the impact of long term care on the financial well-being of a family. Consider that for 70% of couples over age 65, at least one spouse will need LTC, and the current average cost is $300/day (over $100,000/yr) (http://www.nyspltc.org/agents/e_learning/ch01/chapter01_03/content.htm). For a couple needing, say, $150,000/yr in net income to fund post-retirement lifestyle, the sudden need to produce an additional $100,000/yr of income for LTC may be impossible without invading principal and jeopardizing the lifestyle of the healthy spouse. Affordable LTC insurance is available, but the features can be somewhat complicated, especially when considering NY State's Partnership for Long Term Care which is designed to reduce cost to the consumer and provide enhanced protection of the family's assets by coordinating with Medicaid Extended Coverage. Further, recent passage of health care reform legislation includes provisions for LTC. Consult a qualified financial advisor to evaluate suitable alternatives.

A good plan is designed to work under all circumstances, not just under one specific set of assumptions. If you have already coordinated and integrated your savings, investment, and estate plans, then you have likely positioned your family to weather the potential impacts of these retirement risks.



Source: http://www.usinflationcalculator.com/inflation/historical-inflation-rates/)

If not, you'll want to ask yourself these questions:

- **Is my current failure to proactively plan in the best interest of my spouse and family?**
- **Is there any upside to waiting?**
- **Is it their responsibility or mine?**

Fortunately, there are strategies for addressing these sources of uncertainty, but inaction is not one of them.

James M. Sperry, MBA

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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). Jim joined Centra Financial Group in June 2006.

Resisitant Hypertension at the Office Visit

Matthew Funderburk, MD, FACC

Matthew Funderburk, MD

When assessing cardiovascular risk in patients, hypertension is one of the most common risk factors we encounter, and often one of the most frustrating to manage. Defined as failure to achieve goal BP using full doses of a three-drug regimen including a diuretic, resistant hypertension often can seem an all too common occurrence. The increase in patients meeting this definition is also related to a drop in "goal BP" for patients with diabetes and renal disease in hypertension guidelines, for whom JNC VII guidelines recommend BP controlled to less than 130/80.

So, how do we approach these patients? As we all know, there is no great "cookie cutter" approach we can apply broadly. Rather, focusing on the most common reversible causes will usually identify likely reasons for resistant hypertension in the individual patient.

First and foremost, ensure the BP readings are as accurate as possible with appropriate cuff size. Consider "white-coat" hypertension, and give strong consideration to some type of ambulatory blood pressure monitoring. This can be accomplished via ambulatory automated BP cuffs that patients use at home and keep a log of BP's for review. Alternatively, a formal automated ABP (ambulatory blood pressure) monitor can be worn by the patient for 24 hours, and is nice because you can easily see average blood pressures outside the office and assess for circadian variability as BP's are monitored at night while the patient is sleeping as well. The more BP data you have, the more confident you can be in identifying the true resistant hypertension patient. If end organ effects of BP are noted such as renal insufficiency, left ventricular hypertrophy identified by echocardiogram, or proteinuria this will also raise the likelihood that you are dealing with true resistant hypertension.

Noncompliance with medications and dietary factors are common reasons for "resistance" to BP control. Open communication with patients to allow them to feel comfortable being honest enough to "confess" not taking their medications is important. Often this leads to deeper issues of problems with cost, or side effects that can be the real issue that has to be addressed to allow for successful treatment. Careful questioning is important. When I ask "Have you been taking your medications every day?" the answer is usually "Yes." However, when I ask "Have you taken your medications yet today?" we often discover the reason that the blood pressure is elevated in the office but has been normal at home.

High salt diet and excessive alcohol intake are common contributors as well, as most patients are often not aware of the high sodium levels in their diet, or that excessive alcohol use contributes to elevations in blood pressure. Often brief questioning in the office can identify specific dietary items leading to difficulty in managing hypertension. Common offenders: simply adding salt with the salt shaker to food, canned vegetables or canned soups, packaged noodles with seasoning packets, packaged deli meats, frozen dinners, vegetable juices (they're supposed to be healthy...right?), chips/pretzels/nuts, marinades (watch out for regular soy sauce!!). Black licorice can contribute due to mineralocorticoid activity, but I seem to rarely find patients that eat this.

