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Combating Stroke with Collaborative Care



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Cover Story



Beating the 'Brain Attack': Combating Stroke with Collaborative Care

Prevention, awareness and the critical timing of treatment play a vital role in reducing the occurrence, avoiding re-occurrence and minimizing the devastating long-term effects on the patient and their families.

With a proactive determination, the medical leadership within the network of the Rochester Regional Health System work together instituting a coordinated model of delivery focusing on speed of treatment—saving lives and preserving function. This newly expanded Health System brings together a deep pool of expertise to build on the recognition and success of the System's stroke centers. With an eye on the future, this next generation of providers focuses on expanding awareness and refining ways to improve speed of delivery and access to care in rural communities.

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Dr. Kelly Matmati in front of a CT scanner.
Cover Photo: Lynne Tseng



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Welcome to Volume 1 of *Western New York Physician* where you will find informative stories and articles about and for physicians in western NY.

The Aging Patient is the theme of this issue and our cover profile takes a current look at Stroke Care and Rehabilitation in our region. Here in Western New York we are fortunate to have numerous health care facilities that have taken measures systemically and devised protocols of delivery achieving remarkable recognition by the American Stroke Association. With Stroke, speed of treatment is the key to saving lives and restoring function. In this article we speak with Drs. Matmati, Burke and Fanciullo who discuss the importance of screening, prevention and treatment.

Back in the Practice, Financial and Liability sections you will find timely articles from local experts on asset protection, contracts – understanding liability, and various tips on managing personal finances.

Participate in the Conversation

I continue to be pleased to hear from many readers wishing to contribute articles to future issues. Sharing your expertise is a valuable way to communicate with your medical colleagues. If you would like to be a part of an upcoming story or wish to submit an article, please email or call me to discuss timing and submission criteria. In the meantime, please enjoy the numerous other articles within the issue.

As always, we thank each of our supporting advertisers -- your continued partnership ensures that all physicians in the region benefit from this collaborative sharing of information and provides the WNYP editorial staff with a deep pool of expert resources for future interviews and articles.

Think Spring!

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A Regional Update on Diabetes

Trends, Treatments and New Discoveries



Robert Bingham, MD

A Q&A with Dr. Robert Bingham.

Recent studies project approximately 10 million newly insured have entered the healthcare system under Obamacare. Add to this the estimated 2-3 million children and sub 26ers and we are looking at a whopping addition of 13 million new patients entering the U.S. healthcare system. How well are we poised regionally to manage the comprehensive chronic care for patients with Diabetes?

Q. Dr. Bingham can you provide a current snapshot on the diagnosis and trends in Diabetes among patients under the age of twenty-one in western NY?

A. The rate of Type 1 diabetes has increased slightly over the years. However, due to the epidemic of obesity, we are seeing more younger patients who are presenting with adult onset (Type 2) diabetes.

Q. It's widely agreed that there is a strong and direct correlation between Obesity and Diabetes such that recently the term 'diabesity' has been coined. Are we losing this war? What role does education play in changing mindsets especially in the young patient?

A. We clearly are not winning the "war" on obesity – as rates of obesity continue to increase not only in the U.S. but worldwide. In reference to diabetes – measures of the average blood sugar control of patients with diabetes, which have trended down over the last 20 years are now nearly constant. I guess I would call it a stalemate, but there remains much room for improvement.

Education is probably the most critical factor in prevention of both obesity and diabetes. Studies show that moderate exercise can prevent the transition from pre-diabetes to diabetes – but the intervention must be earlier to prevent the obesity in the first place. We need to focus starting at a very young on consistent daily exercise for children as well as better education on proper nutrition.

Q. How will Diabetes and Endocrinology poised themselves to absorb and manage the new flood of patients into the practice?

A. Managing the influx of new patients that are referred for diabetes is certainly a challenge. In the last 5 years we have gone from 1 physician to a group of 3 physicians and 1 nurse practitioner. As there are only approximately 4000 endocrinologists in the country – it is challenging to recruit new physicians to the Rochester area. I think we will see an increase in care delivered by allied health professionals (nurse practitioners and physician assistants) in endocrinology/diabetes care.

Q. Where have you seen the greatest advances in treatment options – i.e. recent FDA approval of insulin via inhaler, new pharmacology, pumps?

A. I don't feel that there is any one new medication or technology that is the greatest advance in diabetes treatment. There are many new families of medications for adult onset (Type 2) diabetes, so we have many more tools at our disposal to treat adults with diabetes. This allows us the ability to tailor their medications to their specific needs. For patients with Type 1 diabetes, new sensors that continuously monitor blood glucose (and some even interact with an insulin pump) are an exciting and evolving technology that has a bright future.

Robert James Bingham, MD received his medical degree from the Johns Hopkins University School of Medicine, completed his Residency in internal medicine at the URMC and a Fellowship in Endocrinology at the Mayo Clinic. Dr. Bingham is Board certified in Endocrinology and Internal Medicine and has been a practicing endocrinologist at RGH for the past 11 years recently joining in practice with K.K. Rajamani, MD, who heads the Unity Diabetes Center. Additionally Dr. Bingham serves as an assistant professor at URMC and a clinical instructor and guest lecturer at Rochester Institute of Technology.



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Beating the 'Brain Attack'

Combating Stroke with Collaborative Care

By Jenn Bergin



Photo: Lynne Tseng

Dr. Dustin Fancullo and his Physician Assistant, Taylor Indivero, performing surgery.

Stroke is a leading cause of death in our country, but for every person who dies from a stroke, more than five will survive. Those who endure are often left with debilitating physical and emotional damage. Rochester has one of the highest rates of stroke diagnosis in New York State, and it's estimated that area hospitals will see more than

3,000 stroke admissions annually over the next three years, according to the Centers for Disease Control. While these statistics are sobering, local hospitals are poised to meet the needs of patients. With standards for excellence in care that have become a signature of the city, Rochester Regional Health System is helping to lead the way.



Dr. Kelly Matmati and Stephen Armstrong, performing a Transcranial Doppler on a patient.

The New York State Department of Health, in conjunction with the Joint Commission, designated Rochester General Hospital as the first primary stroke center in the region. This distinction recognizes that systems of care are in place to treat patients with acute stroke, and that the infrastructure facilitates a collaborative approach to stroke care. This includes administration of the clot-dissolving protein called tissue plasminogen activator (tPA), the only FDA-approved stroke intervention, which can increase a patient's odds of recovery by 30 percent if delivered within the first three hours of the onset of symptoms.

"Primary stroke centers are where 'the rubber meets the road' in stroke care in this country," says Dr. Chris Burke, neurohospitalist and medical director of the Stroke Center at Unity Hospital. "Protocols and specialists are ready to treat stroke as it's happening with tPA. Beyond giving that medication, the hospital has the capability to monitor the patient afterward."

Still, local stroke care has been fragmented due to disparate and competing health care systems and providers, according to research from the Stroke Treatment Alliance of Rochester (STAR), a community-wide initiative led by the University of Rochester Medical Center, that brings together a consortium of area experts seeking to overcome institutional barriers in helping to provide comprehensive stroke care.

The formation of Rochester Regional Health System, which merges Rochester General, Unity and Newark-Wayne Community hospitals as well as United Memorial Medical Center in Batavia, will facilitate change. All four hospitals within the Rochester Regional system are state-designated primary stroke centers and the collaboration will help advance stroke care in the community.

"Part of the importance of the primary stroke center designation, particularly with this merger, is the capacity for dedicated stroke coordinators and directors to share results and knowledge," explained Burke. "Everyone has worked so hard independently, and now coming together – that is what's gotten us this far and will take us further."

As an indication of Rochester Regional's excellence in stroke care, both Rochester General and Unity have been awarded the Gold Seal of Approval from the Joint Commission several years in a row, as well as the Stroke Gold-Plus Quality Achievement Award from the American Heart Association/American Stroke Association.

"We've worked hard in this region to maintain a consortium of stroke care providers that share data and best practices, but there are always limitations from system to system," says Dr. Burke. "This collection of hospitals under Rochester Regional, and this new relationship, is different – we are coworkers working in the same positive framework to deliver care more efficiently and effectively."



The Importance of Intervention

Two million brain cells are lost every minute during a stroke, making the speed at which effective treatment is administered a leading factor in a patient's chance of achieving a full recovery. "Intervention therapy can stop the stroke as it's happening and lessen its intensity," says Dr. Burke. "On average, the tPA delivery rate is

3 to 4 percent. In the Rochester community, we have rates that run between 10 to 15 percent, which is very high. We are continuously looking at our performance and striving to

"Intervention therapy can stop the stroke as it's happening and lessen its intensity"

improve it." Even some of the largest medical centers in the country have sustainable rates that are only around 20 percent. Still, in terms of the larger stroke population it's a drop in the bucket, largely because only 25 percent of patients arrive at the hospital in time to be treated, he says.

"At that point, it's too late for any chance to intervene on the

stroke,” says Dr. Burke. “We can focus on rehabilitation and prevention of a recurrence, but the damage is done. If we could get 50 or 75 percent of patients to the hospital in time, it would be a giant leap forward in preventing the damage.

Even after suffering a stroke, few patients can define the major signs, and most have ignored symptoms. Patients don’t recognize what’s happening, and more importantly – they don’t recognize it as an emergency. To some degree, this includes doctors. “Many providers don’t recognize the importance of acting on these patients quickly,” says Dr. Burke. “Until the mid ’90s, there was no FDA-approved intervention for stroke and this has had residual effects, many people think nothing can be done – but that is just not true.”

“If a practitioner suspects a stroke, the patient should be sent directly to the emergency room, immediately.”

