

Western New York

VOLUME 6 / 2013

PHYSICIAN

THE LOCAL VOICE OF PRACTICE MANAGEMENT AND THE BUSINESS OF MEDICINE



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Photo: James Montanus

Region's Redesigned Medical Centers Ensure Efficiencies, Convenience for All

As the healthcare landscape undergoes major transformation, the building and renovation of new medical space has become a more complex piece of the puzzle calling on healthcare administrators to more critically evaluate design choices. In our cover story this month, hear from three experts as they share insight on recent projects.

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Welcome to Volume 6 - 2013 of *Western New York Physician* where you will find informative stories and articles *about and for* physicians in western NY.

Medical Space Design – that is the focus of our cover story. How will the new medical centers and space that we build today improve convenient access to high quality care? Hear from three experts Jeff Peacock, Executive Director at Rochester Ambulatory Surgery Center; Robert Donahue, VP of Ancillary & Support Systems at Unity and Wendy Wilts, Senior Vice President Clinical Service Lines at Unity as they share some insight on recent projects.

Care of the aging patient is the focus of our clinical section. In the Orthopaedic Discussion hear from three surgeons discuss some of the latest approaches to caring for the geriatric patient. Also find articles on the newly opened Rochester General Wound Healing Center, the linkage between inflammation and modern day diseases and how a comprehensive approach to memory disorders and dementias at Unity impact quality of life and supports caregivers.

In the coming months, *Western New York Physician* magazine will be launching its sister publication in the Buffalo region – expanding the clinical and practice management collaboration and discussion between our neighboring healthcare communities. For those wishing to be a part of the premier issue, please email me at WNYPhysician@gmail.com.

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.

All the best in 2014 –

Andrea Sperry

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Preventing and Managing Chronic Inflammation



Leila Kirdani, MD

As a society, we are experiencing the first generation that is projected to have shorter lifespans than their parents because of the increasing incidence of several major diseases. Interestingly enough, all of these diseases have one thing in common: inflammation. Inflammation has been shown to cause diabetes, heart disease, auto-immune diseases, arthritis, digestive ailments, and even cancer. If we can reverse inflammation, we can greatly reduce both the incidence and severity of these diseases. There are several things that lead to increased inflammation. These include altered cortisol levels from stress, low levels of vitamin D, low levels of sex hormones or poorly balanced sex hormones, environmental toxins, food allergies, and of course, genetic propensity. Fortunately, most of these are treatable.

THE STRESS RESPONSE THAT IS INITIATED AT THE FIRST SIGHT of danger includes increased cortisol production, leading to an entire cascade of changes in the body to ensure our survival. Inflammatory cytokine messaging increases during the stress response, signaling the immune system to clot wounds and fight bacteria. Natural killer cells, which fight viruses and cancer, are suppressed in the face of immediate danger. For our paleolithic forefathers, this response kept them alive. In the 21st century, however, our threats are perceived (time, relationships, finances), not real dangers, and last a lifetime. Essentially we are fighting 40 year wars, and the immune system will be chronically altered because of it.

Treatment of altered cortisol levels includes stress reduction techniques such as exercise, adequate sleep, and meditative practices. Supplements that support healthy adrenal function can be quite beneficial. These include Rhodiola, Relora, and L-theanine.

Naturally, we can't forget about vitamin D. While vitamin D is important for bone health, it also plays an essential role in optimal functioning of the immune system. If blood levels of vitamin D levels are not optimal (less than 50 ng/dL), the body may have enough for healthy bones but will not have enough for healthy functioning of the immune system. Vitamin D has been shown to decrease the number of inflammatory cytokines and boost natural killer cell function, so low levels of vitamin D lead to increased inflammation. This is evident, as low levels of vitamin D have been implicated in everything from diabetes to cancer. As a society we have changed the way we interact with our environment dramatically as compared with our Paleolithic ancestors. We used to live and work out doors, wearing very little clothing. Now we live and work indoors, and when we are outside we have clothes or sunscreen covering most of our bodies, so the majority of the population, especially those living in northern climates, are deficient in vitamin D. Due to a weaker northern sun, vitamin D requirements for western New Yorkers range between 4000 IU to 10,000 IU daily to maintain optimal blood levels.

Sex hormones for both men and women play a vital role in the optimum functioning of the immune system. Bio-identical hormones are made to be the exact same molecule that our bodies produce. Retrospective studies comparing traditional HRT to bio-identical hormone replacement therapy (BHRT) show a decrease in stroke and cardiovascular risk with BHRT, as well as improved immune system function. Pharmaceutical, or altered estrogen and testosterone molecules, have been shown to increase inflammation, so they do not provide the same benefit. Bio-identical hormones are available through compounding pharmacies and need to be well-balanced to have the most beneficial effects

Environmental toxins cause problems on multiple levels. Fundamentally, they increase the amount of free radicals and hence increase oxidative stress. These toxins include food additives and preservatives, phthalates from plastics, pesticides and insecticides, and heavy metals such as lead and mercury. Chelation of toxins can be achieved through traditional chelating agents such as DMSA and DMSO, however blue-green algae are also fairly effective at binding toxins in the intestines and pulling them out through the stool.

Our health is truly the combination of our genes and the environment we put them in. Some patients with extensive family histories have what I like to call “pro-inflammatory genes.” While our environment is currently one of high inflammation, the good news is that we can change the environment our genes are in, thereby changing their expression. Additionally, alpha lipoic acid, an enzyme helper in the Krebs cycle, can significantly help patients with pro-inflammatory genes.

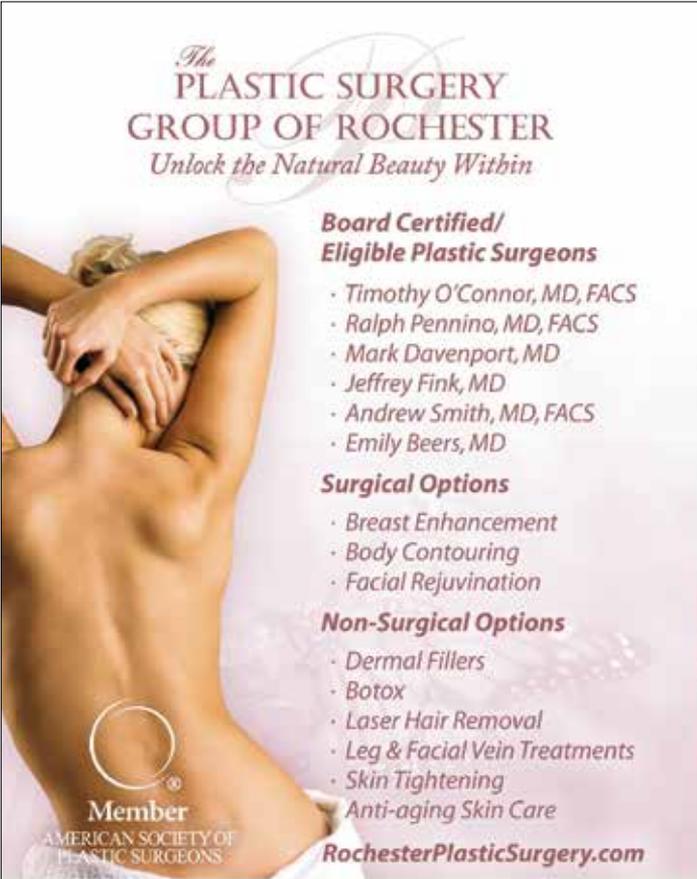
Last but not least in the inflammation list is food allergies. The most common food allergens include wheat, corn, shellfish, dairy products and peanuts. Avoiding these allergens can significantly reduce inflammation.

Taking measures to reduce inflammation is the best way to prevent almost every modern day disease we have. Low inflammation is the key optimal health!

Dr. Leila Kirdani completed her MD at SUNY at Buffalo School of Medicine and Biomedical Sciences and her residency board at York Hospital in Pennsylvania. She is Board Certified in Family Medicine and in Metabolic Anti-Aging, Regenerative and Functional Medicine. Dr. Kirdani moved to Rochester, NY to complete a fellowship in Family Systems which allowed her to explore her interests in Family Therapy and Biopsychosocial medicine.

She was a practicing Family Physician 15 years before completing a fellowship through the American Academy of Metabolic Anti-Aging, Regenerative and Functional medicine. This additional training has allowed Dr. Kirdani to integrate her love of more natural medicine with her traditional medical background to provide her patients with cutting edge health care.

Dr. Kirdani specializes in hormone balancing using bio-identical hormone replacement therapy, adrenal fatigue, and disease management through correction of metabolic imbalances and the use of supplements rather than pharmaceuticals.



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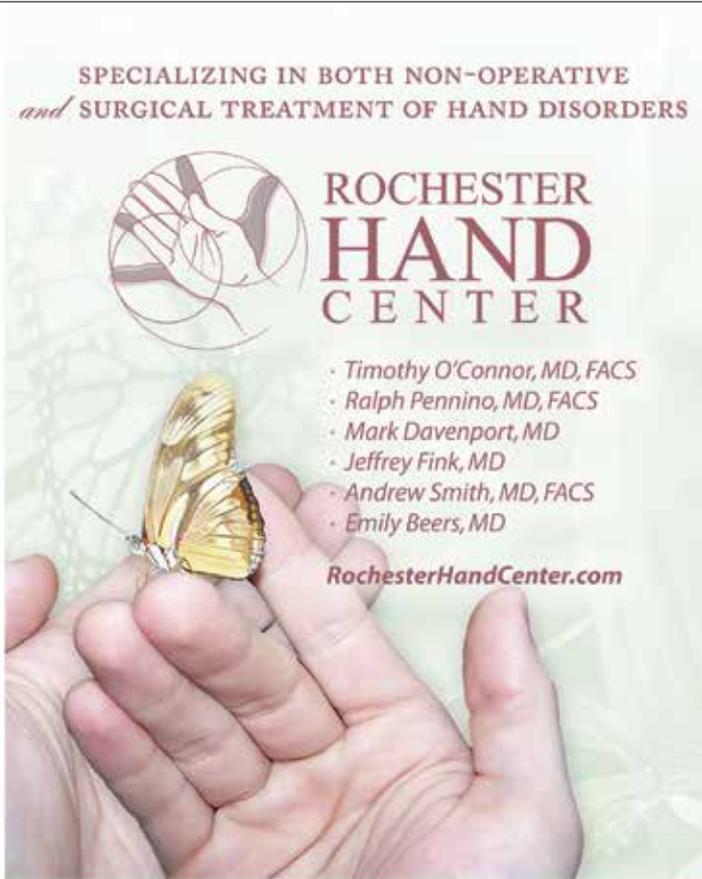
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Region's Redesigned Medical Centers Ensure Efficiencies, Convenience for All

By Julie Van Benthuisen



The new, state-of-the-art ambulatory surgical center at 360 Linden Oaks in Penfield opened in October as part of Rochester General Health System's expansive network. "Ambulatory care is critical to our region's future," says Jeff Peacock, RASC's Executive Director.