Investigate for illicit and over-the-counter drugs. Regular

NSAID use or pressor agents in cold remedies (eg. phenylephrine, pseudoephedrine) can counter the therapeutic effect of the patient's antihypertensive medications. Consider a urine tox screen as well, as the surprise positive screen for cocaine can be priceless when considering a more expensive work-up.

If pursuing these common remediable causes fails to lead to an identified reason for resistant hypertension, consider volume overload as the next most likely cause. Whether this is from salt intake, or volume retention due to kidney disease or liver disease, inadequate diuretic therapy is a common reason for inadequate hypertension control. Consider thiazide diuretics such as chlorthalidone, as the longer half-life of this generic medication versus HCTZ may lead to better diuretic efficacy. In patients with significantly reduced GFR, changing a thiazide to a loop diuretic, or combining the two classes may be needed.

If all easily reversible causes are identified and corrected, and hypertension persists, further evaluation for a cause of secondary hypertension is indicated. This should consist of considering polysomnography for obstructive sleep apnea, screening for hyperaldosteronism with an aldosterone: plasma renin activity ratio, screening for pheochromocytoma with urine metanephrines and/or plasma metanephrines, and imaging with CTA or MRA for renal artery stenosis. Consider echocardiography to screen for aortic coarctation, or even CT angiogram of the aorta if there is strong clinical suspicion for this based on brachial-femoral pulse delay on exam. If abnormalities in these screening tests are found, or if they are normal and resistant hypertension persists, referral to a hypertension specialist (often a cardiologist or nephrologist) is indicated.

In the vast majority of patients' thorough evaluation for the contributing factors as reviewed above usually leads to successful treatment. In truly refractory cases there has been some promising blood pressure reduction in feasibility trial data using an implanted carotid baroreflex stimulator, known as the Rheos Baroflex Hypertension Therapy System. This is a battery-powered generator inserted under the skin near the clavicle, with two electrical leads that run under the skin to the left and right carotid sinus. There are ongoing clinical trials with this device in progress, and this may become an effective option to consider in the near future for truly refractory patients.

Dr. Funderburk is board certified in internal medicine and cardiovascular disease. After completing his internship, residency (as Chief resident) and fellowship at the University of Rochester Medical center, Dr. Funderburk chose to remain a member of the Rochester community and joined the team of cardiologists at UCVA.

EDITORIAL CALENDAR

A Look Ahead

Join the conversation and share your expertise with your colleagues. If you are interested in submitting an idea or an article to be included in an upcoming issue, please email:

WNYPhysician@Rochester.rr.com.

JUNE

Cover Story: Spinal Surgeon M. Gordon Whitbeck, MD

Clinical Focus: Obesity and Geriatrics

A comprehensive review of obesity – the wide impact on healthcare and a look at how physicians are battling the epidemic locally.

Also, addressing the specialized healthcare needs of the geriatric patient – trends, treatments, advances – a local perspective.

- *Melanoma Detection and Prevention*
- *Stroke Care and Treatment*

JULY

Cover Story: West Ridge OB GYN

Clinical Focus: Women's Health

An in-depth look at the diseases and medical issues affecting women. Hear from local physicians on current trends and treatments for issues relating to fertility, sexuality, heart disease and continence.

***Special Focus:** Women & colon cancer*

AUGUST

Cover Story: TBD

Clinical Focus: Pediatrics

A current look at childhood diseases, medical conditions and the special needs of caring for this patient group.

***Special Focus:** Pediatric Plastic Surgery*
Pediatric Obesity

WHAT'S NEW IN Area Healthcare

John Valvo, MD recently performed the 3000th a robotic-assisted prostatectomy.

Rochester General Strengthens Status as National Leader in Minimally-Invasive Robotic Surgery

Program ranks among top 4% in U.S. and serves as a global observation center

John Valvo M.D. FACS, Rochester General Hospital's Medical Director of Robotic Surgery recently performed the 3000th a robotic-assisted prostatectomy. It was not only a potentially life-saving procedure for his patient, but it also marked the 3000th Robotic Surgery performed at RGH. Rochester General's burgeoning Robotics program is the largest in the region, and its volume places RGH among the top 4% of U.S. hospitals currently offering robotic surgery options.