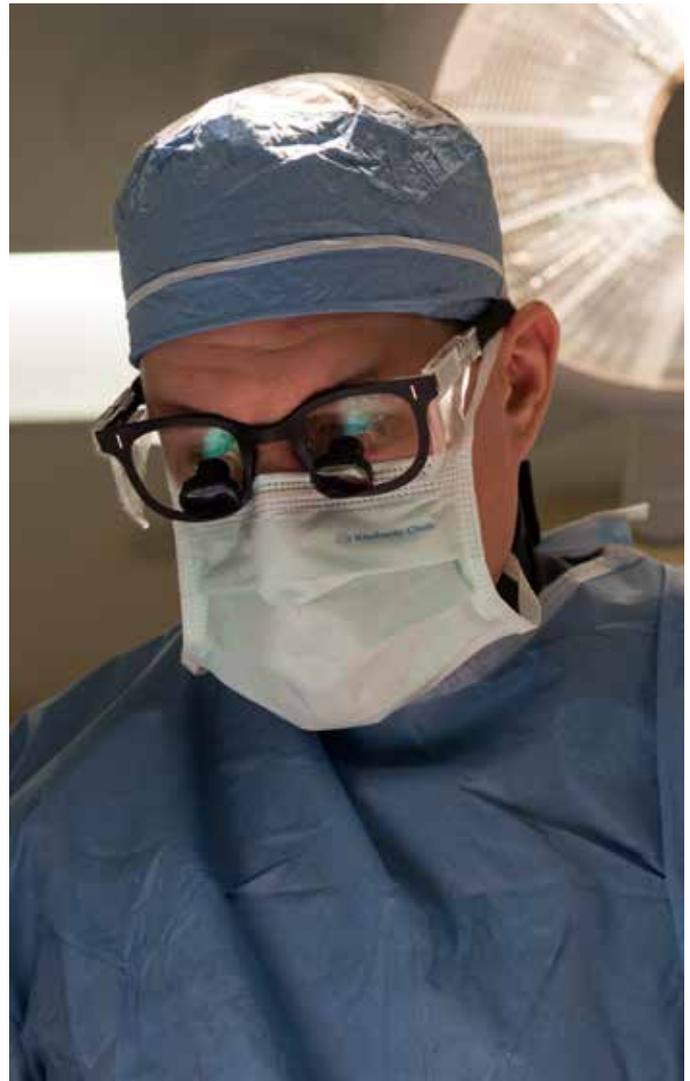


Often times, he doesn’t have the opportunity to see a patient until hours after the stroke has occurred. “I’m always shocked when patients tell me they called their doctor with stroke symptoms and were given an appointment for later in the day,” says Dr. Burke. “If a practitioner suspects a stroke, the patient should be sent directly to the emergency room, immediately.”

Stroke treatment is changing at many different points of care, he says. “It’s a continuum that begins with intervention. After that step, there’s a fork in the road. We begin an effort to prevent the next one, and advanced imaging and studies can help us to figure out why this happened. Then, it’s a focus on rehabilitation.”

The Continuum of Care

Secondary stroke prevention is crucial to this continuum of care, says Dr. Burke. It is critical that providers recognize the significant risk factors for stroke, particularly cardiac atrial fibrillation, hypertension, diabetes and high cholesterol. When these things remain marginally treated, the risk of stroke grows, and as patients age, risk factors are likely to accumulate. Of 800,000 strokes suffered annually, 200,000 of those are a recurrent stroke – and with each ensuing stroke, the likelihood of incapacitation increases exponentially.



Dr. Dustin Fanciullo performing surgery.

Photo: Lynne Tseng

“Every decade beyond the age of 55, the risk of stroke doubles,” says Dr. Burke. “If doctors don’t stay on top of these risk factors, these are patients that are going to go on to have a stroke, and a second or third. Providers need to pay attention to risk factors – and recognize stroke as a medical emergency that we can do something about.”

Focus should be placed on a wellness model, preventing a sickness model, says Dr. Dustin Fanciullo of Vascular Surgery Associates, a private practice aligned with Rochester General. High blood pressure, obesity, cholesterol, heart disease and smoking can each be mitigated and improved, unlike heredity, age or gender. One of the benefits of the Stroke Center at Rochester General is the screening made available through imaging, which is one of the easiest ways to evaluate carotid arteries. According to Dr. Fanciullo, with the advances in imaging technology, the picture quality is better, standards for ultrasonography have been raised, and the labs are accredited and reliable. All of these measures ensure better screening for



Dustin Fancullo, MD, Taylor Indivero PA-C, and radiology technician Walter Bayley looking at an angiogram during surgery.

when they're far from the hospital, far from the stroke center," she says. "One thing we have been talking about is a tele-medicine program, which would allow smaller hospitals, without stroke centers, to give tPA." A tele-stroke network would allow stroke experts to consult via video conferencing, and make recommendations to emergency doctors. Such advances would allow patients, even in rural areas, access to the expertise of a larger hospital.

"Standardized excellent vascular care, even more than several years ago, is now made available here, so that people in the entire region have access to the same care," says Dr. Fancullo.

Despite progress in tele-medicine, enhanced imaging techniques and new rehabilitation angles, all agree that the greatest need for advancement is in awareness.

the patients.

Higher incidence of early-onset diabetes, obesity and hypertension is leading to more strokes in young people. Still, stroke is most prevalent in those over 80 years of age, a population that continues to increase along with the average life span.

Caring for the growing and high-risk elderly patient group, particularly in rural areas, is an added challenge. "Acute stroke treatment requires that patients arrive at a hospital within three to four-and-a-half hours, which means they need to recognize their symptoms and seek care within that time frame," says Dr. Kelly Matmati, neurohospitalist and program director of the Stroke Center at Rochester General Hospital.

All four Rochester Regional hospitals are Primary Stroke Centers. This helps because it means patients in Wayne or Genesee counties who have a stroke only need to get to United Memorial or Newark-Wayne in order to get tPA and fast treatment, she added.

Dr. Matmati says there are cultural as well as other medical issues that also need to be taken into account, in addition to social concerns with the elderly population.

"Support networks can diminish, and for patients in rural areas it's hard to get them in during the treatment window,

"There has been a giant leap forward in the past 10 years, we've seen colossal changes collectively in all stroke disciplines," says Dr. Burke. "But in the next 10 years, the biggest change that needs to occur is intervening on acute stroke – which means that we need to make the public more aware of what stroke is – that it's a medical emergency, and there's a limited time when the brain is deprived of oxygen and nutrients to intervene."

Looking Ahead, On a Local Level

The culture within Rochester Regional is pro-tPA for acute stroke treatment. Some other emergency care communities are reluctant to administer the drug, due to concern about adverse effects. But, the local process and perspective for care is having a positive effect.

"Over the past several years, hospitals throughout the Rochester area have made an

effort to decrease door-to-needle times, and the hospitals of Rochester Regional Health System have played a leading role in developing these protocols that enabled those improvements and that are now broadly adopted by Rochester-area hospitals."

New to the leadership team at Rochester General, Dr. Matmati came to the Stroke Center at a time when the program was already recognized for high-quality care. Her goal is to take it to the next level. "The key to that is neuro-

"We've really made an effort to decrease our 'door to needle' times"

endovascular acute stroke care, for ischemic strokes, ruptured aneurysms and subarachnoid hemorrhage— comprehensive care for a full-range of cerebral vascular diseases,” she says. “With the addition of biplane angiography technology at Rochester General in 2013, these types of endovascular procedures can be performed for the most complex stroke cases.”

Over the last decade, endovascular intervention has been a growing area of interest in stroke care. While the procedure is similar to what a cardiologist does to open arteries and establish blood flow to the heart, the fragility of the brain makes the process more time sensitive. “It’s a blooming and blossoming part of interventional stroke care that our community has embraced,” agrees Dr. Burke.

Having come to Rochester from South Carolina, and trained in New York City and Long Island, Dr. Matmati chose Rochester for its culture of excellence in medicine. “There is a long tradition of pioneers in this state,” she says. “And the approach to medical care is distinct to this area. In Rochester, there’s a much more integrated health system – where patients really maintain contact with their primary care physicians, and the hospitals do a good job communicating. There’s more continuity of care. Much more so here than in other hospitals I’ve worked, I see people really coming together for the best in patient care.”

With Rochester Regional Health System’s focus on clinical integration, the hospitals convene regularly as part of a stroke coalition, to assess standards, troubleshoot and discuss ideas. “The collaborative nature of the stroke program means that neurologists work with the emergency department, radiologists, technicians, nurses, the surgical ICU – we’re all working closely together to provide streamlined stroke care,” says Dr. Matmati. “And this works well because everyone buys into the process.”

***“we’re all working closely together
to provide streamlined stroke care”***

Dr. Burke was drawn to neurology because he’s fascinated by the intricacies of the brain and cognition, and the potential to make dramatic changes in what is one of the most debilitating medical emergencies. With Rochester Regional Health System, it’s not just potential – it’s definite progress. “This is a part of neurology where we’re actively engaging in new therapies and management – what we know about stroke, and how we can change and manage it, is evolving daily.”

Rochester Regional Health System proves that in terms of stroke care, hope is not just on the horizon – but right here in Rochester.



Photograph by Jeff Blackman.

Vascular Surgery Associates, from left to right: Kevin Geary, MD, Dustin Fanciullo, MD, Patrick Riggs, MD, and Jeffrey Rhodes, MD.

Rehabilitation after Stroke

A Q & A with Dr. Mary Dombovy



Mary L. Dombovy, MD, MHSA

Q. *What are the specific challenges when rehabbing the aging patient? (falls, cognitive integrity, depression.)*

A. Age alone is not an issue, but as people age they tend to have other medical and functional issues that impact recovery. Our oldest patient to date turned 100 the day after he went home from inpatient rehabilitation totally independent! That being said, his health in general was excellent and he was very active. His stroke occurred after playing 9 holes of golf! Also as people age their support system may diminish - a spouse may have passed on and children or friends may not be able to lend any support or supervision that would allow a return home.

Q. *Are there particular comorbidities that affect progress and recovery potential?*

A. Other medical problems impact progress and outcome during rehabilitation. Cardiovascular limitations, severe arthritis, recent injuries, recent treatment for cancer, kidney, liver and lung issues as well as others may all have an impact. It is the role of the rehabilitation physician to take the patient's total medical, functional and social situation into account when setting expectations for recovery, designing a rehabilitation program specific to the patient, and deciding what setting is best for rehabilitation.

Q. *What is considered when guiding a patient towards the delivery of rehabilitation - in-hospital center, transitional care unit or in-home?*

A. This is partially answered above, but we take into account the medical, functional, and psychosocial aspects of the patient in deciding the appropriate setting for rehabilitation. It is important to know what services and support are offered at these different settings (Acute rehabilitation, Nursing home, home care, outpatient) and match them with the needs of the patient and family.

Q. *What impacts the scope of full recovery?*

A. Recovery is impacted not only by the location and severity of the stroke but comorbidities, family support, the patient's motivation, as well as the skill and capabilities of the rehabilitation program.

Q. *Is there a gender differential that affects outcomes?*

A. There are significant gender differences in stroke. While stroke has dropped to the 5th leading cause of death in men, it is still the 3rd leading cause of death in women. Stroke incidence increases with age, and thus more women are affected and affected at an older age. More strokes in women are due to a heart rhythm problem called atrial fibrillation and tend to be larger and more severe. They

are less likely to have a spouse to help care for them at home and more likely to end up in a nursing home.

Q. *How are caregivers educated and included in the rehab and recovery process and what impact do you see on the quality of a Stroke patient's recovery?*

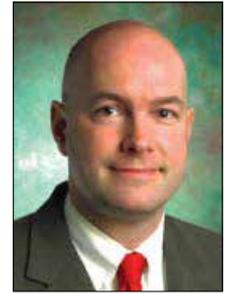
A. Our rehabilitation program involves caregivers thru all aspects of the stroke patient's recovery. We encourage caregivers to attend therapy, work with them in developing any skills needed for care after discharge and allow caregivers to stay overnight. Part of our education also focuses on prevention of another stroke and adopting a more healthy lifestyle. Our nurse navigator meets our patients and families in the acute hospital and follows them thru rehabilitation and ensures they have follow-up in our stroke clinic within 7 days of hospital discharge. Stroke is confusing to patients and families and we have found that our early post-hospital stroke clinic and nurse navigator to be key factors in keeping patients on their treatment regime (e.g. treatment for HTN, cholesterol, diabetes, etc.) and in preventing readmission to the hospital.