Whether it's an elderly patient in need of dialysis or an injury requiring emergency care, our region's leading health systems are continuing to make substantial investments to ensure that the best possible care is available both inside and outside of the hospital proper.

Rochester Ambulatory Surgery Center represents one of a growing number of facilities established in anticipation of changing patient needs and the future of healthcare delivery. The new, state-of-the-art ambulatory surgical center at 360 Linden Oaks in Penfield opened in October as part of Rochester General Health System's expansive network. "Ambulatory care is critical to our region's future," says Jeff Peacock, RASC's Executive Director. "It provides new options for patients and a more convenient, comfortable and dignified patient experience."

Healthcare reform, new technology and the overall need to

keep healthcare affordable while maintaining high standards are all factors contributing to the increasing demand of these services. "RGHS was looking for a way to expand its outpatient services to essentially become a hospital without walls," he says. "We were already serving more patients in this manner and knew the trend would continue." What began as the Lattimore Community Service Center back in 1991 was acquired by RGHS in 2011. "The plan was to relocate to the east side of town to offer outstanding outpatient surgical services to the community."

The original location was approximately 12,000 square feet, which included four Operating Rooms. The new facility is nearly triple in size, standing at 30,000 square feet, with six ORs and two mini-procedure rooms. "The surgery center is all new construction attached to an existing medical office space," says Peacock. About 85% of its services currently consist of orthopedics

(hand and general ortho), with the remaining percent encompassing ENT, plastic surgery, podiatry, gynecological services and general surgery. Opened just this past October, RASC's considerably larger capacity has resulted in a notable rise in cases, with plans to increase staff as volumes continue to grow.

The design was developed mindfully. "We really wanted a collaborative effort with input from our existing surgeons and staff, as well as local and national consultants. As part of the initial design process, staff met with consultants from Boulder Associates, and visited several successful ASC's built in the Denver area. "We saw what worked well, and came back with a lot of good ideas," he says. "We recognized that an exceptional design is one that supports an efficient operational plan."



Photo: James Monratus

"Our lobby is the farthest thing from a clinical setting – it feels more like a coffeehouse, very aesthetically pleasing with lots of options for comfortable seating."



Jeff Peacock, RASC's Executive Director

Safety, Convenience, Comfort

The facility's convenient location within minutes of the 490 expressway and free parking both contribute to a more stress-free experience. The layout is far more patient, physician and staff friendly as well, with natural lighting and inviting colors throughout. The main lobby is split into half, incorporating a child's play area with TV and programming options, as well

as a separate area for patients and their families. "One side is quieter and more secluded for reading and privacy," he says. "Not to mention that the location at Linden Oaks is beautiful, with scenic window views of mature trees and landscape." He adds that patients notice the difference immediately. "Our lobby is the farthest thing from a clinical setting – it feels more like a coffeehouse, very aesthetically pleasing with lots of options for comfortable seating."

The design also took into account patient prep and recovery time. There are identical recovery spots once the patient is out of the OR. "Many places have a Stage 1/Stage 2 recovery area, which necessitates the patient being moved during recovery" he says. "Our new facility has more equipment available for better monitoring and safety." All 29 patient bays are identical in capability, allowing patients to stay in one place rather than be moved around. "It's nice for the doctor/patient relationship as well." At the beginning of each day, doctors are assigned a number of bays for their patients and know exactly where they will be, contributing to better efficiencies and allaying potential patient anxieties.

"For us, it was critical that our patients not get lost within the hospital setting," he says. From a convenience standpoint, the admittance and discharge process is so much easier, with patients spending less time at RASC than they would at a hospital. "We're built around providing efficiencies in our surgical cases – lasting between 15 minutes to two hours, with recovery typically complete within one hour. Our new Center also allows us to do many things more cost-effectively than we can within the hospital setting. We can do the same procedures at a reduced rate, so as insurance plans continue to change, we can offer a less expensive alternative." Peacock also notes that infection rates are typically lower at the Center than within hospitals.

The staff, which helped provide invaluable input to ensure efficiencies in all areas, has warmly embraced the new facility. "Having a hand in it has really helped set us apart."

Unity Hospital Modernization and Expansion Project

Back in 2007, planning began for Unity Health System's largest renovation and expansion project in the organization's history. Construction on the Unity Hospital campus started in 2010, and today, with less than six months remaining, about 80% of the 260,000 square feet that has been either renovated or added to the hospital.

Extensive renovations have been made to eight units of the actual Unity Hospital building – which included expanding and modernizing all patient rooms.

A fourth floor with four more units was added to accommodate additional medical/surgical beds. Space and modernization enhancements have also been made to the Joint Replacement Center at Unity Hospital and Cardiology Unit. The site is also the future home of the Golisano Restorative Neurology and



Robert Donahue, VP of Ancillary and Support Services for Unity Health System

Rehabilitation Center, which will be relocated from the Unity St. Mary's Campus in May 2014.

The project includes a fresh look to the facility's exterior shell, an increased number of larger sized elevators, and the renovation of the Hospital main lobby to contain a coffee shop, concierge desk, and construction of a larger, contemporary cafeteria for staff and visitors. Over 700 free parking

spaces have been added to the Hospital Campus.

Thirteen design teams were established with representation from nursing, IT, clinical engineering, security, materials management, nutrition, infection prevention, security, facilities and design teams. Physicians were also heavily involved throughout the process, as well as patient advocates. "Our patient medical & surgical rooms were almost 40 years old, with an outdated size and an inefficient flow to each room," says Robert Donahue, VP of Ancillary and Support Services for Unity Health System. "We needed to virtually gut every room and start over."

In 2011, the second and third floors of the Golisano Center opened for medical and surgical patients. This past year, the expanded facilities for the Unity Dialysis and Unity Endoscopy Services were relocated from the third floors to the first floor, offering even more convenience for patients. "Previously, some of these patients had to go up an elevator, and on their way out would often be unstable because they were treated with conscious sedation," he says. "We've eliminated that, by shortening the walk right into the waiting room."

More convenience for all means that three different quadrants were established for patients, visitors and clinicians – virtual rooms with different components depending on the need, including computers in every room. The rooms themselves are all 30% larger than traditionally sized medical & surgical rooms, with the walking distance from bed to bath about half the distance as before.

Donahue also notes how important the aesthetics of the rooms have improved patient satisfaction. "We've gotten rave reviews from patients already – from comparing Unity to a Five-Star hotel to noting the lack of noise. Believe it or not, noise is the biggest patient complaint within a hospital setting. Working with an acoustical engineer when designing our walls, floors and doors, our new design took that into account, and now patients can't hear anything going on outside their own rooms."

Safety was a critical component. Part of the design ensured wide open space, with no columns or pillars obstructing view of care. "With the ratios we have to maintain, having a patient

care spaces with great site lines is key." "We spent a lot of time considering everything from older patients with multiple illnesses and the risks for potential falls. A fair number of the rooms now have a ceiling lift system, which makes it safer for both staff and patients."

"Our new units are now built around the work flow of staff and the needs of the patients. In the past, the staff used to have to work around the design. "We performed a great deal of research and reviewed health care design magazines, which was more efficient than multiple site visits. We highlighted other the characteristics of the spaces that we wanted to replicate and had a similar design philosophy to what we were trying to accomplish, then we threaded those concepts and strengths into our own design."



Wendy Wilts, Senior Vice President Clinical Service Lines at Unity

Branching into Brockport

In June of 2012, Unity Hospital also opened an 18,000 square foot medical office building in Brockport, a town that's been designated by the Federal Government as having a shortage of health professionals. While Unity has had a presence in Brockport for the past decade, it had outgrown its office space. "We also had several offices in Rochester that were at capacity, so we were looking for the right space,"

says Wendy Wilts, who has been instrumental in planning and business development for the new outpatient space. "Many patients were leaving Brockport and coming into Rochester to see their PC or a specialist, so we felt we needed to push care back to Brockport as much as possible."

Of the 8,100+ people who live in Brockport, 5,000 are Unity patients. "Many of our patients had been requesting that we create something 'closer to home' for them," she says. "The new building will allow them to visit the providers they currently are driving many miles to see, right in their own neighborhood."

The first component of the design planning was location. "We knew it wasn't necessarily going to be where the current Brockport medical community is contained, but more where people were living, especially the geriatric population." Being conveniently located in the Wegmans Plaza at the major intersection of Routes 31 and 19 also made sense. "We wanted our patients to have fewer stops to make, so having a pharmacy and bank nearby were also considerations." Parking is convenient and free with easy access to the facility's front door.

"It was also critical in our design that we look at the building itself through the lens of the patient," she adds. "We wanted to make sure older patients had exam rooms closer to the lobby." Every factor was considered. An Ob/Gyn patient who typically



Bringing needed health care services to Brockport residents supports Unity's long-standing mission to make a positive difference in the health and well-being of its patients.

requires a urine sample and height and weight measurement before an exam, can now more easily navigate the office using the color and pattern keys on the office floor. "We made the distance from the exam rooms to the doctor's office in closer proximity, and ensured that doctors, nurses and patients alike are all within the line of sight."