Since the installation of its first daVinci Surgical System in 2004, Rochester General has become one of the nation's elite Robotic Surgery programs, and one of the most diverse, offering high-tech, minimally invasive options for urologic, gynecologic and colorectal cancer treatment. Rochester General is also one of just four "case observation centers" in the world, and draws visiting physicians from around the country who come to observe the latest techniques being pioneered by RGH surgeons.

URMC Geriatrician Named President of National Association


Paul Katz, MD

Paul R. Katz, M.D., professor of Medicine and chief of the Division of Geriatrics and Aging at the University of Rochester Medical Center, was elected president of the American Medical Directors Association (AMDA). The premier organization representing long-term care professionals, AMDA provides education, advocacy, information, and professional development to support the delivery of quality medicine in nursing homes.

"My personal vision is to make what we do as providers in nursing homes recognized and more credible, and to facilitate research to prove that our work makes a difference in quality in nursing homes," Katz said. He is an advocate for the creation of a nursing home physician specialty, similar to the role hospitalists serve in acute-care settings.

Lifespan recognized Katz's contributions at it's the recent Celebration of Aging, presenting him with the Carter Catlett Williams Award for Excellence in Long-Term Care/ Aging Services.

Transitional Care Unit at Living Center at Geneva-South Receives Score of 100% Patient Satisfaction

The Transitional Care Unit (TCP) at the Living Center at Geneva-South is proud to have earned a score of 100% patient satisfaction, November – December, 2009. Of those surveyed, 100 percent of respondents gave top ratings for "Recommendation to Others" and "Overall Satisfaction."

The Transitional Care Program offers a comprehensive rehabilitation approach designed to improve the functional independence of patients who have had a hip or knee replacement, fractured bones, an amputation, a cardiovascular accident, pneumonia, congestive heart failure, heart ailments, or other diagnoses. Following care at TCP, 85 percent of patients return to their home environment, and others transfer to a different level of care.

RGH Physician Earns Prestigious Designation from the Society of Hospital Medicine


Balazs Zsenits, MD

Balazs Zsenits, MD, FACP, SFHM/Medical Director of the Hospitalist Division at Rochester General Hospital has earned the designation Senior Fellow in Hospital Medicine (SFHM), awarded by the Society of Hospital Medicine. Only 150 hospitalists nationwide were selected to receive this first-ever credential.

The inaugural class of SFHM designees represents hospital medicine's most experienced leaders. To be designated as a Senior Fellow in Hospital Medicine, an applicant must:

- Serve as a hospitalist for at least five years
- Be a member of SHM for at least five years
- Demonstrate their dedication to quality, process improvement, commitment to organizational teamwork and leadership, as well as lifelong learning and education.

"It is a great honor to be awarded the Senior Fellowship by SHM, the society that leads hospitalists in improving quality and effectiveness of patient care in hospitals - the most complex, most expensive, and riskiest settings of health care," said Dr. Zsenits. "I am fortunate that our excellent team of hospitalists at Rochester General Hospital has been supported in their work by our hospital's forward-thinking leaders. Among its other achievements, our hospitalist program has reduced in-hospital mortality to half of what is expected [based on New York state hospitals' data for matched disease severity] and our entire hospital team remains focused on safety, service, and the efficiency of patient care."

University of Rochester Expands Robotic Surgeries to Oral, Pharyngeal Cancers


Matthew Miller, MD

Doctors at University of Rochester Medical Center are first in upstate New York to incorporate the precision and dexterity of a surgical robot to remove cancerous tumors in the mouth and throat. The first transoral robotic procedure – a partial glossectomy – was performed Feb. 8 by surgeon **Matthew Miller, M.D**. This procedure expands the Medical Center's robot-assisted surgery capabilities to include procedures for head and neck, urologic and gynecologic conditions. "Unfortunately, therapies for head and neck cancers haven't offered any significant increase in survival over the past several decades. Yet our ability to improve our treatments – through surgical advances such as robotics, targeted radiation therapy and better chemotherapies – has had a dramatic impact on the quality of our patients' lives," said Miller, assistant professor of Otolaryngology and the James P. Wilmot Cancer Center. Oral cancers affect about 28,500 people in the United States each year.