Q. *What are the latest advances in pharmacologic, modalities and other therapeutics?*

A. Our program focuses not only on the stroke that has occurred but making sure we treat all other active medical and functional issues. For example, sometimes an injection for an arthritic knee can make a major difference. It is critical to identify and treat depression as it has been shown to have a very negative impact on stroke outcome if left untreated. We also use selected medication to try and improve memory and attention if needed. The key to recovery continues to be intense practice of the lost skill, whether that be walking or use of an arm or speech. We have several new devices an equipment that allow us to assist patients in achieving this level of repetition an practice at an earlier stage than before. This is also key - as the earlier we can start the rehabilitation process, the better the outcome. New approaches are on the horizon, and we are often a site chosen to pilot new devices and treatments.

Mary Dombovy, MD is the Vice President of Neurosciences and medical director of both the Stroke Center and the Spine Center at Unity Hospital. She is Board Certified in Neurology, Neural Repair and Rehabilitation, Vascular Neurology, and Physical Medicine and Rehabilitation. Dr. Dombovy is also a Clinical Associate Professor of Neurosurgery, Neurology, and Physical Medicine and Rehabilitation at the University of Rochester. Dr. Dombovy developed the St. Mary's Brain Injury Program in 1989. Under her direction, the program has grown into the Acute Rehabilitation and Brain Injury Program, which is one of the prominent programs within the Department of Rehabilitation and Neurology, of which she has been chairperson since 1997.

Adventures in Asset Protection



Joel Redmond, CFP

It seems an axiom of wealth management that those of lesser means think about return, while those of greater means think about risk. For this latter crowd, one of the most fertile fields in finance is that of asset protection – essentially, creating sufficient barriers around personal wealth so that adverse parties will have little to no chance of accessing those assets as a result of a court proceeding.

Asset protection is nothing new, and despite the stereotypes of Swiss accounts, offshore trusts, and frontier-market tax havens, presents no breaches of ethical or legal principles – at least, under the right conditions. What are these conditions? The primary ones are that the principal aim of the asset protection stratagem used has a legitimate purpose other than to defraud creditors, and that the stratagem is employed well in advance of a creditor event taking place.

With this said, what are some of the primary asset protection strategies in place for the wealthy today, and in what situations might they work? There are a great many, and different situations call for different measures. Here are a few of the more common methods out there today, presented in decreasing order of their effectiveness. (Keep in mind that laws and statutes can vary significantly from state to state: a technique that works perfectly in Tallahassee might be disastrous across the state lines in Savannah. Be sure to confirm any of these strategies with your legal counsel prior to using them.)

First line of defense: Statutory provisions (personal homestead exemptions, retirement plans, life insurance)

In general, US law derives largely from British common law, from which the phrase “a man’s home is his castle” can be ultimately traced to. Today, this sentiment is expressed as the “homestead exemption” – essentially the amount of equity in a personal residence that is considered protected in a creditor proceeding.

How can a forward-thinking, asset protection-conscious client take advantage of this exemption? Let’s say this client has a \$1MM house with no mortgage, and the fear of a future lawsuit from, say, a grandson grossly injuring someone in an auto accident. To prevent his home being attached in such an event, this client may not need an expensive trust: he may need simply to encumber the house with mortgage debt. If, say, the homestead exemption in his state (as in New York) is \$150,000 for a mar-

ried couple, he might take out an \$850M mortgage against the house to make it an unappealing asset for a creditor’s counsel to go after, and prevent a forced sale of his personal residence. (Obviously, again, far before the unfortunate event happens.) In many (even most) states, similar statutory protections also exist for money placed into 401(k) plans, Individual Retirement Arrangements, other retirement plans, and life insurance policies. These instruments are afforded special protections under various federal and state laws, because they fulfill the public policy goals of helping people save for retirement and protect their families after a breadwinner’s death. Because of these protections, they generally should be the first line of the “pre-emptive defense” that is necessary with most viable asset protection strategies.

Second line of defense: Insurance

Perhaps the most overlooked asset protection strategy in existence may be the use of the humble insurance policy. Two main types of insurance – life and disability – protect the human capital of current and future earnings. Professional liability insurance helps hedge the risk of a malpractice suit. Business interruption insurance hedges against the risks of losing patient revenue due to an interference with normal operations. “Those aren’t asset protection strategies,” you say. Why? Because they don’t involve offshore jurisdictions or complicated trusts? The use of insurance to shift and reassign risk to a third party is one of the simplest and best asset protection strategies available. It can also be one of the least expensive.

3) Third line of defense: Entity & trust planning

Other strategies that can be employed in asset protection are the straightforward concepts of limited liability companies (LLCs) and irrevocable trusts, which have the general effect of placing a cap on the magnitude of the loss their owners/settlers may be sued for. Even in the second decade of the technologically enlightened 21st century, it can be astonishing to see how many of the wealthy still insist on owning substantial real estate and business assets in their own names. Many labor under the mistaken notion that a revocable trust will protect them from lawsuits, or that the transfer-on-death account they set up years ago is an asset protection device. Some simple and clear solutions to this

problem, particularly for those with significant business assets, are to combine three separate facets of planning: entity structure, trust ownership, and estate/succession planning. More often than not, it will be easier to defend an asset protection decision before judge and jury when all three of these facets are considered at once (think of the original premise of asset protection planning in the first place, which is that the main purpose is not to defraud creditors).

To review one quick example, consider the case of a real estate businessperson with \$15MM of financial assets and real estate properties owned in his own name, a wife and three children, and a desire to leave the business in five years. This person has just a simple will that leaves everything to his wife outright and then to their three children equally. If both husband and wife are killed in a car crash, there might be very unfortunate results. The executor of the estate, who is the eldest child, has to pay \$1.7MM in federal estate taxes, and another \$2MM in state estate taxes (again in New York). He has to do this within nine months, when all he really wants to do is be with his siblings to mourn their parents. The younger brother and sister contested the will when they discovered that their brother was named the executor and they weren't, even though they always got along perfectly prior to now. The executor is trying to figure out where to come up with the cash, and since Dad and Mom had gotten rid of their life insurance, and any buildings would need to be sold at a loss, he decides to raid the retirement assets to get \$1MM. The problem is that the funds are qualified, so he ends up paying another \$300,000 in income taxes to withdraw them from the IRA. Perhaps most importantly, he then receives word that an elderly tenant has slipped and broken her neck on an icy sidewalk his property manager missed salting one morning, and the tenant's daughter is suing him for his full \$5MM interest in the business and personal assets. These problems could have been avoided by putting the real estate into LLCs and gifting shares of the LLCs into an irrevocable trust for the benefit of the wife, and then the children. If this had been done, the federal and estate taxes could have been avoided, there would have been no will contest (because the assets would already have been in trust, obviating the possibility of probate and a sibling contest), the trust corpus would have been protected from the lawsuit (though not the distributions, likely), and the executor wouldn't have the threat of personal ruin. This is an extreme example, but it illustrates the value of combining entity, succession, and estate planning at once.

Advanced strategies

For those seeking still more planning techniques to shield assets from adverse parties, there are multiple ways to do so. Many of these hinge on the natural flexibility that inheres in entities

—specifically, the ability of the owner of a company to recapitalize that company. This technique is used more as an estate planning technique than a pure asset protection technique. That said, it shields the future appreciation in a business from one of the best-known creditors: federal and state taxing authorities.

A recapitalization might work as follows. Suppose a woman is the sole owner of a \$20MM company, and she continues to be astonished at the stratospheric growth of the firm over the past few years. Constructing pro formas one evening, she realizes that, if she's not careful, she's going to be worth \$40MM in five years' time! It's a nice problem to have, but she realizes now that she has to do some planning to keep the current value of the company, while gifting the appreciation to someone else. Prior to this time, her company had had only one class of stock, but now she decides to recapitalize it. With the help of her attorney and accountant, she creates a class of preferred stock worth \$19MM, which she retains 100% ownership of, a suite of Class A voting common stock that she retains 100% ownership of (worth \$500,000) with a fixed dividend, and a suite of class B non-voting stock (also worth \$500,000) that receives a fluctuating dividend based on residual corporate profits.

The preferred and Class A common shares, in this scenario, have no growth — they are designed to preserve their current value, and pay the owner income. All the growth — the net income of the company — accrues to the Class B stock. This stock creates the future value of the company — and the future estate tax liability.

To avert this liability, the owner gifts this Class B stock into a trust for the benefit of her children and grandchildren. She pays herself a 5% dividend on the preferred, which amounts to \$950M per year, she receives a fixed dividend on the Class A shares, and she knows that the residual profits are accruing to the B shares, which is where the bulk of the \$20MM appreciation is going to end up. She now has capped her net worth at \$20MM, managing her estate tax; she has provided for her family with the trust shares; and she has established security for herself with the preferred dividend. She has also saved herself about \$8MM in future potential estate taxes by doing so (assuming the Class B shares grow to \$20MM, as she predicted they would).

Most individuals and families have worked hard to accumulate their wealth. But as wealth increases, the need to protect can quickly supersede the need to build. While there is no all-encompassing and suitable stratagem when it comes to asset protection, a well-structured, comprehensive plan for risk mitigation is critical to ensure the preservation and protection of wealth.

*Joel T. Redmond is a senior financial planner for Key Private Bank in Rochester. He is the author of *The One-Minute Financial Planner*, available at www.amazon.com. He is a native of Central New York.*

*Information not intended as individual legal or investment advice.



Hypertension PUZZLE



John D. Bisognano, MD, PhD
UR Medicine preventive cardiologist

Monitoring and managing blood pressure is a steady challenge for aging adults as well as for their physicians. An estimated 67 million adults in America have hypertension—very common disease is a major cause of stroke, heart failure and kidney disease—and only about half are able to keep it under control.

Our aging population—one in five people will be 65 or older by 2030 – makes hypertension one of the greatest threats to community health.

The mammoth generation of baby boomers is causing a spike in prevalence of hypertension—which makes logical sense as this large generation is now nearing retirement age. It's a disease that occurs more frequently as people age and while modern medicine extends lives, it doesn't come without other health problems.

As doctors, we make a habit of using the arm cuff to check our patients' levels as often as we can. We look at both the top and bottom numbers closely because when the force of blood pressing against the walls of your arteries is elevated, it raises the heart's workload and can cause serious damage to the arteries as well as to the heart itself.

The first number of a blood pressure reading is the systolic pressure, when the heart is squeezing. The second is the diastolic blood pressure, when the heart is relaxed between beats and when the elastic recoil of the arteries continues to push blood forward. Both numbers are important.