The design is intended to meet not only today's needs but those of the future. To that end, all exam rooms are the same size, not customized, to offer flexibility down the road in case more rooms are needed for Ob/Gyn care, for example. "We designed common areas and waiting rooms that are open and not sectioned off," she says. "That way, we know who is close by in a room and who is waiting, instead of someone being far down the hallway." Everything was factored in -- from the size of the room, to energy efficiencies and maximizing sunlight to incorporating plumbing to serve two exam rooms instead of one. Each exam room is patient-friendly, utilizing Electronic Medical Records. Medical staff has access to what they need while still allowing for the ease of face to face interaction. "Our staff is able to log on in a far more adaptive way."

"Our patients love the new facility," she adds. "They appreciate the stability it brings to the town. The doctors are also pleased, recognizing the importance of specialty outreach. For the staff, it's a matter of being able to do their work better and not having to adapt their work around a facility they've outgrown. "They're excited that we've thoughtfully designed the space to ensure success."

also been added, as well as Medical specialty services including Infectious Disease, Diabetes Care and Education, Neurology, Pulmonary, and Vascular. "Patients don't have to traipse through a big building for the services they need. They are all right here."

Bringing needed health care services to Brockport residents supports Unity's long-standing mission to make a positive difference in the health and well-being of its patients. Doctors who regularly service Unity can now be rounding in Brockport. "This is especially beneficial to our geriatric patients, having a



range of providers from endocrinologist, diabetic educator and orthopedic surgeon to cardiologist and pulmonologist." "Not to mention the added community benefit of more working healthcare professionals supporting other local Brockport businesses."

A Collaborative Model of Wound Healing



Kim Petrone, MD



At 42 inches in diameter, the twin HBOT chambers at the Rochester General Wound Healing Center are the largest in use in the region.

In November, Rochester General Health System (RGHS) and St. Ann's Community launched the Rochester General Wound Healing Center, an ambulatory facility that combines the expertise of two leading healthcare institutions and brings cutting-edge wound care services to a community in need.

The result of more than two years of careful planning, our Center has been designed to serve a broad range of clients. Our location on the St. Ann's campus in Irondequoit offers convenient access to patients from all over eastern Monroe County; and with our highly collaborative approach to treatment we can work closely with a patient's primary care provider – while also accommodating patients who may lack a steady relationship with a PCP, and who may have had difficulty managing ongoing medical conditions that can lead to wounds.

We expect to treat a lot of patients with diabetes-related recalcitrant wounds, or with hard-to-heal burns, surgical sites, pressure sores or venous stasis ulcers, to name only a few conditions. Any wound that has not begun to heal in two weeks

or is not completely healed in four weeks may benefit from our services. Following a thorough initial evaluation, recommended treatments may include compression therapy, total contact casting, negative pressure therapy, the use of cellular tissue products or hyperbaric oxygen therapy (HBOT).

HBOT represents the state of the art in wound care, and in planning the Center we wanted our hyperbaric units to offer the newest and best benefits to the community. With daily two-hour sessions for up to six weeks, patients spend a lot of time in these chambers, and it's not uncommon for claustrophobia to be an issue. That's why we now have the region's two largest chambers at 42 inches in diameter – wide enough to accommodate bariatric patients (a valid consideration, given the link between diabetes and hard-to-heal wounds) or to increase the comfort of any HBOT patient.

Diabetic foot ulcers are the most common HBOT cases, as well as any deep, infected wound that has been resistant to other therapies for a month or more. For the 10 percent of our patients who are expected to need HBOT, it might be the only thing standing between them and an amputation or other serious permanent outcome.

Regardless of the modality, our goal is not just to heal the wound; we want to determine what caused it and work with the patient, their PCP and whatever team is needed to resolve the underlying problem. Without that approach, a successfully treated wound has too strong a chance of recurring. We want to keep patients healthy, active and free of any wound problems. In a way, we know we're successful if the patient never has to see us again.

This collaborative model means working with a network of doctors and specialists. Thanks to the alliance between St. Ann's and Rochester General Health System that has made this Center possible, our patients not only have access to the skilled St. Ann's team here on site, but also to an exceptionally

Fast Facts

The Rochester General Wound Healing Center is located on the Irondequoit campus of St. Ann's Community, 1500 Portland Avenue. Hours are Monday through Friday, 8am until 5pm. Visit stannscommunity.com or rochestergeneral.org/woundcare to learn more; or call 922-HEAL (4325) to arrange a referral.

HBOT Indications

Indications suggestive of hyperbaric oxygen therapy (HBOT) include:

- Diabetic ulcers of the lower extremity
- Chronic refractory osteomyelitis
- Osteoradionecrosis
- Soft tissue radionecrosis, including radiation cystitis and radiation proctitis
- Compromised skin graft or flap
- Progressive necrotizing infections, including necrotizing fasciitis and brown recluse spider bites
- Clostridial myonecrosis (gas gangrene)
- Actinomycosis
- Crush injuries / suturing of severed limbs
- Acute peripheral arterial insufficiency
- Acute traumatic arterial insufficiency
- Acute carbon monoxide / cyanide poisoning
- Cerebral air or gas embolism
- Decompression illness



talented team of RGHS specialists who may provide care over the course of their treatment. The Wound Healing Center team coordinates care between our network of specialists, our patients, and their PCPs.

Although a patient doesn't need a referral to come to us, as a primary care physician I always tell patients to work directly with their own provider first, if they have one, and all of our treatment plans include a firm commitment to regular PCP communications. Rochester General-affiliated physicians can access their patients' data any time via the Care Connect EMR used by Rochester General Health System; and no matter their affiliation, we send every PCP written updates after the initial evaluation, every 30 days during the patient's course of treatment, and at discharge. Upon request we can increase the frequency of those write-ups, and also include photographs of the wound so the PCP can also monitor the healing progression.

This team-based process makes the PCP's role easier. Patients with recalcitrant wounds can require a lot of attention from a primary care doctor, and we can lift some of that burden from the physician's shoulders without reducing their oversight of their patient's long-term health.

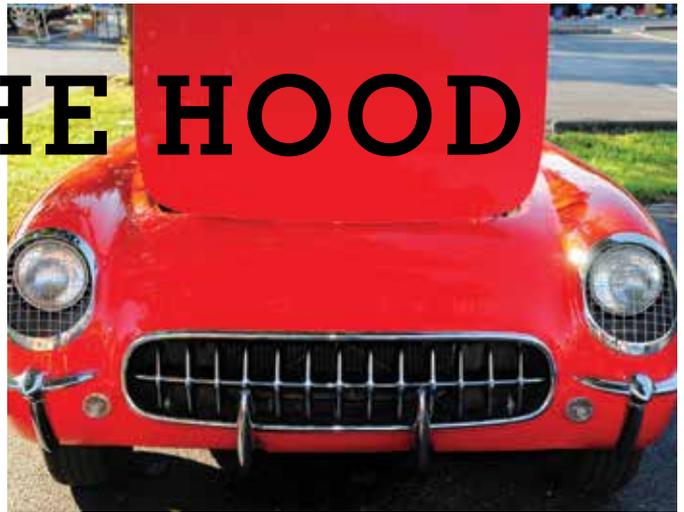
Perhaps the most exciting aspect of this Center is the St. Ann's / RGHS alliance that made it possible. Too often, silos of care between acute, outpatient, rehab and skilled nursing can obstruct communications that are in the patient's best interest. This relationship supports a better way of delivering care – an innovative clinical architecture that replaces those silos with a patient-centered model.

We're very excited about the Rochester General Wound Healing Center – for our patients, our partner PCPs and specialists, and the community at large.

Kim Petrone, MD, is associate medical director of St. Ann's Community and medical manager of the Rochester General Wound Healing Center. She is AMA board-certified in Geriatric Medicine and Internal Medicine, and a Certified Wound Specialist.

UNDER THE HOOD

by Jill Eisenstein
Associate Director of the Rochester RHIO



Electronic health record (EHR) systems are the backbone of medical records in more than half of physician practices, utilizing data generated both in the practices and from external sources. Clinicians review, compare and diagnose based on information presented by the EHR. Under the hood, however, EHR systems rely on normalized data to aggregate, organize and store patient health information.

EHR SYSTEMS REQUIRE THAT DATA BE SPECIFICALLY MAPPED to be readable and usable. The question arises, though, how is the data mapped? And, does the person who creates these maps have the clinical information required for accurate mapping?

Meaningful use requirements address this issue by including data normalization by use of recognized structured terminologies. In response, many EHR vendors, IT staff and office managers assign these codes based on limited information.

Nearly 250 physician practices in the Rochester region receive clinical results electronically, where results flow into EHRs. Regional labs are working with the Rochester RHIO to address the need for accurate community codes for lab results across the region. Leadership from area labs, Monroe County Medical Society, and the RHIO's Regional Data Normalization project funded by the Greater Rochester Health Foundation are collaborating to build a community compendium of the 200 most common lab tests, and the normalized codes that link similar tests.

Community physicians confirm that patients commonly seek services from different healthcare organizations. Comparing data from distinct sources is a daily task for physicians. The benefits of normalized codes include confidently incorporating like results in a flowchart format without having to map local test names and codes from multiple labs, increased speed in interpretation of results and accurate quality reporting.

The accurate coding of lab results is critical to the effective comparison of values to support patient care, quality reporting and "meaningful use" requirements. However, an assessment of regional healthcare providers points to some concerns with this coding process.

- Assigning LOINC codes is more complex than it seems. The coding schema, in its most complete format, requires knowledge of lab processes and methods. Use of the codes at a general level may hide relevant variances.
- A simple approach will likely result in inaccurate comparisons and trending.

For example, the Rochester RHIO receives test results from multiple labs for the same test, but each lab may use a different test description for the same analyte. Data normalization addresses this issue by incorporating LOINC codes in lab HL7 messages.

The normalization of data can be performed accurately and cost effectively by those who generate the data. Currently, laboratories identify tests in Health Level Seven (HL7) messages by their internal test codes. In order to achieve interoperability, laboratories will map their local catalogs to Logical Observation Identifiers Names and Codes (LOINC®) to normalize for differences with test codes and descriptions.

LOINC provides a set of universal names and ID codes for identifying laboratory and clinical test results. LOINC facilitates the exchange and pooling of results in EMR's flow sheet format, such as hemoglobin A1C, serum potassium, or vital signs, for clinical care, outcomes management, and research.