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

The Joint Replacement Center at Unity Hospital has earned the Gold Seal of Approval™ for health care quality. The Joint Commission awarded the Joint Replacement Center Disease-Specific Care Certification for knee and hip replacement.

"This certification means the Joint Replacement Center at Unity Hospital does the right things and does them well for knee and hip replacement patients," says Jean E. Range, M.S., R.N., C.P.H.Q., executive director, Disease-Specific Care Certification, Joint Commission.

"We are extremely pleased and proud to have received certification as a Center of Excellence for both hip and knee replacement from The Joint Commission," said Michael Klotz, M.D., medical director of the Joint Replacement Center at Unity Hospital. "This recognition represents the culmination of a great deal of hard work by all of our dedicated and enthusiastic staff, which includes nurses, technicians, therapists, doctors and support staff. It is our commitment to excellence in the service of our patients, continuous assessment and improvement, and evidence based practice which has made the Joint Replacement Center at Unity Hospital the choice for more people in the greater Rochester area than any other hospital."

Unity Health Reach-Health Care for the Homeless Program Expands Services

Unity Health Reach-Health Care for the Homeless celebrated the opening of its new facilities. The new clinic, located at 819 West Main Street, will provide additional resources to homeless patients and includes a waiting room, a physician's office, two exam rooms, and a group visit room.

Funded by a federal grant for capital improvements, the

facility allows Unity to provide follow up care to patients in a dedicated and private location.

Currently, about 24 patients per week are seen at the clinic. The addition of the clinic helps to meet the growing demand for services for Rochester's homeless. Health Reach has seen a more than 50% increase in the number of patient visits from 2008-2009.

Health Reach-Health Care for the Homeless "provides a holistic approach to health care. We treat more than just a person's physical ailments. We can offer them help with mental health, chemical dependency, dental and dietetic services," says Jennifer Thomson, program manager, Health Reach- Health Care for the Homeless.

University Expands Orthopaedic and Rehabilitation Care with Center in Greece

Western Monroe County Patients Benefit from Expert Care in Convenient Location

University of Rochester Medical Center Orthopaedics and Rehabilitation is expanding services by opening a new center for comprehensive musculoskeletal care and recovery in Greece. The center, which opened in March, offers convenient access to the expertise of the region's largest and most experienced orthopaedic team to residents in Monroe County's western towns.

The 8,000-square-foot center in South Pointe Landing, at the corner of Long Pond Road and Gates Greece Townline Road, will offer specialty care in orthopaedics, physiatry, sports and spine rehabilitation, hand and upper extremity rehabilitation, and imaging services to adults and children, along with daytime urgent care for injuries.

Tejan B. Patel, MD, FACC, FSCAI Interventional Cardiologist Joins UCVA As the Director of the Interventional Cardiac Catheterization Lab at the Unity Hospital

Tejan Patel, MD

Tejan Patel, MD is one of the highest volume interventional cardiologists performing elective and emergency PCIs in New York State. Dr. Patel performs procedures at both Unity and Rochester General Hospitals and is highly experienced in trans-radial artery cardiac catheterization/angioplasties, being the first interventional cardiologist to perform such catheterizations at these facilities. After receiving his cardiology fellowship in Chicago and his Cardiopulmonary transplant fellowship in Madison, Wisconsin, Dr. Patel moved to Rochester and completed his Interventional Cardiology Fellowship at the University of Rochester Medical Center. Dr. Patel is a Fellow of the America College of Cardiology. He is also a Fellow of the Society for Cardiac Angiography and Interventions.

Wilmot Cancer Center Gets Excellence Award for Cancer Care Programs

American College of Surgeons' Honor Recognizes Multidisciplinary Care for Patients

The James P. Wilmot Cancer Center at the University of Rochester Medical Center has received a New Program Outstanding Achievement Award from the Commission on Cancer of the American College of Surgeons. This prestigious award was given to only eight cancer centers in the country.