A reading below 120/80 is normal. If your top number is between 120 and 139 or your bottom number is 80 to 89 you are on the way to having hypertension. That means you probably need to make some lifestyle changes to prevent or at least delay becoming hypertensive and needing medications to get the numbers down.

If your top number is 140 or above and your bottom number is 90 or above, you have hypertension, or high blood pressure. The higher the number, the greater your health risks, and your physician will likely recommend a combination of lifestyle changes and medication to lower your blood pressure and reduce your risk of heart disease, kidney disease, or stroke. For some people over 60 without diabetes or kidney disease, a blood pressure over 150/90 triggers the need for treatment with medications.

One in five Americans has high blood pressure and doesn't know it, because you don't feel any different — in the short term — despite the damage that it's doing to your heart and other organs.

Primary hypertension

Primary hypertension is the most common form of the disease, caused by bad genes and boosted by a salty diet, overweight, and inactivity. Typically people are diagnosed in their late 30s and 40s and the condition worsens as they move through their 50s.

Medications such as ACE inhibitors, calcium channel blockers, diuretics, and beta blockers— are used to lower the pressure and physicians urge patients to eat right and to exercise. Losing 15 to 20 pounds can make a significant difference in blood pressure and potentially cut the amount of medication needed per day.

Since the baby boomers are now in their 50s and 60s, physicians and cardiologists focus on managing their blood pressure and heart function, as well as a host of other ailments they face. Baby boomers are heavier and more of them have diabetes than ever before. That combination significantly increases their risk of stroke and heart and kidney disease.

As a result, physicians are tackling blood pressure as the most direct way to reduce the chance of stroke, heart attack or kidney failure – which can be deadly. The medications available for treatment of high blood pressure come with a minimum if any side effects and are far different than the medications that were around 40-50 years ago. We are fortunate to live in an era where there are so many great ways to approach this disease.

Secondary hypertension

Secondary hypertension occurs rarely and is caused by a specific, often reversible reason such as an overacting thyroid gland, sleep apnea, or adrenal gland diseases. If a patient's blood pressure is unresponsive to treatment or they have signs of these other disease, a physician will likely order additional testing to seek out a secondary cause of hypertension.

Some middle-aged adults don't realize they have hypertension until they have survived a heart attack and face recovery with lifestyle and medication changes. In fact, many adults rarely see a doctor except for the few times they go to an emergency room, often for an unrelated condition. It is important not to ignore high blood pressure readings, as it is unfortunate to miss an opportunity to decrease one's chance of heart attack, stroke, kidney disease, or heart failure.

Sleep apnea is increasingly associated with hypertension. Suc-

Successful management of the apnea is essential to improve health and quality of life. We all feel better after a good night's sleep and it contributes to a modest reduction in blood pressure levels as well.

The challenge of managing secondary hypertension is that without treatment for the underlying causes, successful blood pressure control is hard to achieve.

Tips for avoiding hypertension

You can take steps to maintain safe blood pressure levels by:

Avoid alcohol, tobacco and obesity. They are among the best things you can do to avoid disease.

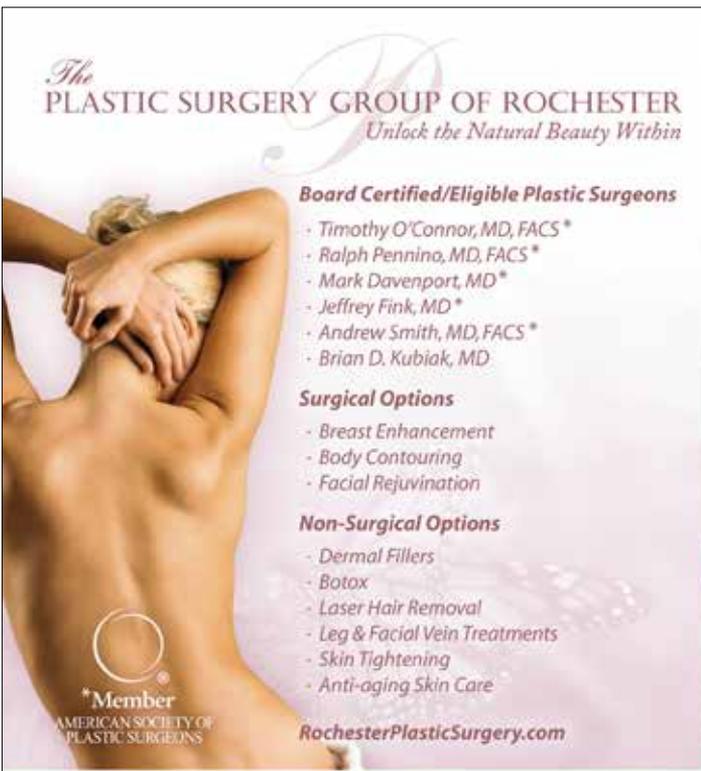
Choose a low-fat diet to keep weight under control.

Exercise at least 30 minutes five or six times a week. It's good to get your heart and muscles working regularly.

Watch the amount of salt you eat — try to keep it under 6 grams a day.

- Think about this: if you eat soup and sandwich for lunch, that could be a lot of your daily sodium intake. A can of soup has 1 gram of sodium, add a ham sandwich and you've doubled that. Add cheese and you've doubled it again; and if you're at a restaurant, those quantities are even higher. When making a salad, choose the light dressing instead.
- Sweeten up your diet. Consider a few small bites of dark chocolate – bites, not bars – which scientists say can help lower your blood pressure as well.
- As delicious as it sounds, it won't do the whole job. You have to combine it with a nutritious diet and exercise.
- Making these lifestyle changes will help you will lose 10-20 points on your blood pressure reading. If you're overweight, choose to exercise and you'll see your blood pressure drop as you lose the pounds.
- If you have tried dieting and are not losing weight, consider seeking help from a dietician or weight-loss physician to explore other dietary options that may work for you. For some, weight-loss surgery may also be a reasonable option.
- Lastly, if your doctor has prescribed medication to lower your blood pressure, take it every day. And pay attention to your blood pressure using the monitors at supermarkets and drug stores.

John D. Bisognano, MD, PhD, is a UR Medicine preventive cardiologist and director of outpatient cardiology and hypertension program. He is a professor of Medicine at the University of Rochester School of Medicine and Dentistry and president-elect of the American Society of Hypertension.



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Project ECHO® in Geriatric Mental Health (ECHO® GEMH)

The older adult population of New York State is growing dramatically, and so too is the number of seniors with mental illness and dementia. These disorders represent significant public health challenges through impaired quality of life and increased health care utilization, cost, morbidity, and mortality. Specialty care for late life psychiatric and memory disorders is associated with better outcomes and lower costs. However, access to specialists is limited, both in urban and rural areas where most late life mental health care is provided by primary care providers. There is urgent need to support primary care providers in providing quality mental health care for New York State elders.

The Extension for Community Healthcare Outcomes (ECHO®) model was developed at the University of New Mexico to improve access to complex chronic disease and specialty care in underserved communities through the use of videoconferencing technology. By providing primary care clinicians with skills and knowledge to treat complex patients in their own practices, ECHO® aims to improve health outcomes while also improving the health care experience of the patient and family and reducing the cost of care through a multidisciplinary team-based approach. Currently being disseminated by its originators at the University of New Mexico, the ECHO® model has been replicated at diverse sites nationally and internationally. Rigorous evaluation has shown it to improve outcomes in patients with hepatitis C, and ECHO® shows promise in ongoing applications to care for chronic pain, chemical addiction, cardiovascular disease, breast cancer, childhood obesity, diabetes, sports medicine, thyroid disease, HIV, nephrology, liver disease, autism/ADHD, and geriatric syndromes.

The University of Rochester Medical Center (URMC) Project ECHO® in Geriatric Mental Health (ECHO® GEMH) is the first ECHO® in New York State. Project ECHO® GEMH, supported in part by grants from the New York State Health Foundation and the Health Foundation for Western & Central New York to the URMC Office for Aging Research and Health Services (OARHS), is designed to help integrate behavioral health services into primary care. Our primary objective is the establishment of TeleECHO Clinics that connect “hub” URMC specialists (an interdisciplinary team consisting of psychiatry, geriatrics, nursing, social work, psychology, and pharmacy) with “satellite” primary care practice (PCP) sites across New York State using videoconferencing technology. The only technology required on the part of the participating spoke site is a broadband connection and webcam. The service is free.

TeleECHO GEMH Clinics occur biweekly for 90 minutes. They include both knowledge and skill acquisition components. PCPs present difficult cases in a structured format followed by guided group discussion and recommendations by the hub specialty team. Content knowledge is supported through short didactic presentations provided by hub specialists as well. The aim over time for the “community of practice” that results is to increase skills, knowledge, and self-efficacy of PCPs in their management of older adults with complex mental illness or dementia. As PCPs become expert in care of these patients, they become resources to their practice partners and care delivery systems, reducing reliance on remote geropsychiatry and memory care services, improving outcomes, patient/family/provider satisfaction, and quality of care regionally.

Benefits to PCPs of participation:

- Access to a multidisciplinary team of mental health and dementia care specialists
- Team-based interdisciplinary professional development
- Expanded delivery of evidence-based best practice care
- Improved health outcomes for patients and caregivers
- Cost savings at service system level by decreasing unnecessary service utilization
- Potential for increased practice revenue through gain sharing agreements
- Increased practitioner and patient satisfaction
- CME credits at no cost or travel

For information:

Contact the OARHS office at 585-273-1812 (Vicki Perry, Administrator), or

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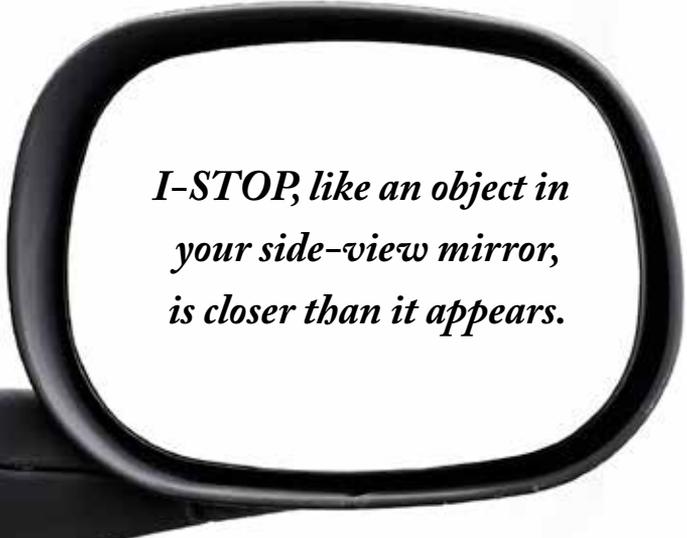
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I-STOP is Closer Than it Appears

By Dr. Peter Kaufman



I-STOP, like an object in your side-view mirror, is closer than it appears.