The primary characteristics taken into account when mapping local lab terms to LOINC are:

- Substance or entity being measured or observed, such as glucose, sodium or cholesterol.
- The characteristic of the analyte, such as mass concentration or enzyme activity.
- The interval when the test was taken, such as a one-point-in-time result or a result compiled over the course of 24 hours.
- The organic origin of the specimen, such as from whole blood, urine or spinal fluid, or from a substance such as the liver or tissue.
- Reported as qualitative or quantitative measurement or as a narrative report.
- In most cases, the manufacturer or instrument platform is not taken into consideration in assigning the appropriate LOINC code for a given test. (Regenstreif Institute, Inc., 2013)
- Where relevant, a LOINC code includes the method used to produce the result. Use of method specific LOINC codes for a test should be only considered if:
 - The interpretation is affected.
 - The method provides a distinction between tests that measure the same component (analyte) but which have different clinical significance or very different reference intervals.

In order for EHR systems to benefit from this data normalization effort, physicians will need to take a peek under the hood. If the EHR vendor supplied the specific lab code mapping for the practice, or if IT staff created the mapped values, the practice may need to request updated mapping of lab values in the coming months. For specific questions, please contact your EHR vendor. For further information, a more complete description of this project is available at www.RochesterRHIO.org/providers/services.aspx

This material contains content from LOINC® (<http://loinc.org/>). The LOINC table, LOINC codes, and LOINC panels and forms file are copyright © 1995-2013, Regenstreif Institute, Inc. and the Logical Observation Identifiers Names and Codes (LOINC) Committee and available at no cost under the license at <http://loinc.org/terms-of-use>.

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New York State Estate Tax Planning for Married Couples



Jennifer N. Weidner, Esq.,
Boylan Code



In New York, tax-planning trusts remain a viable tool for a married couple to implement in their Wills to reduce the impact of estate taxes. To understand the usefulness of a tax-planning trust, at least a broad overview of the current estate tax laws is necessary. In December 2010, the Congress implemented new federal gift and estate tax exemptions and rates, but only for estates of decedents dying in the years 2011 and 2012. This 2010 tax law provided for a federal unified gift and estate tax exemption of \$5,000,000 per taxpayer. A prior \$1,000,000 limit on the exemption for lifetime gifts was removed, so that a taxpayer could give assets valued up to \$5,000,000 without having to pay gift tax. This 2010 law limited the maximum estate tax rate to 35%.

In December 2012, Congress extended the 2010 tax law and indexed the exemption amount to inflation so that this year, the available federal exemption is \$5,250,000. The maximum federal estate tax rate was raised to 40%.

Property passing from a deceased taxpayer to his or her spouse qualifies for the marital deduction for both New York and federal estate tax purposes. Therefore, the estate of a taxpayer who passes all of his or her assets to the surviving spouse incurs no estate tax. The surviving spouse's own assets, together with those inherited from the estate of the first spouse to die, are subject to estate tax in the surviving spouse's estate. Under the

federal estate tax laws in effect before 2010, only the surviving spouse's federal exemption would be available. The New York and federal exemptions of the estate of the first spouse to die were typically used with a tax planning trust provided for in the Will of the first spouse to die which was called a "credit shelter trust".

Exemption portability is a feature of the recently-enacted federal law that changes the old pre-2010 "use it or lose it" rules. The executor of a married taxpayer's estate can elect on the federal estate tax return to have any unused federal estate tax exemption available for use in the surviving spouse's estate. This means that if a married taxpayer leaves all of his or her assets to his or her spouse and the executor makes the election, the spouse will have up to \$10,500,000 (indexed for inflation) of available federal estate and gift tax exemption to use in the second estate.

From a federal tax perspective, exemption portability eliminates the need for a credit shelter trust in the Will of the first spouse to die. However, credit shelter trusts can still be attractive for taxpayers to save New York (or other state) estate tax where the exemption levels are lower. Note that New York currently has only a \$1,000,000 gift and estate tax exemption and New York does not permit portability of an unused exemption. The rule in New York is still if the New York exemption is not used in the first estate, then you lose it. In order to take

advantage of the \$1,000,000 exemption in the first estate and to keep that amount sheltered from New York estate tax in the second estate, it may be good planning to "disclaim" up to \$1,000,000 so that it will be held in a Disclaimed Property Trust ("DPT"). This will save New York estate taxes in the second estate, as described below.

A DPT can accomplish the same tax-savings as a credit shelter

"A prior \$1,000,000 limit on the exemption for lifetime gifts was removed, so that a taxpayer could give assets valued up to \$5,000,000 without having to pay gift tax"

trust, with the added benefit of providing flexible post-mortem planning. A Will that contains a DPT can provide that the testator's entire estate will pass to the surviving spouse (which qualifies for the marital deduction in the first estate); provided, however, the surviving spouse can elect to disclaim or "push" some assets from the first estate into the trust for his or her benefit, thereby keeping those assets out of the second estate for estate tax purposes. There will be no New York estate tax in the first estate because the marital deduction will be applied to all assets not sheltered by the New York exemption. By using the DPT, the New York exemptions of both spouses can be fully utilized in both estates. The New York estate tax savings achieved by fully using both exemptions, rather than just the second estate's exemption, amount to \$99,600 in the scenario of a husband and wife owning \$2,000,000 of combined assets. In larger estates, the New York estate tax savings can be even more, as the New York estate tax rate is a graduated rate.

The disclaimer must be made, if at all, within nine months of the death of the first spouse, which permits the surviving spouse to make an informed decision as to the extent the DPT should be funded and which assets should be used to fund it. The surviving spouse is not required to fund the DPT, and may

indeed determine, based on circumstances existing at the time, to a) fund the DPT to the full amount of the unified gift and estate tax exemption available in the first estate, b) partially fund the DPT, or c) not fund the DPT at all, in which case it would never be formally established.

Because New York recognizes the validity of same-sex marriages, these laws apply to married couples regardless of the gender of the spouses involved.

One important point to keep in mind with the tax planning described above is that beneficiary designations on insurance policies and retirement plans must be reviewed and updated in order to make those assets available to the surviving spouse to fund the DPT. If your estate planning attorney fails to advise you with respect to beneficiary designations, you should take the initiative to inquire and see to it that the correct designations are in place.

Jennifer Weidner is a Partner at the law firm of Boylan Code LLP, concentrating her practice on transfer tax planning and estate and trust administration. For more information, please contact Jennifer at (585) 232-5300 or jweidner@boylancode.com.

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Do I Buy it or Lease It?

“Quick decisions are unsafe decisions.” ~Sophocles

As the classical Athens' great tragic playwrights states making a quick decision can be unsafe or in business terms, end up being, in and of itself a tragedy. I regularly get the question from clients to assist them in their decision to either buy or lease equipment. There is no one right answer as each business situation is unique; therefore, the decision must be made on a case by case basis. I will discuss advantages and disadvantages of both options.



Steven Terrigino, CPA

Leasing Equipment

One of the biggest advantages to leasing equipment is the ability to quickly acquire assets and not have a significant outlay of cash. This results in the benefit of not having to go to a bank to obtain financing. Leases usually offer flexible terms allowing you to negotiate a longer payment plan and allowing you to utilize cash for other business operations. Lease payments are generally tax deductible on your tax return, thus reducing the net cost of the lease. Finally, one of the biggest advantages to leasing equipment is the ability to upgrade equipment on a more frequent basis. When evaluating whether to lease or buy you will have to consider the time horizon as to when you plan to replace the equipment. If the equipment you are contemplating acquiring becomes obsolete quickly, leasing may be the way to go.

However, on the minus side, there are several points to consider as well. Leases can come with a hefty interest rate baked or disguised into the “low” monthly payment, the salesperson is promising you. I have analyzed several leases, and when the principal and interest rates were calculated, the interest rates were in the double digits! Generally, leasing equipment will cost you more money than outright purchasing it. Also, when you lease equipment you will not build equity or own the equipment by the end of the lease term. Therefore you will either have to “buy-out” the lease or extend the terms of your current one.

Purchasing Equipment

The biggest advantage of purchasing equipment is that you will have ownership in the property. When considering to buy or to lease one of the main question you will need to ask yourself is how long do you plan on keeping the asset. Office furniture, for example, are items you would typically purchase rather than lease. These assets are generally held over a long period of time. Purchasing equipment also will allow you a variety of potential tax deductions. Depending on what you buy, you may be eligible for accelerated depreciation under IRS code Section 179. In 2013, for example, you could write off as much as \$500,000 of eligible asset purchases, if certain requirements are met. Assets not qualifying

for accelerated depreciation can generally be written off under other depreciation conventions.

On the flip side, the financing aspect of purchasing equipment may be difficult and come with some obstacles. Most lending institutions will require a down payment, some as much as twenty percent. That can be a big cash outlay! This could become problematic if cash is needed in the future for an unforeseen emergency. When you acquire debt, the ability to further borrow funds in the future becomes increasingly more complex as lending institutions will cap your credit limit. While ownership may be a positive, it is also a negative. If you own equipment that becomes obsolete quickly, you are going to have a difficult time selling it or trading it in, as its residual value will be minimal.

In summary there are several factors to consider when contemplating whether to buy or lease equipment. These include but are not limited to determining how long you will own the equipment, lease terms, interest rates and potential tax benefits. You should always perform a complete analysis to compare and contrast the pros and cons of both, before making your final decision. Knowledge is power and when provided with all the facts you will hopefully avoid making a quick tragic business decision.