"This is important recognition for the outstanding doctors, nurses, scientists and staff at the Wilmot Cancer Center who maintain the highest standards of care for our patients," said Richard I. Fisher, M.D., director of the Wilmot Cancer Center.

The Wilmot Cancer Center last year received a three-year accreditation with six commendations for outstanding care, placing the center among the tops in the nation. The ACoS Commission on Cancer is a consortium of organizations dedicated to improving survival and quality of life for people with cancer through prevention, research, education programs, and the monitoring of comprehensive quality care. The Wilmot Cancer Committee is led by Kristin Skinner, M.D., chief of surgical oncology.

Share the news

- *New Practice, Physicians, Locations*
- *New Clinical Appointments*
- *Accreditations and Distinctions*
- *Expansion Plans*

Email us your news along with a high resolution photo to be included in the *What's New in Area Healthcare* section.

WNYPhysician@Rochester.rr.com

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Stat Law

UPDATE 2010

Late breaking news on medical-legal developments affecting physicians and health care providers.

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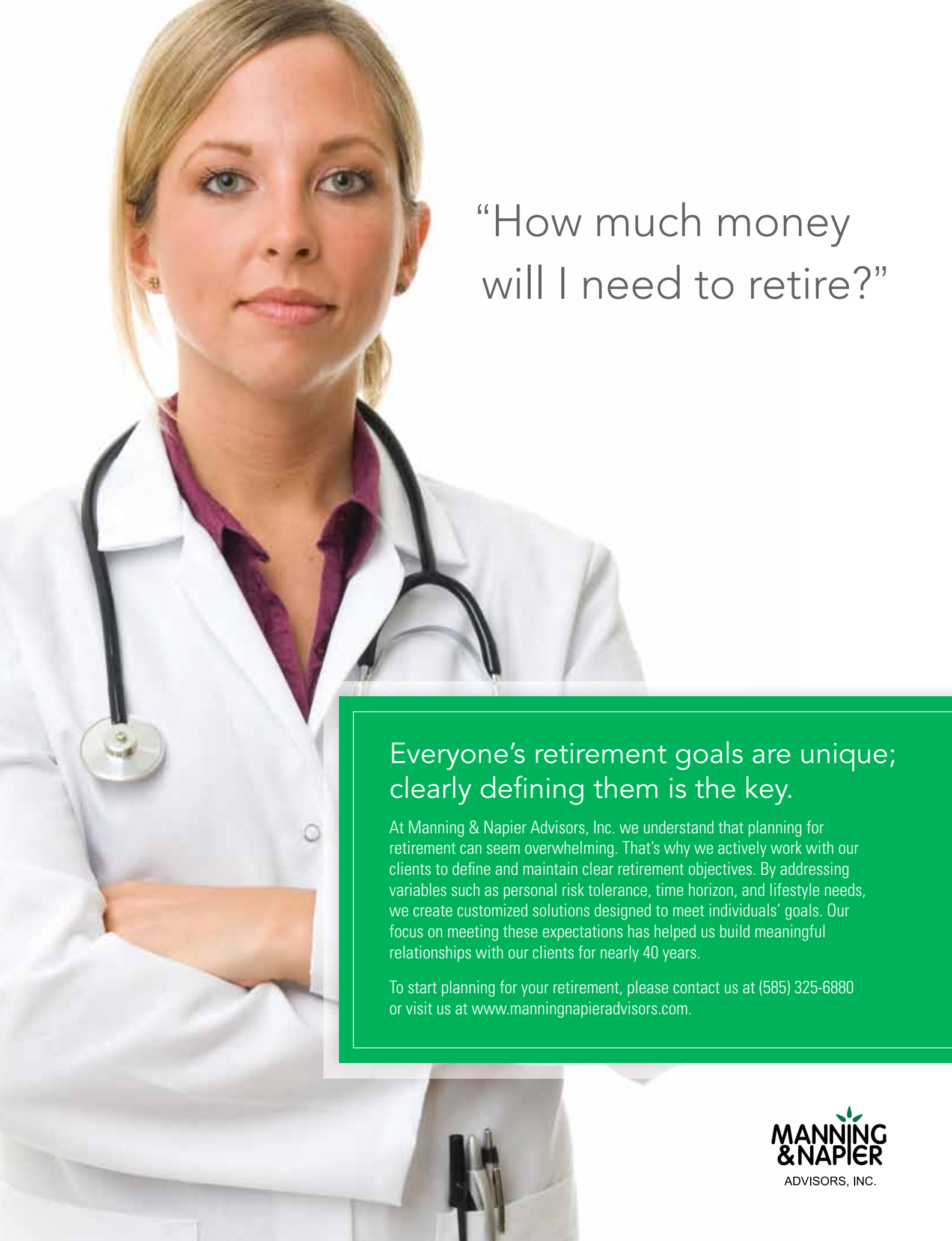
President Expands Overpayment Recovery Efforts: On March 10th, President Obama issued a directive expanding the use of "payment recapture audits" to identify and recover overpayments. Medicare's Recovery Audit Contractor Program (RAC) was highlighted by Obama as being particularly successful in identifying improper payments. According to the President, the RACs accounting specialists and fraud examiners use specialized technology to uncover overpayments and are compensated on a contingency basis related to the recoveries obtained. Due to the aggressive nature of the RACs (because they are paid on a contingency?) and the substantial exposure that can result from these audits, physicians should treat a RAC audit as they would an IRS audit, and consider engaging legal counsel as soon as they are confronted by a RAC audit. For more information, contact Michael Schoppmann at KACS.