Consider this: your patient comes in, and you prescribe your patient Tramadol; you handwrite a prescription on NY-state issued tamper resistant paper and send the patient on her way to fill her prescription. Unbeknownst to you, your patient cannot get her prescription filled, because all controlled substance and legend drug scripts must be sent electronically per New York's Internet System for Tracking Over-Prescribing/ Prescription Monitoring Program legislation.

This scenario will be real for physicians who don't realize that I-STOP is closer than they think. In fact, many New York physicians are not ready for I-STOP and assume that they will be able to either continue writing paper scripts or be able to successfully set up e-prescribing at the last moment. Additionally, many physicians incorrectly assume that there are no repercussions for failing to send prescriptions electronically.

While providers have actively e-prescribed non-controlled drugs for years, many have not yet adopted the technology required to write controlled substance prescriptions electronically. Providers haven't adopted EPCS for a number of reasons, including the time they believe it takes to complete the identity proofing process.

EPCS in New York

The I-STOP law has a couple of important provisions related to controlled drug prescribing. First, it requires physicians to check the state controlled drug registry prior to writing a prescription. Typically, doctors comply with this regulation by having their staff check patients prior to their visit. Second, by March 27, 2015, providers are required to use electronic prescribing for

every prescription, both controlled and non-controlled.

On or before that date, every prescriber in New York must already have or acquire technology that will allow him or her to send prescriptions electronically. Setting up the technology for sending controlled drugs electronically is considerably more complicated than for sending non-controlled drugs, and requires that prescribers accommodate the following:

NIST Level 3 identity proofing

Access Control—proving that you are permitted to send controlled drug prescriptions

Obtain and use two-factor authentication for sending each controlled drug electronic prescription

Why Aren't More Physicians Adopting EPCS?

Ever since the Bureau of Narcotic Enforcement adopted regulations for mandatory electronic prescribing back in early 2014, NY prescribers have questioned whether or not they need to comply. Some physicians point to the chicken or egg question (pharmacies not being EPCS-ready, and physicians not writing prescriptions with EPCS) as the reason why they haven't adopted. In fact, although 55.3 percent of New York pharmacies are EPCS-enabled to date, it shouldn't be a barrier since pharmacies must also comply with the I-STOP deadline of March 27, 2015.

Let me assure you, despite all the reasons why you or your colleagues might not be adopting EPCS, all New York practitioners are required to comply with the law and begin electronically sending all prescriptions.

On the Countdown: What You Should Be Doing Now

Time is running out, *so now* is the time to find a solution that will enable you to e-prescribe both legend and controlled substances. If you don't have the capability, you should contact your EHR, EMR or stand-alone e-prescribing vendor as soon as possible to find out their plans for supporting EPCS and e-prescribing.

If your point-of-care vendor doesn't offer electronic prescribing of controlled substances (EPCS), you should evaluate vendors that do offer EPCS functionality. Surescripts has a list of approved vendors for EPCS as well as legend substances.

Once you've gone through the necessary steps to get started with EPCS you will need to complete the following:

- Complete the identify proofing process
- Receive your two-factor authentication
- Gain "access" to use your EHR or e-prescribing solution for EPCS (this is a specific process required by the DEA)
- Contact the BNE and send them the appropriate paperwork
- Send a prescription for a controlled drug to an EPCS-enabled pharmacy

Per I-STOP, prescriptions must be sent electronically by March 27, but if you have a solution now, begin sending all your prescriptions electronically so it becomes a habit, and keep in mind:

- Check the PMP before you prescribe
- EPCS prescriptions may only be processed for one patient at a time
- Faxed prescriptions will be invalid after March 27
- You may keep paper prescriptions in your office for out of state prescriptions or in the case of a network failure

I-STOP Implications

I-STOP will arm physicians with real-time data to help identify doctor-shoppers and drug diverters and stop them in their tracks. Further, I-STOP has implications outside of New York: it's likely at least some other states will similarly legislate EPCS for ambulatory and acute settings down the road.

While it may seem far off, getting started with EPCS and e-prescribing now is more important than ever, because I-STOP is approaching quickly and it's closer than it appears.

¹DrFirst's Proprietary Data

Dr. Kaufman is DrFirst's Chief Medical Officer. Dr. Kaufman is a member of the Health IT Standards Committee, Transport and Security Standards Workgroup for ONC (Office of the National Coordinator for Healthcare Information Technology). Representing the American Gastroenterology Association's (AGA), Dr. Kaufman is a delegate to the AMA and was the co-chair of the Physicians Electronic Health Record Consortium (PEHRC). He has participated on workgroups at CCHIT (stand-alone e-prescribing), HIMSS (e-prescribing), and NCPDP (e-prescribing).

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A Current Look at Alzheimer's



Anton P. Porsteinsson MD

A Q&A with Anton P. Porsteinsson MD

*Director, Alzheimer's Disease Care,
Research and Education Program (AD-CARE)*

Q. What is the scope of Alzheimer's in our region and what trends are you seeing with the disease?

A. In the Greater Rochester Metro area and surrounding counties we have about 26 – 30,000 individuals with dementia and Alzheimer's disease constitutes about 2/3rd of these cases. We anticipate close to 3500 new cases per year. With the aging of society, we expect these numbers to triple between now and 2050. This will pose a great strain on our health care resources.

Q. What are the latest developments in diagnosing and treating this disease?

A. Diagnosing someone with dementia is not necessarily hard but defining the exact etiology is much more challenging. Identifying someone once they have full blown symptoms is too late, akin to diagnosing someone with adult onset diabetes once they have prominent end organ damage or cancer once it has metastasized. In the past decade, much of the work in research has focused on identifying earlier symptoms of the disease, ranging from much subtler clinical symptoms such as constitute Mild Cognitive Impairment or establishing imaging techniques and biomarkers that allow identification of people at risk before they have any clinical symptoms. These include high resolution MRI scans, beta-amyloid PET scans, tau Pet scans, and CSF and blood biomarkers.

Q. Can you describe the predictive blood test for Alzheimer's – how does it work, is it reliable and accurate?

A. There are several predictive blood tests in development for AD, ranging from genetic markers, microRNA, protein profiles and lipid profiles. Further work is required to fully establish and validate these biomarkers. Researchers at the University of Rochester and Georgetown University recently published their findings on a blood phospholipid profile that was quite accurate in predicting those at near term risk of progressing to more severe memory loss.

Q. Are there implications of early testing for the patient and the physician and insurance coverage and reimbursement?

A. Whereas some of the biomarkers are commercially available, insurance companies, including Medicare are generally not covering the cost which can run into the thousands of dollars. That may change as these tests offer clearer benefits in terms of impact on clinical care decisions. For now, the biomarkers are tools used mostly in research.

Q. What new discoveries do you see on the horizon?

A In the near term, the diagnostic ability to identify people at risk will progress rapidly. This sets up the opportunity for prevention studies conducted in people with well-established risk profiles. The first one is already underway and another one is funded. Several more are in the planning stages. If we can prevent or delay the onset of AD, we have taken a very big step forward. At the same time, multiple studies are underway in Mild Cognitive Impairment and early stage AD to see if the course can be mitigated. The interventions target the underpinning of the disease instead of dealing with the consequences of the neuronal damage like current treatments. Multiple clinical studies and trials are underway at the University of Rochester with these goals in mind.

alzheimer's 
association

Count on the Alzheimer's Association to help you stay up-to-date

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For more information, 800-272-3900 or www.alz.org.

Anton P. Porsteinsson, MD, is director of UR Medicine's Alzheimer's Disease Care, Research and Education (AD-CARE) program, as well as the first William B. and Sheila Konar Professor of Psychiatry at the University of Rochester. One of the nation's leading clinical researchers examining Alzheimer's disease and dementia, Porsteinsson is involved in numerous national and international studies into the treatment and prevention of this illness.

Late Career Starts, Heavy Debt Burdens

Get the Cure for Sagging Finances



Cynthia Turoski, CPA

A 2014 national survey by AMA Insurance reports that employed physicians continue to have concerns over their financial well-being. The top three financial concerns are having enough money to retire (72 percent), followed by being able to fund long-term care expenses (65 percent), and having the right estate plan (51 percent). Many employed physicians consider themselves only “somewhat” or “not very knowledgeable” about personal financial issues, or “confident” they are making the right decisions.

It's no wonder when you consider the limited time physicians have to manage their overall personal financial affairs and the competing issues when trying to balance it all. Every dollar is typically pulled in multiple directions. Though the majority of the population grapples with these issues, physicians have the added complications of starting their careers later and having significant debt burdens. That means delays in saving for retirement. Their liability risks further complicate matters, requiring an awareness of proactive asset protection planning—just in case.

Let's address some important aspects of personal financial planning that may help shed some light that physicians of all income levels can benefit from.

Cash/Debt Management

Though typically emergency reserves should be three to six months of living expenses in cash, most physicians don't hold more than a couple of months of living expenses. A home equity or personal line of credit is another resource to turn to should a temporary need arise, as long as they aren't tapped unnecessarily. Have the line of credit available before a need arises since getting one approved when there's a major financial issue might not be possible.

Most individuals at all income levels can benefit from having a spending plan to better understand what they spend their money on and how they could possibly save more. But a spending and debt management plan can help you with paying down debt and prioritizing which debt to pay down first. Manag-

ing your credit score is critical to minimizing borrowing costs, amongst other things. Each year, you can request your free annual credit report at www.annualcreditreport.com from each of the three major credit reporting agencies. You could pick one every 4 months to monitor your credit throughout the year to catch errors and keep track of what you have outstanding, not to mention to spot signs of identity theft.

Investments

Most people think financial planning is only about investments, but they are only a subset of your overall personal finances—a piece of the puzzle. Just as your overall personal finances need to be coordinated, your investment piece also needs to be coordinated. Most physicians have money invested in different places such as in their employer retirement plan and personal investments through different investment advisors. It is important to be sure your investment strategy is coordinated across all of your accounts for proper asset allocation. What rate of return should you target in order to meet your objectives? Can you afford to invest more conservatively or do you need to invest more aggressively to reach your nest egg goals? Are your portfolios tax-efficient? These are some of the questions needed for this piece of the puzzle in order to be sure you have the right investment strategy.

College Education Funding

How much should you save for your children's college education without jeopardizing your own retirement security? Most parents want to help their children as much as possible and some can fully. Many can't. You need to understand if there are any limits to your ability to do so or if there are trade-offs you need to consider otherwise.

Once you determine how much you can save towards your children's college education, you should consider using a 529 college savings plan as the investment vehicle. New York's plan allows an annual income tax deduction for contributions of up to \$10,000 per couple. The funds can grow tax-free if used for qualified education expenses. You can take advantage of free college savings dollars at www.upromise.com. When the time comes, it is important to time the withdrawal from the

529 plan account in the same tax year the qualified education expenses are incurred to avoid unintended tax consequences. Grandparents can also fund 529 plan accounts for grandchildren, though note that those monies could become an available resource should the grandparent need long-term care.