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AAIR Expands to Meet Growing Need for Infusion Therapy



John J. Condemni, MD

You are probably aware from television advertising, friends and family that there are now more new medications being given by injections or intravenous infusions than in the past. In the past pharmaceutical companies were often spin offs from chemical companies that had chemicals looking for diseases to treat. The development was often by trial to determine if a chemical would have an effect in an animal model of disease or in a test tube reaction without an understanding of the chemicals potential. Currently many drugs are being developed from knowledge gained in the laboratory by a scientist who understands the role of a cell or its product in causing disease. They then develop a biologic to kill or inhibit the cell function or remove its product from the body. These drugs are called biologics because they are made from living organisms or their products such as mice or molds. One must first isolate the cell or product causing disease. When injected into mice the mouse will produce antibodies that can be purified and humanized. When given to humans the cell or product will be killed or removed with a reduced potential to cause an allergic reaction in humans. Another strategy is to obtain the gene making the antibody from the mouse plasma cell and introduce the gene into a mold that will produce a human antibody. This significantly reduces the risk of an allergic reaction. The process is more expensive than making a chemical and may never allow the production of a true generic drug. For this reason it will be called a “biologic similar” rather than generic drug and be more expensive. We do pharmaceutical sponsored studies and will soon be studying a biological similar drug. It is estimated that the drug cost per infusion will be 80% of the current cost of drugs we infuse, which ranges from \$529 to \$3,800.

When we opened our infusion center, there was only one infused drug called Remicade being used for the treatment of rheumatoid arthritis. It was initially approved for the treatment

of Crohn’s Disease and subsequently approved for the treatment of psoriasis and psoriatic arthritis. We currently are using Remicade to treat ten different diseases and are referred patients from dermatologists, gastroenterologists and ophthalmologists. It is an anti-inflammatory agent that removes tumor necrosis factor which causes the inflammation in many diseases, no matter the cause or mechanism. In addition we have increased the number of biologics infused from one to twelve. These are capable of inhibiting T cells function, T and B cell interaction, remove B cells, IgE and down regulate TNF production. This technology has significantly decreased the time it takes to go from a laboratory discovery to drug development.

It is estimated that the drug cost per infusion will be 80% of the current cost of drugs we infuse, which ranges from \$529 to \$3,800

Our infusion center does not treat cancer patients and can offer a pleasant environment with lounge chairs and individual entertainment centers. Patients can cocoon in a chair or make new friends. There is always a physician present and the nurses are all certified. We are not hospital

based so have free parking and are close to the expressway. The number of infusions is increasing so we are expanding from our office in Brighton, 300 Meridian Centre, to our office in Greece, 1 Saredon Place.

In addition to biologic drugs to treat asthma, ankylosing spondylitis, Crohn’s, giant cell arteritis, hydradinitis, psoriasis, psoriatic arthritis, pyoderma gangrenosa, rheumatoid arthritis, ulcerative colitis, uveitis, systemic lupus erythematosus, and Wegener’s granulomatosis, we do treat patients with intravenous gamma globulin and intravenous drugs used for osteoporosis.

We currently are studying additional biologics for asthma, rheumatoid arthritis, systemic lupus erythematosus and others are studying drugs for neurologic, eye, Sjogren’s, hematologic, psoriasis, and intestinal diseases. It is safe to say every specialty will have a biologic drug, which will require more infusion chairs, improve patient’s health and increase the cost of medical care.

New Approaches to Geriatric Orthopedic Care

Improving Recovery and Longevity

by Julie Van Benthuisen



Dr. Stephen Kates, Co-Director of the Geriatric Fracture Center at Highland Hospital

With a rapidly rising elderly population, area physicians are predicting a potential national crisis in terms of managing patients with orthopedic issues – particularly hip fractures. In both men and women, hip fracture rates increase exponentially with age, with people 85 and older 10-15 times more likely to sustain them than those ages 60-65.

Dr. Stephen Kates, Co-Director of the Geriatric Fracture Center at Highland Hospital, has been at the forefront of developing a Rochester model of co-managed care for the geriatric hip fracture patient. This progressive model not only benefits the patient, but all healthcare providers and health systems involved in the patient's care. Dr. Kates has dedicated his career to spreading the word, teaching strategies to surgeons

and medical staff around the world for improving their geriatric care models.

As a surgeon, Dr. Kates specializes in locking plate technology, dynamic helical hip systems, joint replacement and arthritic hip, knee and shoulder surgery. It's the critical nature of hip fractures, however, that takes up a considerable portion of his time these days. While he notes a variety of new techniques that are helping his patients, the most critical improvement is the actual system changes in care. "More important than the hardware itself are the outcomes of using different approaches," he says. "We're seeing double digit improvements with fracture outcomes by devising a better, more collaborative system."

Dr. Kates has been working with the American Academy of Orthopedic Surgeons and the Orthopedic Trauma Association to achieve system improvements on a regional and national level. "It seems devilishly simple," he says. "By providing co-managed care between surgeons, consultants and PCs, we can help our elderly patients manage their complex medical problems better when they sustain a fracture." All the more necessary, he says, as the diminishing availability of practicing geriatricians in this country is down to about 9,000 currently.

At the Geriatric Fracture Center (GFC), patients are co-managed daily by a geriatrician and orthopedic surgeon, emphasizing total quality management, timely treatment and standardized care. Both the orthopedic and geriatric leadership of the GFC program recognize the connection between surgical delays and risk of adverse outcomes. "To ensure that an elderly patient gets the right treatment, we need a standardized work flow – almost like a 'cookbook' to follow," he says. "Early surgery and a combination of treatment strategies including the use of blood thinners, are far more effective tools in changing the way we deliver care."

Troubling Statistics

The reality surrounding hip fractures is startling. Approximately 25% of elderly patients will die within one year of a hip fracture, when their medical problems worsen. Only about 20% regain independence after a fracture, which in turn proves very costly to the patient and the healthcare system. When patients are

hospitalized for a fracture, says Dr. Kates, they bring with them a host of other issues. “They don’t die of the actual fracture, but from surgical complications like infection or pneumonia. With an inter-disciplinarian approach, we can help lower those fatalities.”

When an estimated 78 million baby boomers turn elderly by the year 2020, approximately 18% of our Western New York population will be considered part of this population. “This ‘silver tsunami of older folks’ represents an enormous health crisis.” But the problem doesn’t necessarily begin once a person ages. “We have a large population with bad bones,” he says. “Our nation’s sedentary lifestyle, especially in our youth, has led to ‘indoor kids’.” By age 25, a person’s bones are ‘set’, so an unhealthy lifestyle up to that point can dramatically affect the chances of serious fractures later on. By age 50, a patient with earlier unhealthy habits now undergoing menopause, for example, will lose even more of her bone strength and become far more susceptible to fractures. In fact, more elderly people die from complications from a hip fracture than they do from breast cancer and several other cancers combined. “There’s no pink ribbon awareness out there for someone breaking a hip, yet it affects a huge portion of our population.”

Nearly 70% of patients in the GFC program undergo surgery within the first 24 hours and 95% within the first 48 hours of hospital admission. The program follows five key principles: most patients benefit from surgical stabilization of their fracture; shorter times to surgery result in less time to develop iatrogenic illness; co-management with frequent communication avoids iatrogenic problems; standardized protocols decrease adverse outcomes; and discharge planning begins at admission. “Patients in our program have lower than expected lengths of stay, complications and readmission rates, and mortality.”

A patient-centered, protocol-driven standardized care approach includes the essential team of surgeon, geriatrician, anesthesiologist, midlevel providers, nurses, occupational therapists and physiotherapists, social worker, nutritionist, and patient care aides. The care team all set the same expectations for the patient in each case, and families and patients are considered part of the care team. The GFC is also loosely affiliated with many assisted-living facilities and nursing homes as a preferred site for geriatric admissions.

Dr. Kates is encouraged that both private and university hospitals are embracing this model. “Doctors at some of our best universities are recognizing that this means better results for patients.”

Better Opportunities for Knee Repair

When it comes to treating knee issues, options can be more



Dr. David Privitera, orthopedic surgeon at Rochester General Health System

limited for the elderly, says Dr. David Privitera, newly appointed orthopedic surgeon at Rochester General Health System. Arthritis is often the primary culprit. Fortunately, physicians today are more aware of and better able to detect arthritis, despite the difficulty understanding the paradigm of arthritis and ensuring patients return to a functional level. For example, a patient may come to his PC complaining of knee

pain, while his x-rays might look completely normal. “It’s a tough picture,” he says. “We have to go up the tier to consider other things.” Once an orthopedic surgeon determines an accurate diagnosis, patients can work with a PT to tailor a program that might help avoid surgery. Conservative measures include bracing, weight loss, physical therapy, and injection.

If these measures aren’t enough and the arthritis is isolated, an osteotomy might be recommended. “It’s a very well-prescribed procedure, and an appealing alternative to knee replacement.” The bone can be cut to shorten, lengthen or change its alignment, or to straighten it if it’s healed crookedly following a fracture. “An osteotomy can relieve the pain in arthritis, especially in the hip and knee, without having to undergo a joint replacement,” he says.

On the flip side, recovery time may be extensive. Careful consultation with the patient’s PC is key to ensure a successful recovery, which can take three months to heal. Tools exist to assist recovering patients who may have non-weight bearing requirements, including bedpans, dressing sticks, long-handled shoe-horns, grabbers/reachers and specialized walkers and wheelchairs. “Once the knee is protected and weight-bearing is reduced, the patient really takes off.”

Fellowship-trained at Harvard, Dr. Privitera specializes in far more than corrective osteotomies, however. Biologic joint preservation, cartilage transplants and autologous chondrocyte implantation are also areas of focus. One of the newer techniques being adopted from Europe is regenerative cartilage -- taking a patient’s own cartilage cells, growing them in a culture and ultimately injecting them back into the patient via an open surgical technique. Cells divide slowly, but within two years, the cartilage cells grow thick. “Unfortunately, this can be a long time to wait for an elderly patient.”

In the meantime, however, he is encouraged by another recent technique – the DeNovo NT Natural Tissue Graft – which is resulting in major improvements in knee pain and swelling. The DeNovo technique implants small amounts of cartilage from deceased juvenile healthy donors into a patient’s lesion,

which is then sealed with a protein-based glue. Within a few months, cells from the donor cartilage migrate to surrounding tissues, multiply, and new cartilage begins to grow. “Instead of two procedures, it’s a one-stage, relatively quick and less painful operation for an older patient.”

Microfraction is also seeing substantially good results by creating tiny fractures in the underlying bone and encouraging new cartilage to develop from a “super-clot”. The minimally-invasive surgery typically lasts between 30-90 minutes with significantly shorter recovery time than a knee replacement.