New York Law Expands Maximum Civil Penalties for Medicaid Provider Violations: New York State is engaged in its own efforts to recapture monies paid by Medicaid. A new law has increased the maximum civil penalty for persons who receive overpayments or otherwise inappropriate payments from Medicaid. The law now allows for penalties of up to $10,000 for a first offender and $30,000 for repeat offenders – for each item of care, service or supply! If a Medicaid program audit finds more than twenty-five percent of the audited claims resulted in overpayments, the State can recover both civil penalties and the amount of the overpayment. If less than twenty-five percent, the State must choose between the amount of the overpayment and the civil penalty. If only one inappropriate payment is uncovered, the State is limited to receipt of the amount of the overpayment. Given these enormous potential penalties, physicians should redouble their efforts to assure that their billing and coding efforts are accurate and that the patient's medical record fully reflects the services provided.

Significant Expansion of National Practitioner Data Bank: The National Practitioner Data Bank (NPDB) was established in 1986 as an information clearinghouse to collect and release certain information related to the professional competence and conduct of physicians, dentists and, in some cases, other healthcare practitioners. Effective March 1, 2010, the so-called "Section 1921" (of the Social Security Act) expands the information collected and disseminated through the NPDB to include reports on all licensure actions taken against all healthcare practitioners, as well as healthcare entities. Limited querying of the NPDB is now granted to Quality Improvement Organizations, Federal and State Healthcare Programs, State Medicaid Fraud Control Units, and other law enforcement agencies. To learn more about the Section 1921 expansion of the NPDB, go to www.drlaw.com.

HIPAA/HITECH Implementation Update: The Office for Civil Rights (OCR) has yet to issue a proposed rule to implement new privacy and security provisions of the Health Information Technology for Economic & Clinical Health (HITECH) Act. These provisions include business associate liability, new limitations on the sale of protected health information, marketing, and stronger individual rights to access electronic medical records and restrict the disclosure of certain information. OCR advises that, although the effective date (February 17, 2010) for many of these provisions has passed, the anticipated rule will provide specific information regarding the expected date of compliance and enforcement of these new requirements. The new Data Breach Notification rule and new civil money penalty amounts applicable to HIPAA are effective, however. Covered entities and business associates must comply now with breach notification obligations for breaches discovered on or after September 23, 2009, although OCR used its enforcement discretion not to impose fiscal sanctions with regard to breaches discovered before February 22, 2010. A form of Data Breach Notification policy is on our website at www.drlaw.com.