Retirement

After likely starting your career later, are you on track to have the life in retirement you envision after factoring in health insurance costs, taxes, inflation, changes in expenses and possibly a longer life expectancy? The AMA survey indicated that having enough money to retire is the top financial concern. Some physicians thought their retirement financial plans are on track but many felt they are behind. We see that it can take a significant amount of money to retire, but the biggest factor is lifestyle. What is enough for one physician might not be enough for another. When you index that lifestyle for inflation, it becomes more and more expensive over time, just like it has through our working years. What effect does that have on the ability of your money to last longer than you do? Once the paycheck stops and the cash-flow spigot turns off, you'll need whatever you've accumulated at that point to last possibly 30 years. It's important to assess where you are in this area, no matter what age you are, or even if you're already retired, so you know what the parameters are and what your options are.

Employee Benefits

Make sure to refresh yourself on the employee benefits that are available to you to make sure you are fully utilizing them and coordinate them with the rest of your financial picture to fill any gaps. Review beneficiary designations on group life coverage to be sure the primary and contingent beneficiaries are properly named.

Asset Protection

For asset protection purposes, review your asset titling and consider the use of lifetime trusts. These steps have to be taken proactively, not when an issue arises in order to be effective.

Risk Management

The second highest concern in the study is being able to fund long-term care expenses. You can do retirement planning and get yourself on the right track, but that could go right out the window should you and/or your spouse need long-term care with no plans to pay for it. It is important to evaluate long-term care insurance coverage to understand your options and make an informed decision in light of your overall finances. Equally important, review your life and dis-

ability insurance coverages for adequacy, quality and suitability. Be sure your homeowners and auto deductibles are fitting for your financial situation—perhaps the deductibles could be increased if you have sufficient cash reserves or cash flow in order to reduce ongoing premiums.

Estate Planning

Having the right estate plan is the third highest concern in the study. Your estate plan should be coordinated with your asset protection plan as asset titling and trusts impact how your estate plan is going to work and whose will directs the distribution of assets. Remember, not all assets are controlled by your will. It is important to review your overall estate plan to understand how your will, asset titling and beneficiary designations all come together should something happen to you “tomorrow.” Often, this review shows that the overall estate plan wouldn't play out as intended. Estate planning isn't just about saving estate taxes, but also about when and how your assets are going to be distributed and to whom – no matter how much you have. For the wealthier, it also may involve wealth transfer strategies to family and/or charity.

These are some of the areas you should regularly address, at least annually, to make sure your financial well-being is “on track” and “protected.” Personal finances have many demands to prioritize and coordinate. The issues can be complex, but the time is now to address them before another year creeps by.

Cindi Turoski is a Tax CPA financial planner and managing member of Bonadio Wealth Advisors LLC, a subsidiary of The Bonadio Group. There she helps clients with their overall personal financial affairs, providing consulting and planning at a professional service level. Cindi can be reached at cturoski@bonadio.com

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What is My Liability?

I Enter into a Contract: Part 1

Issue

Our professional lives are replete with contracts. Most professionals will be party to dozens of contracts at any given time. Not all contracts are labelled to be contracts; conversely not every document labelled as a 'contract' represents a legally binding contract. More obvious examples of contracts include: employment contracts, insurance policies, mortgages, leases, and subleases. On the other hand there are many documents which have the force of a contract but whose nomenclature only implicitly implies the existence of a contract such as: medical staff privileges and appointments, operating agreements, managed care contracts, provider agreements, corporate bylaws, medical staff bylaws, codes of conduct, pledges, and even informed consent documents. A contract may be construed to exist, under a theory of either an express contract, or as an implied contract. An express contract is communicated by direct language which binds parties; on the other hand, an implied contract is inferred from conduct which indicates parties' intention to be contractually bound.

In my role as an attorney my expertise is typically retained to (1) develop or write a new contract; (2) review a proposed contract document for the purpose of mapping and counselling a party about implicit risks; (3) negotiate changes in a proposed contract to shift risk between parties; (4) re-negotiate existing contracts; and, (5) litigate breaches or perceived breaches of contract. When I write contracts for my clients, and when I represent clients who are considering accepting a contract which has been offered to them, my role is to delineate and define the risks inherent in a contract and both make sure that they are clearly understood and also to propose changes or clarifications which may help mitigate, shift, or eliminate some of the more concerning areas of risk. It is natural that each party in a contract will try and shift as much risk as possible onto the



James E. Szalados, MD, MBA, Esq.

other party, since risks are associated with financial, equitable, or other legal liabilities. The problem with contracts, as with any legal document, is that plain English language has important legal ramifications, such words and phrases are referred to as 'legal terms of art' and the legal implications of words and phrases may not be obvious to a casual reader. The terms and clauses that are included in a contract are extremely important; however, equally important to a successful relationship are the potential terms and clauses which are not, but could or should be, included so as to protect a party from future liability. In some instances, missing terms may and can be supplied by a court if they are either consistent with parties' intentions, or if they are statutorily or legally required; however important missing terms can have serious ramifications. The importance of reviewing any and all potential agreements with an attorney who has experience in contract and/or healthcare law cannot be underscored. In the event of untimely termination or breach, contract litigation can be very costly.

The first threshold issue in any contractual analysis is whether a contract actually exists. Although verbal agreements may represent contracts, they are extremely difficult to enforce. A contract may be defined as a legally-binding agreement, which contains a promise or set of promises, to fulfill specific terms and conditions, which the law in some way recognizes as duties, for which, in the event of breach, there is exists a legal remedy. Contract formation requires (1) an offer; (2) consideration; (3) acceptance; and (4) absence of defenses or bars to contract. The fundamental purpose of a contract is to formally define obligations in a legally binding way; but a more implicit and equally important function of a contract is to shift risk between parties. The acceptance of various forms and levels of risk is one of the most important analyses which will determine the progress of negotiations and whether a final contract will ever be agreed upon.

An offer expresses a promise or commitment to enter into a contract. Offers must be specific and communicate its terms with sufficient definiteness and certainty to form the

basis for a contract. It is extremely important to understand that preliminary negotiations or invitations to deal are not binding contracts. One of the more notorious examples of a preliminary negotiation is the Letter of Intent (also referred to as a Memorandum of Understanding or Memorandum of Agreement). Letters of are used to signal parties' agreement to the basic structure of ongoing and proposed serious negotiations with the intention of coming to an agreement to contract. Letters of intent typically follow a round of preliminary discussions and even possibly after the signing of a Confidentiality Agreement. Letters of intent serve important business purposes (1) a commitment to begin serious negotiations toward a business transaction; (2) a commitment to a timeline of negotiations which may include a deadline to close a deal; (3) an understanding that each party will incur effort and costs associated with due diligence such as consultation with an attorney (if one is not already involved); (4) to estimate the expenses and risks associated with contracting; and, (5) to design or determine the conditions for mutual acceptance. A Letter of Intent is most frequently interpreted to represent an offer; this may or may not legally be the case. The problem with Letters of Intent is that depending on the terminology, some may actually represent enforceable contracts and some may not. Some Letters of Intent emphatically state that that they are not formal agreements and then proceed to set forth agreed terms for a proposed transaction, which, when relied upon, may be interpreted as a formal contract by a court. Furthermore, if a Letter of Intent is in fact determined to represent a binding contract by a court, then the parties are faced with a contract that contains general essential terms but also lacks important terms which are considered important to a complete and final agreement such as liability limits, warranty waivers, indemnifications, non-compete clauses, and detailed expressions of responsibilities, benefits, and terms of compensation. Enforceability is only an issue when one party insists it didn't intend to be bound. If upheld in court to represent a binding contract, a Letter of Intent may represent a very poor binding agreement in which either the court or the parties will have to work out all the subsequent details when the parties are already somewhat at odds with each other. If the parties agree that they intended to be bound by a Letter of Agreement, mutually accepting that the Letter of Agreement was in fact perceived as a contract, then there is little question that the Letter will be binding and in the event of a disagreement or breach, the court will only need to determine whether the Letter contained enough crucial information to allocate enforcement and damages. So, for example, a graduating resident receives a Letter of Intent and perceives it as a contract, arranges to relocate and enters into a

lease or buys a home in a different state, and then learns that the Letter of Intent represented not a final contract but only an invitation to negotiate – these are the types of problems that could be avoided by a timely consultation with and attorney early in the contract negotiation process.

Consideration in legal contracting refers to a 'bargained-for-exchange' and a legally defined 'value' and generally refers to an obligation which would not exist absent the proposed contract. The process of negotiation and risk assignment lies within the purview of consideration; however, simply 'thinking about it' does not meet the requisite for legal consideration. The consideration must be mutual or bilateral; if only one of the parties is bound to perform, then the promise will be illusory and may not be enforced in a court. When the requisite consideration has been met, there may or may not be an acceptance which, if communicated appropriately, "inks the deal" and forms the binding obligation. The acceptance, the expression of absolute and unconditional agreement to all the terms set out in the offer, must mirror exactly the terms of the offer. A counter-offer is not an acceptance; however a counter-offer does formally extinguish the original offer: one cannot make a counter-offer and then decide to accept the original offer. Nonetheless, a request for further information or for clarification of terms is not a counter-offer and parties are free to complete the negotiation process if they chose to do so.

The next issue will focus specifically on contract terminology of interest to healthcare providers.

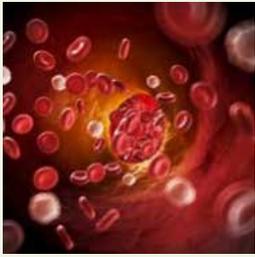
Dr. Szalados is a licensed physician engaged in the practice of anesthesiology and critical care; a senior-level hospital administrator, and an attorney admitted to the practice of Law in New York and concentrates his practice in the areas of Health Law. Dr. Szalados is an attorney with healthcare law firm of Kern Augustine Conroy & Schoppmann, P.C.

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New Study Probes Link Between HIV Drugs and Vascular Disease

A new \$3.8 million grant will bring together clinical and bench researchers to better understand why individuals who receive anti-retroviral treatment for HIV are at greater risk for heart disease and stroke.



“The good news is that the drugs being used to fight HIV are increasing life expectancy to normal levels,” said University of Rochester neurologist Giovanni Schifitto, MD, one of the co-leaders of the study. “However, one of the long-term complications is that these treatments, the infection itself, or

a combination of the two are increasing risk for cardiovascular and cerebrovascular disease in this population.”

The study will bring together a multidisciplinary team of individuals with medical and engineering backgrounds, deploy new imaging technologies developed at the University of Rochester, and will involve a unique collaboration between clinical and basic science researchers.