Dr. Privitera urges doctors to look for patients complaining of a catching sensation or swelling in the knee, even if normal standing x-rays come back, and immediately refer to an orthopedist to see if it’s related to a cartilage injury. Pain in the front of knee might be a kneecap tear issue or something difficult to detect with x-rays, and unfortunately somewhat tougher to treat, he says



Dr. Raymond Stefanich at Orthopaedic Associates of Rochester

Addressing Shoulder Issues

Dr. Raymond Stefanich at Orthopaedic Associates of Rochester, specializes in Hand and Upper Extremity Surgery. Like Dr. Privitera, he also cares for elderly patients with arthritis. “Primary Care doctors have classically treated patients with arthritis of the shoulder joint with NSAIDs, physical therapy, and cortisone therapy,” he says. “More recently,

however, we are finding better success by injecting shoulder joints with a protein/sugar compound that has decreased in an osteoarthritis patient.” These shots usually work best in more moderate arthritis. Synvisc One, which has been used extensively in the knee, has met with success in treating shoulder arthritis, he adds. “It’s usually given through a posterior approach into the shoulder joint. Ultrasound-guided injection techniques have been used with increasing frequency in recent years to increase accuracy.”

Dr. Stefanich also cites rotator cuff pathology as another key problem for his aging patients, because partial and/or complete tearing increases in frequency with advancing age. “New technology has resulted in the ability to fix the majority of these tears arthroscopically. However, once repaired, a healing response is still necessary to repair the tendon back to the bone.” Unfortunately, results of arthroscopic rotator cuff tendon repair are less favorable in older individuals who cannot heal the repairs adequately.

On a positive note, patients presenting with long-standing

rotator cuff tears with secondary arthritis are seeing success with reverse shoulder replacement – a more commonplace procedure in recent years. In this procedure, the glenoid and proximal humeral portions of the implant are reversed such that the “ball” of the shoulder is attached to the glenoid and the “socket” is attached to the humerus. “Patients with rotator cuff arthropathy, which was previously inoperable using a standard total shoulder replacement, are now candidates for this procedure. It restores rotator cuff function via its specific geometry and reconstructs the shoulder joint,” he says, “eliminating the arthritic surfaces.” The reverse shoulder replacement has recently seen increased use for the treatment of proximal humerus fractures in the elderly, which have been classically treated with a hemiarthroplasty. Post-op immobilization is less and patients can start PT more readily with active shoulder motion within a few days.

In geriatrics, fracture fixation devices such as locking plates have also improved the ability to stabilize fractures of the upper extremity including the wrist. “These devices stabilize fractures better than traditional plates as the screws themselves lock into the plates producing a more rigid construct.” For example, traditional treatment for a Colles fracture involved closed reduction and short arm cast immobilization for six weeks followed by wrist mobilization. However, with use of the newer locking plate technology, fractures can be surgically stabilized allowing more rapid mobilization and return to function. “With current fracture fixation using a locking plate, patients are well on their way to achieving nearly full mobility by six weeks as opposed to when the cast comes off.”

Upper extremity compressive neuropathies have also seen advances in treatment options. Minimally invasive, endoscopic techniques have been utilized for several years for treatment of carpal tunnel syndrome. This procedure involves a small incision proximal to the wrist flexion crease through which the transverse carpal ligament is released endoscopically. When carpal tunnel release is done endoscopically, patients return to normal activities more quickly as no incision is made in the palmar surface of the hand. Similarly, in patients with ulnar nerve compression at the elbow, release of the ulnar nerve can be carried out endoscopically through a small incision. “Recovery is much quicker as the nerve is released in situ and not mobilized or transposed. No immobilization is required for this procedure.” Surgical trauma is also much less than the traditional open method.

Depending on the orthopedic issue, geriatric patients have far more opportunities for joint recovery and long-term health than ever before. Whether it’s a knee, hip or shoulder, our region’s leading surgeons are encouraged by the improved technologies and better approaches to collaborative care.

What is My Liability?

Medical Practice Mergers and Acquisitions



James E. Szalados, MD, MBA, Esq.

Issue

The cottage industry model of healthcare delivery is slowly but progressively being replaced by consolidated group practices, hospitals, and hospital-owned practices. In some instances, the new owners are no longer locally-based and may represent regional or national conglomerates. This industry consolidation is being driven by the need to enhance which financial performance of practices can be accomplished in a variety of ways: (1) *economy of scale* refers a potential reduction of fixed costs by removing duplications in operations relative to the total revenue stream, thus increasing profit margins - for example medical practices can consolidate to reduce the costs of compliance with regulatory mandates and practice management overhead; *economy of scope* refers to the potential for increasing market share, scope of services, or the unmet needs of special populations and potentially decreasing the costs of competition within a similar market; synergy refers to opportunities to decrease costs through larger group purchase discounts and decreased marketing costs; *taxation opportunities* allow a profitable company to acquire a financial loser to reduce its tax liability but to simultaneously increase its community presence or to provide a mission-advantageous marketing advantage; *resource transfers* specifically target resources such as a hidden asset, workforce talent, or a unique patent or niche market opportunity; and the utilities associated with *vertical or horizontal integration*.

The processes by which practices consolidate are known as mergers and acquisitions. Mergers and acquisitions are associated with significant potential liability – for the seller, the buyer, and the employees of the practices. In my experience, private physicians and practice administrators will delay involvement of legal counsel until the negotiations are already in progress – a practice which increases the liability for both

buyer and seller. Technically, the legal definition of a *merger* is that of a combination of two entities in order to consolidate and form a new entity; whereas an *acquisition* refers to the purchase of one company by another (no new entity need be created) and the purchaser becomes the controlling owner the larger whole. In reality, either structure can result in the desired economic and financial consolidation of two entities. Corporate acquisitions can be characterized for legal purposes as either “asset purchases”, or “equity purchases”. Asset purchases are very common practice in technology transactions where the buyer is most interested in particular intellectual property rights but does not want to acquire liabilities or assume contractual relationships; note that such a notion is not foreign to the intent underlying many medical practice acquisitions. In the case of a stock (“all-out”) purchase, the purchaser acquires all the assets (accounts receivable) and liabilities (payables, obligations to employees, malpractice actions). In such a transaction, a complete due diligence process is important to limit liability on the buyer who will remain responsible for even previously unrecognized legal liabilities. An acquisition may occur in a structured buyout fashion over a fixed time period allowing a buyer to gradually assume full ownership of a practice and also allow the seller to retain an interest in his or her practice for a defined time period. The responsibility for liabilities can be contractually negotiated, but there is a requirement for specificity of each liability, without which a target practice’s liabilities are transferred to the acquirer under law.

The value of a medical practice ultimately rests in the eyes of the owner and the buyer: for the owner the value of one’s practice frequently represents the equity accumulated through a lifetime of professional practice and thus a vital element of a retirement plan; whereas for the buyer it equally represents an investment in a potential revenue-generating enterprise and potentially a strategic element in local market penetration. Thus, sellers frequently set a selling price based on personal values and buyers may intentionally overpay for a practice if it meets a specific strategic need. Practice valuation is a form

of accounting in which the financial assets and liabilities of a practice are tabulated, depreciated, and tallied. Practice valuation is an essential component of financial due diligence. Assets are either tangible (such as real estate, furniture, accounts receivables, and equipment) or intangible (trained workforce and goodwill). Goodwill is an intangible asset which is based on the practice size, location, reputation, patient market, and potential for profitability. However, a practice's patient list is also form of intellectual property which has a value in its revenue potential. Goodwill is an increasingly a fickle and unreliable asset since patients are free to migrate between practices and cannot be counted upon to remain with a new physician/owner after a practice is sold. I have reviewed many 'black and white' practice valuations that represent *pure asset valuations* and grossly misestimate the value of a target practice; issues such as *historical earnings, future maintainable earnings, relative valuation within the regional marketplace, and discounted cash flow valuations* are critical to determining a the reasonable value of a practice. An estimate of a practice's value is most frequently expressed in a *Letter of Opinion of Value (LOV)* which may be presented by both seller and buyer in preparation to more formal negotiations.

Formal practice valuation, the determination of *fair market value (FMV)*, is at issue when either a bank loan is necessary to underwrite the purchase or when the purchaser is a healthcare institution and the physician sells his or her practice to a hospital and then remains an employee of the practice (Anti-Kickback and Stark implications). Fair market value is the price settled upon through a bona fide bargaining process between a well-informed buyer and seller on the purchase date and does not account for potential generation of volume or value through referrals. The Federal Anti-kickback Statute prohibits the knowing and willful solicitation, receipt, offer or payment of any remuneration, directly or indirectly, overtly or covertly, in cash or in kind, in return for referrals or in return for arranging, recommending, leasing or ordering of any item or service covered in whole or in part by Medicare or Medicaid. The Anti-Kickback Statute is a criminal statute, punishable by up to 5 years in prison and/or a \$25,000 fine, plus exclusion from Medicare and Medicaid programs. Safe harbors to the Anti-Kickback statute may include protection for practitioner to practitioner transactions, where one party to the sale rents equipment or office space from the other party, and an employment safe harbor where the selling physician continues

as an employee or provider of other professional services of the acquiring entity.

Thus, the legal formalities of practice acquisition or merger will rely upon but will also go significantly beyond a financial analysis. *In any prospective merger or acquisition, prudent parties will retain experienced legal counsel at the onset of discussions, before any formal negotiation has even started.* In order to protect the parties, a confidentiality agreement which imposes confidentiality provisions on the proprietary information that is shared, outlines the scope and terms of the planned due diligence process, stipulates a deadline by which all due diligence must be completed, and will probably include a standstill provision barring either party from negotiating with anyone else for a specified period of time. Review of the Articles of Organization and Bylaws is necessary in order to assure that all potential 'Third Parties' have submitted a pre-closing consent to assignment. Finally, the attorney will draft a detailed purchase agreement which may include lease transfers, leasehold improvements,

“at issue when either a bank loan is necessary to underwrite the purchase or when the purchaser is a healthcare institution and the physician sells his or her practice to a hospital and then remains an employee of the practice”

compliance documents, details regarding the specific liabilities to be assumed, employee contracts and benefit plans, warranties and obligations, indemnifications, and probably, a covenant not to compete. In any merger or acquisition where one party is or has ownership in a tax exempt entity classified under Section 501(c)(3) of the IRS Code, there an additional of complexity (and potential liability) within the transaction. Medical records and PHI cannot be transferred without patients' permission, unless under a Business Associate Agreement or similar exemption, under HIPAA. The requisite time period for retention of medical records (even inactive files) is governed by statute. Rarely, where a practice acquisition or merger may confer a local or regional monopoly or significant market power, compliance with the federal Sherman and Clayton Antitrust Acts, and State approval may also be necessary prior to sale. Tax consequences regarding practice sale or acquisition are beyond the scope of this discussion.