New Bill Allows Family of Incapacitated to Make End-of Life Decisions: A bill allowing family members of incapacitated patients to make end-of-life decisions has been signed into law, after languishing for seventeen years in the New York State Legislature. Known as The Family Health Care Decisions Act, the law permits a close relative or a close friend of a patient to make medical decisions, including the removal of life support, in the absence of an advance directive.



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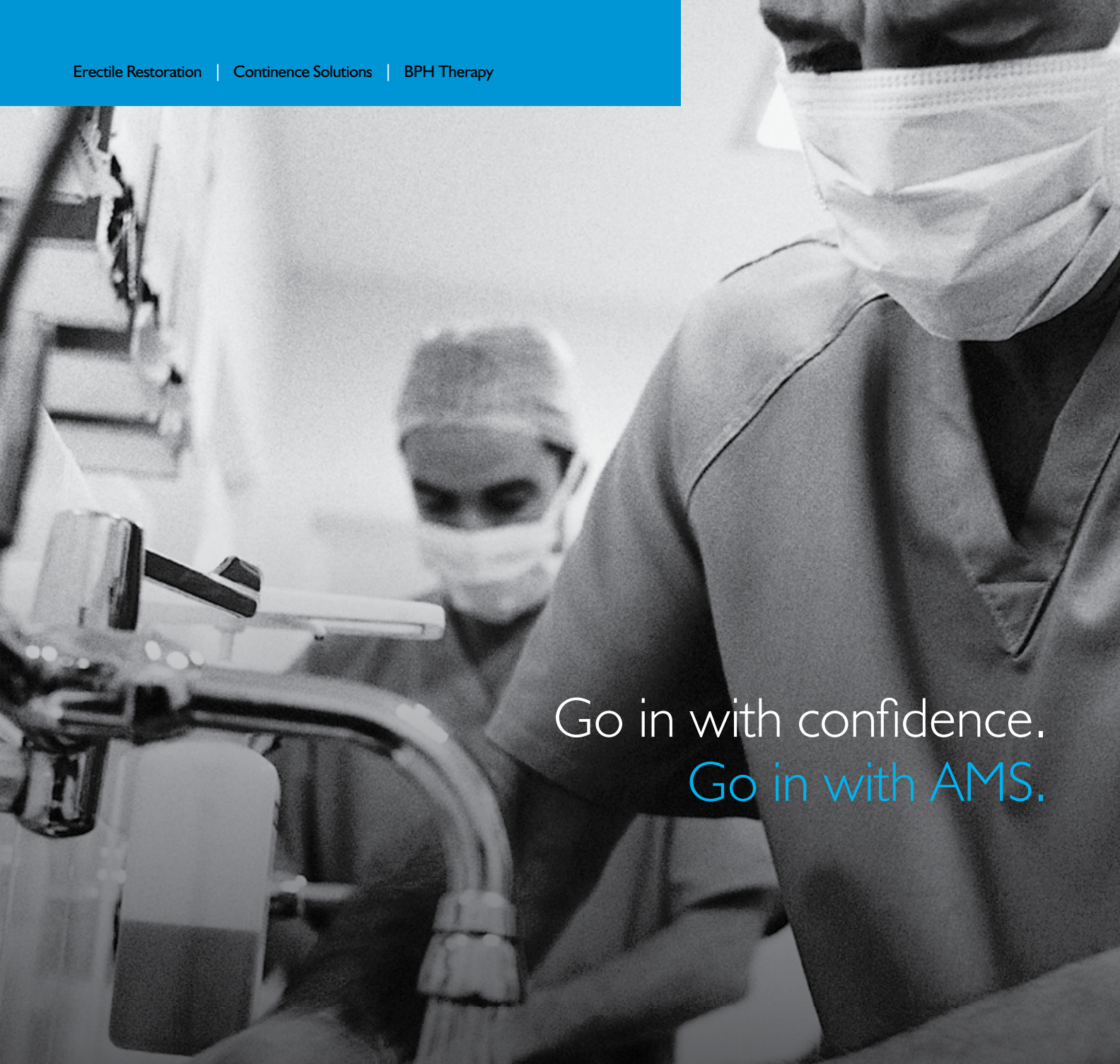

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