People who undergo long-term anti-retroviral treatments for HIV often experience what doctors characterize as an accelerated aging process, particularly in their vascular system. This typically manifests itself in atherosclerosis, a hardening and narrowing of the arteries due to the accumulation of plaque and cellular degeneration. This condition puts patients at significantly greater risk for heart attacks and strokes.

Scientists speculate that this occurs due to some combination of the infection and the treatments themselves which may be damaging cells in the body’s blood vessels.

The study will follow 180 HIV positive and 90 negative individuals who are 50 years and older for three years. One of the key measures will be the thickness and stiffness of the carotid artery – the major blood vessel that serves the head and brain. The researchers will employ a new ultrasound technology developed by Marvin Doyley, Ph.D., with the University of Rochester Department of Electrical and Computer Engineering, to track changes to the vessel over time.

The project will also entail what is commonly referred to as “reverse translation.” In most instances, medical research is first conducted in the lab on cells and animals and these findings are then used to inform research in humans.

In this new study, the information gathered from the human volunteers will be employed by researchers in the lab to better understand the biological mechanism of the disease. Specifically, basic scientists will study cells from volunteers in order to test a theory that the anti-retroviral treatments may be activating proteins that are causing inflammation in the cells and contributing the onset of arterial sclerosis. The researchers will then further probe these findings in an animal model so that new preventive therapies can be tested.

“While the comprehensive approach of this study seems like common sense, it is not as common as one might think,” said Sanjay B. Maggirwar, MBA, PhD., a professor in the University of Rochester Department of Microbiology and Immunology and a co-leader of the study. “By observing this condition in humans while at the same time conducting the basic research necessary to understand the series of events at the cellular level that lead to premature vascular aging, we can more rapidly translate these findings into potential new therapeutic approaches.”

The researchers expect to begin enrolling study volunteers later this month.

The study is being funded by the National Heart, Lung and Blood Institute. The research team will also consist of Jun-Ichi Abe with M.D. Anderson Cancer Center in Texas, and Vikram Dogra, Amneris Luque, and Xing Qiu with the University of Rochester.

Decoding Fat Cells: Discovery May Explain Why We Gain Weight

University of Rochester researchers believe they’re on track to solve the mystery of weight gain – and it has nothing to do with indulging in holiday eggnog.

They discovered that a protein, Thy1, has a fundamental role in controlling whether a primitive cell decides to become a fat cell, making Thy1 a possible therapeutic target, according to a study published online this month by the FASEB Journal.

The research brings a new, biological angle to a problem that’s often viewed as behavioral, said lead author Richard P. Phipps, PhD. In fact, some diet pills consist of antidepressants or anti-addiction medications, and do not address what’s happening at the molecular level to promote fat cell accumulation.

Although Thy1 was discovered 40 years ago and has been studied in other contexts, its true molecular function has never been known. Phipps’ laboratory reported for the first time that expression of Thy1 is lost during the development of fat cells, suggesting obesity could be treated by restoring Thy1.

They’re also working towards developing an anti-obesity drug, a Thy1-peptide, and have applied for an international patent to protect the invention. Phipps has been investigating Thy1 since 1989; The UR is trying to identify a company to help with commercializing the patent asset and bring a new obesity treatment to the marketplace.

“Our goal is to prevent or reduce obesity and in this paper we’ve shown how to do this in principle,” said Phipps, the Wright Family Research Professor in the Department of Environmental Medicine at the UR School of Medicine and Dentistry, and a professor of Ophthalmology. “We believe that weight gain is not necessarily just a result of eating more and exercising less. Our focus is on the intricate network involved in fat cell development.”



Researchers studied mice and human cell lines to confirm that a loss of Thy1 function promotes more fat cells. Mice lacking the Thy1 protein and fed a high-fat diet gained more weight and faster, compared to normal mice in a control group that also ate the same high-fat diet. In addition,

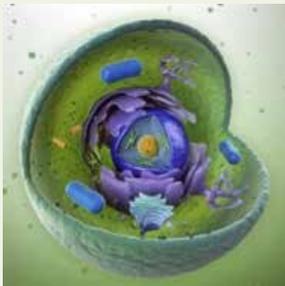
the fatter mice without Thy1 had greater than twice the levels of resistin in their blood, a biomarker for severe obesity and insulin-resistance or diabetes. Experiments using human fatty tissue from the abdomen and eyes showed similar results.

Phipps and colleagues, including key researcher Collynn Woeller, PhD, research assistant professor of Environmental Medicine, are continuing to investigate why cells with the potential to turn into fat cells lose the Thy1 protein, and why fat accumulates faster when Thy1 shuts off. It’s not clear whether Thy1 levels are different in people at birth, or whether they change with time and exposure to various environmental agents.

To address the latter question, Phipps’ laboratory is separately studying whether chemicals known as obesogens – such as bisphenol A (BPA), flame retardants, and phthalates – reduce Thy1 expression in human cells and promote obesity. That study is funded by the National Institute of Environmental Health Sciences. The work reported in FASEB was funded by the National Institutes of Health, as well as grants from the Rochester/Finger lakes Eye & Tissue Bank and the Research to Prevent Blindness Foundation.

An estimated 60 million people are defined as clinically obese in the United States. Diseases associated with obesity include Type 2 diabetes, various heart conditions and some cancers. Worldwide obesity has nearly doubled since 1980, according to the World Health Organization, and Phipps said the obesity epidemic is growing fastest in well-developed regions such as Asia, Latin America, and parts of the Middle East.

Researchers Receive \$1.4M to Study Gene Therapy and DNA Delivery



Since its discovery several decades ago, gene therapy has been a medicinal sphinx, with doctors enamored by its potential as they are frustrated by the riddles it presents.

Researchers at the University of Rochester Medical Center are working to solve one of those riddles.

In order for gene therapy to be effective, doctors must discern how to deliver DNA to a cell's nucleus,

which requires a comprehensive understanding of how DNA and proteins move through cell cytoplasm. Knowledge of this system could lead to huge leaps in gene therapy effectiveness, and could potentially allow researchers to push forward on research into many currently-untreatable diseases.

The research is supported by a 4-year, \$1.4 million grant from the National Institutes of Health.

"One of the best examples is cystic fibrosis," said David A. Dean, PhD, professor of Pediatrics and Neonatology at URM and the study's lead researcher. "For cystic fibrosis, we know what the affected gene is, and

we know what the mutation is. We know the physiology. The road block is the delivery — getting the corrective DNA in there and to the right cells for the right amount of time."

Once DNA enters a cell, it still needs to travel to the nucleus, where it can influence a cell's decision-making and response to diseases. To travel through a cell's cytoplasm, the DNA bonds with proteins, which then ferry it to the cell's center through microtubules that lead to the nucleus.

Dean and his team are researching which microtubules the DNA can use to reach the nucleus, and which proteins it can bond with to travel most efficiently. This means studying the more than 300 proteins within a cell to determine which ones drive DNA delivery.

"In a car, certain people and parts play bigger roles than others," said Dean. "So if we remove the passenger protein, the car will still drive. But if we remove the driver, then it won't, and then we'll know that protein is the one steering the delivery."

The research will also include a study of how the DNA moves around once it is within the nucleus itself.

Dean's lab also studies lung disorders and acute lung injury, the latter of which results in fluid buildup in the lung and is often fatal. A better understanding of DNA delivery may also lead to better treatments for this type of injury.

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PRIVATE PRACTICE NEWS

UCVA Cardiovascular to Join Rochester Regional Health System

UCVA Cardiovascular Practice will join Rochester Regional Health System on January 1, 2015. The two organizations finalized their agreement in October 2014, bringing 15 cardiologists and 110 employees from four office locations into the newly-formed health system.

UCVA has been serving the Greater Rochester and Southern tier areas for more than 20 years, with offices in Greece, Brighton, Dansville and Geneseo as well as providing cardiology services at Unity Hospital for many years. While UCVA will become an integral part of the highly regarded Sands Constellation Heart Institute (SCHI) of Rochester Regional, their patients will experience a seamless transition with little change in day-to-day operations.

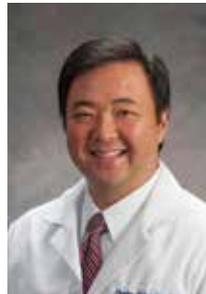
"We are excited about the opportunity to become a part of the staff at the acclaimed Heart Institute," said Maurice E. Varon, MD, Managing Partner UCVA. "All of us at UCVA are committed to continuing to provide the highest quality of care our patients expect, and joining Rochester Regional will ensure our ability to provide seamless and exceptional service long term."

"Bringing the talents and patient-first focus of the UCVA team into Rochester Regional will further position our cardiac team as the best in the Northeast," said Ronald Kirshner, MD, Chief of the Sands Constellation Heart Institute at Rochester Regional Health System. "Our system-wide affiliations, our physicians and staff, and our award-winning quality together ensure our patients experience the best cardiac care available."

Rochester Regional's Rochester General Hospital (RGH) has earned national recognition for excellence in cardiac specialties and continues its affiliation as a Cleveland Clinic Heart Surgery Program. Home to the fourth largest cardiac center in New York State, RGH has been recognized nine times as one of the nation's Top 100 Cardiovascular Hospitals. According to the 2014 report from CareChex®, a division of Comparion Medical Analytics, RGH ranks first in New York for Cardiac Care and Heart Attack Treatment and #2 in New York for Overall Medical Care.

Elmwood Pediatric Group is Pleased to Welcome Jessica Kleinberg, MD to the Practice

Dr. Kleinberg received her medical degree from the University of Rochester School of Medicine and continued to complete her pediatric residency at the University of Rochester Medical School. She has been in private practice in the Rochester area for the past 4.5 years. She is Board certified in pediatrics, a fellow of the American Academy of Pediatrics and has a clinical appointment at the University of Rochester.



Dr. Chester Nakamura of Clifton Springs to Join FLH Medical PC

Dr. Nakamura earned his MD from Tulane University School of Medicine in New Orleans, attended the Graduate School of Public Health in San Diego, completed his residency at the California Pacific Medical Center in San Francisco and a fellowship at the University of Rochester Medical Center. Dr. Nakamura is board-certified in Internal Medicine.



Dr. Julie E. Yoon Announces the Launch of a New Internal Medicine Practice

Dr. Yoon received her medical degree from Upstate Medical University in Syracuse in 2004 followed by completion of an internship and residency in internal medicine at the University of Rochester in 2007 with an extra year of fellowship training in geriatrics in 2008. More recently, Dr. Yoon has been caring for patients at St. Johns Home as well as Strong Memorial Hospital and Highland Hospital. She is excited to be entering into private practice in general internal medicine. Although Dr. Yoon's interests are adult and geriatric medicine, her primary focus is on preventative care and healthy lifestyle choices.

Dr. Yoon's practice is conveniently located

at 300 White Spruce Boulevard where she is currently welcoming new patients eighteen years of age and older.