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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GENERAL**
HEALTH SYSTEM

www.rochestergeneral.org/seniorservices

Unity's CHHA Continues Tradition of Providing Care to Seniors in the Home



Debra Lyda, RN, BSN



In October 2012, Unity Health System was granted approval from the New York State Department of Health to create a Certified Home Health Agency (CHHA). Unity was the only agency in Monroe County – and one of only 27 across the state – that was granted approval. The 2012 approvals lifted a 19-year moratorium on creating Certified Home Health Agencies (CHHA) in New York State.

Unity's Certified Home Health Agency (CHHA) began its operation in July 2013, and is licensed to serve those who live in Monroe County. Unity's CHHA provides short-term in-home care to patients recovering from an illness, injury or surgery.

Unity's CHHA Provides:

- Skilled Nursing Care by Unity registered nurses (RNs) who administer IV drugs, give shots, provide tube feedings, change dressings and oversee diabetes care.
- Physical Therapy to treat injury and disease through exercise, heat, light and therapeutic massage.
- Occupational Therapy Services to help you or your loved on return to activities like bathing, preparing meals and housekeeping.
- Speech-Language Therapy to assist with speech, language and swallowing issues or to address communication problems following a serious injury, illness or stroke.
- Medical Social Services to help manage the social and emotional concerns related to your illness
- Home Health Aides to assist with daily living activities such as bathing, dressing and making meals.

Unity has a long history of providing home and community based services for older adults, including adult day care, care giver support, emergency response systems, housekeeping and companion services, home health aides, long-term home health care program, home delivered meals and medication monitoring systems. With the addition of the CHHA, Unity now provides a complete continuum of care to help patients

maintain independence and safety at home. Offering this wide range of services is especially important now. According to the Finger Lakes Health System Agency (FLHSA), Monroe County is projected to see a 32% increase in the need for home care services by 2020.

Unity's CHHA collaborates with physicians to determine patients' individual needs, and adjust each individual care plan accordingly. Working closely with embedded case managers and practice managers in the physician offices has proven to be beneficial in establishing care plans for those patients who need short term nursing or therapy to allow them to stay in their homes safely. Providing in-home interventions can reduce the use of emergency rooms, which are often used by patients for status changes and symptoms that could be more appropriately triaged and addressed 24 hours a day by the CHHA.

Highly Trained and Experienced Staff

Unity's CHHA employs highly experienced and skilled nurses, physical therapists, occupational therapists and other professionals who are focused on developing fully integrated care plans for their patients with a focus on seamless transition of patients from facility to home. Many Unity CHHA staff have come from hospital settings and have brought their vast experience and years of education to help develop proven protocols that are meant to decrease patient re-hospitalization and improve patient satisfaction. With future hospital reimbursement being based quality not volume, Unity's CHHA has structured its policies, procedures and quality initiatives with that in mind.

Patient satisfaction and good patient outcomes is what we are working diligently to achieve at Unity Health System. The staff and leadership of the Unity CHHA are enthusiastically striving to achieve those goals for the good of the community.

For more information call (585) 368-6342 or visit unityhealth.org/CHHA.

Debra Lyda, RN, BSN, is Senior Director of Unity Home Care Services and the Unity Certified Home Health Agency. Deb attended SUNY Oswego and St. John Fischer.

Unity Memory Center Provides Comprehensive Approach to Memory Disorders and Dementias



Tanya Grace, MD



David Gill, MD

The need for providers to care for patients with cognitive impairment and dementia is becoming a desperate situation, as the number of people with Alzheimer's disease and other dementias is predicted to increase three to four fold by 2040 making what is already a difficult situation an epidemic. The predicted dramatic increase in patients with dementia is due to the "baby boom era" generation beginning to reach the age of 65. In the coming years, providers will be needed to deliver accurate diagnoses, appropriate treatments/interventions, and have greater awareness for dementia related syndromes.

Memory centers have been utilized as a model to evaluate, treat, and research memory disorders and dementias. These types of programs are multi-disciplinary and provide comprehensive diagnostic services, which have been shown to be more accurate in diagnosis than a non-comprehensive model.¹ Obtaining a medical history, neuro-imaging, laboratory tests, neuro-cognitive performance, and assessment of changes in activities of daily living all contribute to the clinical diagnosis of dementia and require a multi-disciplinary team of professionals.

Unity Health System recently opened the Unity Memory Center at its Unity at Ridgeway location, 2655 Ridgeway Avenue. At the Unity Memory Center, we incorporate a comprehensive team approach to diagnosis including assessments by Dr. David Gill, a behavioral neurologist, as well as a team of neuropsychologists, Drs. Tanya Grace, Krista Damann, William Schneider, and Marc Gaudette; our palliative care physician, Dr. Michelle Carpenter-Bradley; our nurse practitioner, Yvonne Harrison; and allied medical staff. Most importantly, we collaborate as a team in determining an appropriate diagnosis and individualized treatment plan to aid in patient centered care. Proper diagnosis and a comprehensive approach allows for care that incorporates the most up to date medical care, including non medication techniques such as cognitive training and rehabilitation, caregiver training and support, and lifestyle modification. Another unique aspect of our program is the longitudinal care for our patients where we help guide our patients through their illness and address issues, such as behavioral changes, as they arise, and future planning for caregivers. Beyond providing clinical diagnostic and treatment planning services, we strive to educate our community at all levels.

Providing an accurate diagnosis is critical. As an example, one patient was referred to us with a diagnosis of frontotemporal dementia, but based on the results of his neuropsychological testing and our review of his MRI, Alzheimer's disease seemed much more likely. A FDG-PET scan confirmed the diagnosis and we

were able to recommend the use of a cholinesterase inhibitor and Namenda, which have been shown to work for Alzheimer's disease, but not frontotemporal dementia. It is important to keep in mind that many patients with Alzheimer's disease have more than one cause for their cognitive impairment and as many as 50 percent of patients with dementia do not have Alzheimer's disease, especially those under 65 years of age.² In general, the medications used for Alzheimer's disease are not effective in non Alzheimer's disease dementias, so correct diagnosis and an understanding of disease course, which often include a concomitant movement disorder, is critical to guide management.

Proper diagnosis and a comprehensive approach allows for care that incorporates the most up to date medical care

Another representative case is that of a 68-year-old man who came to the clinic with his wife who was concerned about his memory. His medical history, neurological examination, neuroimaging, and laboratory findings were unremarkable; however, his neuropsychological examination was very suspicious for Alzheimer's disease based on severe impairments on memory testing.

Because his day-to-day functional skills were intact, he had amnesic mild cognitive impairment (MCI). Nonetheless, the type and extent of his neurocognitive pattern was very concerning for an emerging Alzheimer's dementia. In some studies, elderly patients with amnesic MCI have as high as a 90 percent chance of developing Alzheimer's disease over a 10 year period.³ We recommended techniques to work around his memory impairment and discussed future expectations of his needs with his spouse. In addition, he will need routine follow-up to identify progression to Alzheimer's disease at which time an updated treatment plan can be introduced.

In addition to mild cognitive impairment and Alzheimer's disease, we also see patients with Lewy body dementias (Parkinson's disease with dementia, Lewy body dementia and multiple system atrophy) and frontotemporal lobar degenerations such as frontotemporal disease, primary progressive aphasia, and

corticobasal degeneration. Lastly, we evaluate and follow patients with disorders that cause rapidly progressive dementias such as Creutzfeld-Jakob disease and the praneoplastic/autoimmune encephalopathies.