ROCHESTER REGIONAL HEALTH SYSTEM

Rochester General Hospital Earns Stroke Care Quality Achievement Award

In another indicator of Rochester Regional Health System's regional leadership in high-quality stroke care, Rochester General Hospital has received the Get With The Guidelines® Stroke Gold-Plus Quality Achievement Award from the American Heart Association/American Stroke Association (AHA/ASA). This recognition is earned by hospital teams who achieve specific quality measures identified as vital for the optimal treatment of stroke.

Rochester General was also re-certified by the AHA/ASA as a Target: Stroke Honor Roll hospital, for continuing to meet quality goals aimed at reducing the time between a patient's arrival at the hospital and their receiving the clot-busting drug tPA, the only FDA-approved drug in the treatment of ischemic stroke. Patients who receive tPA within three hours of the onset of stroke symptoms are more likely to recover quickly and avoid severe disability.

Two million brain cells are lost every minute during a stroke, making the speed at which effective treatment is administered a leading factor in the patient's chances of achieving a full recovery. For years, the Rochester General emergency department has treated more stroke patients than almost any upstate New York hospital, and that experience has helped ED teams develop region-leading processes that shave time off the period between a patient's arrival and the administration of tPA.

"Rochester General Hospital has long been known as a leader in developing processes that improve the quality of stroke care," said Dr. Kelly Matmati, Stroke Program Director. "This award is further recognition of our commitment to provide our patients with the best possible care that helps them enjoy longer, healthier lives."

The hospitals of Rochester Regional Health System have all been recognized for high achievement in stroke care. Earlier this year Unity Hospital also received the Get With The Guidelines Stroke Gold-Plus

award; and Newark-Wayne Community Hospital earned the AHA/ASA's Bronze Quality Achievement Award in that program. All three Rochester Regional hospitals are certified as Primary Stroke Centers by the New York State Department of Health.

United Memorial Medical Center Joins Rochester Regional Health System

The Genesee County hospital announced its intention to join Rochester Regional in February 2014. While United Memorial is very strong financially, hospital leaders recognized that changes in health care threatened the long-term outlook for independent rural health care providers. Joining the large regional system will enable continued and even enhanced local services for Batavia-area patients. United Memorial will maintain its name and a local board, and will continue its longstanding tradition of providing a wide range of medical and acute care services in Batavia.

"The full affiliation of United Memorial is another example of how Rochester Regional is creating a model health care system that helps communities get healthy and stay healthy," said Eric J. Bieber, MD, President & CEO, Rochester Regional Health System. "Our model will maintain access and control cost by keeping care within the local community with seamless access to the highest quality specialty acute care for patients throughout the region, no matter where you live or through which system-wide door you enter."

The partnership mirrors a trend among successful hospitals and health care systems nationwide. These system affiliations address the economic realities that community hospitals face with health care reform, enabling them to continue to offer a full range of primary and secondary services locally, while providing a gateway to the best clinical care available when more highly specialized care and technology – like cardiac surgery, stroke services, neurosurgery, and other complex services – are required.

"Joining Rochester Regional Health System secures our ability to provide quality health care to our community for the long-term," said Dan Ireland, President, United Memorial Medical Center. "Though most patients won't notice any difference at the hospital, they will benefit from greater access to specialized services and technology available through the Rochester Regional network."

The two health care institutions are no strangers to each other, having collaborated in the areas of Cardiology, Pathology, Surgery, Urology and Gastroenterology since

2008, and most recently partnered to open a Cancer & Infusion Center at United Memorial.

In making its decision to affiliate with Rochester Regional in early 2014, the United Memorial board cited the system's longstanding focus on high-quality patient care and safety, its expertise in clinical integration, its comprehensive medical and surgical specialties that will enhance existing services available in the Batavia community, and its successful track record of collaboration with smaller acute care hospitals and physicians.



Juan Godinez, MD Joins Lipson Cancer Center at Rochester Regional Health System

Dr. Godinez specializes in Radiation Oncology and completed his Radiation Oncology Residency at the University of Chicago. He has

been honored by the American Cancer Society (ACS) as an ACS Research Fellow.

Prior to joining Rochester Regional Health System, Dr. Godinez worked in private practice in Florida.

HIGHLAND HOSPITAL



Christopher Drinkwater, MD, Named Director of Evarts Joint Center

Christopher Drinkwater, MD, has been appointed director of the Evarts Joint Center at Highland Hospital and chief of UR Medicine's Division of Adult Recon-

structive Surgery. Part of UR Medicine's Department of Orthopaedics and Rehabilitation, the Evarts Joint Center is the most comprehensive joint replacement program in upstate New York, with fellowship-trained specialists offering joint replacement of the hip, knee, shoulder, elbow and hand.

Drinkwater, who is an associate clinical professor of orthopaedics at the University of Rochester School of Medicine and Dentistry, has been an attending orthopaedic surgeon at Highland Hospital since 2005. He is board-certified in orthopaedic surgery and fellowship-trained in joint replacement and arthroscopic surgery. He performs more than 400 total joint replacements for patients with hip and knee arthritis at Evarts each year.

Drinkwater specializes in modern joint replacement techniques including direct anterior hip replacement, hip resurfacing, and partial and total knee replacement.

Drinkwater earned his medical degree at Australia University of New South Wales and completed his residency in orthopaedic surgery in Sydney, Australia.

URMC

UR Medicine's Wilmot Cancer Institute Opens Clinic in Batavia

Wilmot Cancer Institute Batavia, formerly Batavia Radiation Oncology Associates, has opened its offices at 262 Bank St. after several weeks of construction.

With the renovated and expanded space, the clinic now features an outpatient blood draw laboratory, and larger clinical examination rooms. As part of Wilmot Cancer Institute, the Batavia clinic will give patients in Genesee and surrounding counties access to precision diagnostics, targeted therapies, clinical trials and the UR Medicine e-record system.

In addition to providing radiation therapy, the clinic will provide chemotherapy and infusion services, which are expected to be available in Batavia by spring.

Kevin J. Mudd, MD, who served as medical director for Batavia Radiation Oncology for 14 years, continues to see patients at Wilmot Cancer Institute Batavia as a member of the URMC faculty. Mudd and other providers who see patients at the Batavia clinic will be able to participate in weekly tumor board sessions and other consultations to provide a truly multidisciplinary approach to cancer care.

"I am excited to resume our practice of high-quality cancer care here in this community and to see our services growing with our integration with URMC and Wilmot Cancer Institute," Mudd said.

"Cancer care has become so complex, and it requires an entire team to address every aspect of the disease," said Jonathan W. Friedberg, M.D., M.M.Sc., director of Wilmot Cancer Institute. "It starts with the diagnostic process and continues through treatment decisions, follow-up care, and survivorship or palliative care, if needed. Our Institute brings that comprehensive level of service every step of the way, in a setting that's convenient no matter where you live."

New Doctor in Town?
If you have recently joined or changed practices – email us your new or updated address to receive your copy of *Western NY Physician* magazine.
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ACA INSURANCE DIRECTORIES PLAGUED WITH INACCURACIES

Question: How accurate are the lists of participating physicians in the Affordable Care Act (“ACA”) directories?

Answer: Although this study focused on dermatology provider lists, the author of the study does not believe the findings are limited solely to dermatology. In fact, this same problem was discovered in a separate study conducted last month and published in Reuters Health that revealed many errors in insurance directories of psychiatrists as well.

Since private insurance plans offered through Medicare and exchanges set up by the Affordable Care Act are required to offer plan participants a variety of doctors, it is crucial to patient care that these directories are accurate. The JAMA Dermatology article noted that inaccurate directories of doctors covered by an insurance plan may lead to people having very few options and to the U.S. government approving plans that do not meet standards regarding provider availability.

The inaccurate directories, coupled with insurers’ increased “narrowing” of their networks by eliminating contracts with physicians, is seriously limiting the choices of providers offered to patients. The study’s author advocates for insurance companies to stop eliminating providers from their insurance plans since eliminating more providers from an insurance network when there is already a long wait for patients to obtain services can only make matters worse.

MEDICARE PAYMENTS SLATED TO DECREASE IN APRIL OF 2015

Question: How likely is it that Medicare Payments are decreased in April 1, 2015?

Answer: Pursuant to a Final Rule that was issued by the Center for Medicare and Medicaid Services (“CMS”) earlier this month, all physicians could see payments cut by CMS of approximately 21% in April if the Medicare sustainable growth rate formula cuts are allowed to take effect.

Under the rule, the Medicare sustainable growth rate formula - a payment policy that has forced Congress to repeatedly intercede to avoid major cuts to physician payment - would slash reimbursement to doctors by 21.1% as of April 1, 2015.

The rule also affects reporting of manufacturers’ payments to physicians under the Sunshine Act as it finalized the elimination of the exemption for reporting indirect manufacturers’ payments to physicians for continuing medical education participation. According to the CMS, applicable manufacturers and group purchasing organizations now will be required

to report compensation provided to physician speakers at continuing education events, unless the payment or other transfer of value is specifically excluded.

As the cut to CMS payments will not take effect until April of 2015, there is additional time for CMS to revise the rule or for Congress to intercede, as it has done historically, to avoid such a considerable cut to reimbursements. Similar cuts have been proposed in the past, only to be retracted at the last minute. Although there is no certainty this will happen again, it is widely speculated that such a considerable cut will face much scrutiny by Congress and that the final rule, as it is currently constituted, will not survive. KACS will continue to monitor this ongoing situation and keep you apprised of all developments.

STAGE 2 MEANINGFUL USE EHR ATTESTATION PERIOD

Question: I have already attested for Stage 1 of Meaningful Use of my Electronic Health Records (“EHR”) system, so what is the attestation period for Stage 2 of Meaningful Use in 2015?

Answer: Currently, the attestation period for Stage 2 of Meaningful Use in 2015, and subsequent stages and years is one year. Thirty members of the United States House of Representatives have, however, signed and submitted a letter to the Department of Health and Human Services Secretary, Sylvia Mathews Burwell, requesting that she take immediate action to cut the attestation period from one year, to ninety days. The House members believe that this will have a positive impact on program participation and policy outcomes going forward and that shortening the Stage 2 reporting period will give providers more time to safely and effectively implement EHR.

CMS has reported that over 250,000 physicians and other providers will see their 2015 Medicare payments cut by 1% for failing to meet Stage 1 of Meaningful Use criteria in 2013. Affected providers will receive letters from CMS notifying them of the decision. An additional 28,000 providers will receive notices that their payments are being cut by 1% for failure to comply with the Electronic Prescribing Incentive Program. Instructions on how to appeal these determinations are on the CMS website and all appeals must be filed by February 28, 2015. If you have any questions about a notice that you receive or would like assistance with filing an appeal, do not hesitate to contact us.

If you have any questions, please contact our Managing Partner, Michael J. Schoppmann, Esq at 1-800-445-0954 or via email at MSchoppmann@DrLaw.com.



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