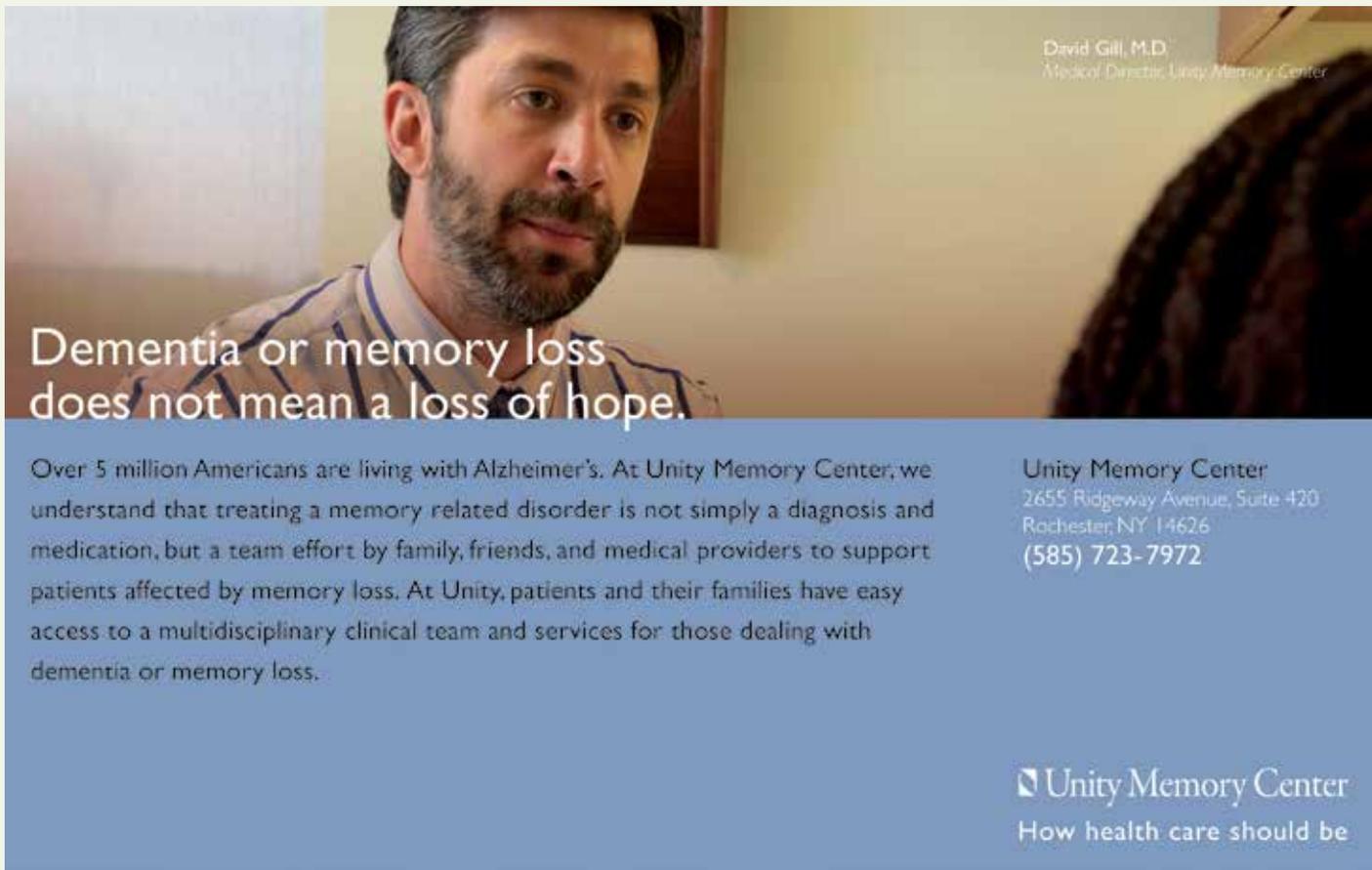
There are success stories for us at the Unity Memory Center. However, we recognize that the majority of our patients will have an incurable disorder of cognition. We specialize in providing a comprehensive approach to diagnosis and treatment for the patient and caregivers throughout the course of their illness. Our primary goal is to maintain their quality of life in a caring and supporting manner.

A question that we often get is what types of patients should be sent to the Memory Center. We would be happy to see any patient who could benefit from our services. In addition, we have the unique ability to further clarify functional and behavioral changes in cognition through formal neuropsychological testing which helps define patterns of suspected change that may or may not be due to solely aging of the brain. We are often faced with the question of whether the cognitive changes are part of normal aging, mild cognitive impairment, dementia, or even depression. Another question that we are often asked to address is whether the person has Alzheimer's disease, another cause of dementia or perhaps a psychiatric illness, which as a multi-disciplinary unit, we have a unique ability to address.

- 1 Brookmeyer, et. al. Alzheimer's Dementia. 2007
- 2 Luce, et. al. Int J Geriatr Psychiatry, 2001 and Verhey et. al. J Neuropsychiatry Clin Neurosci. 1993
- 3 Garre-Olmo, et. al. Neurology. 2010
- 4 Visser, et. al. Neurology. 2006

David Gill, MD is a behavioral neurologist at Unity Rehabilitation and Neurology in Rochester, NY. He also oversees the Unity Memory Center. He completed his neurology residency and behavioral neurology fellowship at the University of Rochester. He then left to oversaw the Penn State Hershey Memory and Cognitive Disorders Program at the Penn State College of Medicine prior to returning to Rochester in 2012. He has close ties with the Alzheimer's Association, having served on the Board of Directors of the Greater Pennsylvania Chapter of the Alzheimer's Association and sits on the Medical Science Committee of the Rochester and Finger Lakes Region Chapter of the Alzheimer's Association. He is board certified in Neurology and Behavioral Neurology and Neuropsychiatry.

Tanya R. Grace, PsyD is a clinical neuropsychologist and licensed psychologist at Unity Rehabilitation and Neurology in Rochester, NY. She earned her doctorate degree in clinical psychology from the Florida Institute of Technology where her interest in memory disorders was cultivated both on clinical and research fronts. Her clinical internship training was completed at Emory University School of Medicine, followed by a fellowship in clinical neuropsychology at Florida Hospital in Orlando, FL. She has recently joined the Unity Memory Center as the dedicated neuropsychologist and is active in several national psychology and neuropsychology conferences and organizations.



David Gill, M.D.
Medical Director, Unity Memory Center

Dementia or memory loss does not mean a loss of hope.

Over 5 million Americans are living with Alzheimer's. At Unity Memory Center, we understand that treating a memory related disorder is not simply a diagnosis and medication, but a team effort by family, friends, and medical providers to support patients affected by memory loss. At Unity, patients and their families have easy access to a multidisciplinary clinical team and services for those dealing with dementia or memory loss.

Unity Memory Center
2655 Ridgeway Avenue, Suite 420
Rochester, NY 14626
(585) 723-7972

Unity Memory Center
How health care should be

in Area Healthcare

RGHS

Rochester General Health System Opens New Dialysis Center in Newark

Rochester General Health System, in partnership with DaVita Healthcare Partners, Inc., is meeting the region's growing demand for outpatient dialysis with the opening of the Newark-Wayne Dialysis Center in Newark. The Center, housing 14 new dialysis stations, is equipped with heated chairs, personal televisions and WiFi, and brings the total number of outpatient dialysis stations operated by RGHS to 83.

"RGHS has been a leader in providing outpatient dialysis in the Rochester Region," said Marvin Grieff, MD, Medical Director at the Newark-Wayne Dialysis Center. "For each of our centers, delivering superior patient care close to where our patients live has been a top priority. We chose to partner with DaVita for the Newark center due to their proven record in partnering with other hospitals to provide excellent care for dialysis patients throughout the US, especially in the more rural setting."

"The growing need for dialysis services is a nationwide trend," said Stephen Silver, MD, RGHS Division Chief of Nephrology. "Diabetes has reached epidemic levels in our community and across the country, and one of the possible medical consequences of that disease is kidney failure. Unfortunately, we see the demand for dialysis services continuing to increase."

RGHS Independent Living for Seniors Program is Renamed ElderONE



Comprehensive senior care program allows participants to live in their homes, supported by coordinated health services

Rochester General Health System has launched a new identity for its popular Independent Living for Seniors (ILS) program, which allows frail seniors to live at home with highly coordinated support from a single team of medical, transportation and personalized care service providers. The program is now known as ElderONE, an affiliate of Rochester General Health System.

ElderONE is a Program of All-Inclusive Care for the Elderly (PACE), a nationally recognized model that provides a full spectrum of medical care – both

those services typically covered by Medicare and Medicaid, and additional medically necessary services. This can include prescription drugs, doctor care, transportation, home care, checkups, hospital visits, and rehabilitation. These comprehensive services allow ElderONE participants to remain in their own homes safely – retaining their independence, their personal and neighborhood connections and their quality of life.

Founded in 1990, ILS / ElderONE was the ninth PACE program in the United States and today remains the only one of its kind in the greater Rochester area.

"In the 23 years since RGHS began providing this program to the Rochester community, the PACE model has earned national recognition as a benchmark for excellence in senior care," said Kathryn McGuire, RGHS senior vice president for behavioral health, long term care and senior services. "With ElderONE, seniors can stay in their homes without compromising their safety or the quality of their care. The program has never been more needed by our community, and we're excited to launch this new identity as a way to increase awareness."

ElderONE's rebranding comes at a pivotal time for senior health services. Due to the growing senior population and rising health care costs, the state of New York has encouraged the carefully planned downsizing of traditional nursing homes in favor of programs like ElderONE that follow a recognized Managed Long Term Care (MLTC) model. Rochester General's long-term care facilities, Hill Haven in Webster and DeMay Living Center in Newark, are undergoing a gradual shift away from institutional long-term care, to focus on short-term post-acute rehabilitation and transitional care for adult patients of all ages.

Additionally, beginning in December New York State will ask all individuals who have ongoing care needs and are dually eligible for Medicare and Medicaid to join a recognized MLTC program such as ElderONE. "Our program's longevity and proven success make ElderONE the leading local choice for seniors in need," McGuire said.

For additional details about ElderONE, including eligibility information, visit www.ElderONE.org or call 922-2831.

URMC

URMC Expands Neuromedicine Teams for Rochester, Ithaca, Southern Tier

Four neuromedicine specialists have

joined the URMC, enhancing programs for traumatic injury, cerebrovascular, spine and Parkinson's care.



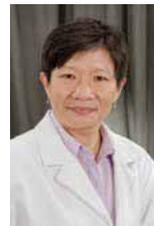
Manjunath Markandaya, MBBS, was named chief of the division of neurocritical care and assistant professor of Neurosurgery, Neurology and Medicine. He specializes in caring for some of the most

challenging and critically ill neurosurgical and neurological patients. A graduate of Bangalore University in India, he completed an internship at Harbor Hospital Center in Baltimore, and then residency in neurology at the University at Buffalo, SUNY. He followed that with Fellowship training in neurocritical care at The Johns Hopkins University and then trauma/surgical critical care at the R Adams Cowley Shock Trauma Center, University of Maryland.



James C. Metcalf Jr, MD, was named assistant professor of Neurosurgery and serves Cayuga Medical Center in Ithaca. He specializes in spine disorders and cancer care. Metcalf served in Navy from 1976 to 1980 and

then on the clinical staff at Naval Medical Center in Portsmouth, Va. He graduated from Medical College of Georgia and completed his residency training at the University of Tennessee.



Su Kanchana, MD, PhD, a neurologist, was named assistant professor of Neurology and serves patients in the Southern Tier Neuromedicine office in Big Flats as well as in Rochester at 919 Westfall Road, Building C. She specializes in the

diagnosis and management of complex movement disorders, with emphasis on Parkinson's disease, deep brain stimulation and Botulinum toxin therapy.

She earned her MD at Wayne State University School of Medicine, completed a neurology residency at University of Wisconsin-Madison, and fellowship training at the National Institute of Neurological Disorders and Strokes at the National Institutes of Health.

Amrendra Singh Miranpuri, MD, joined the team as an assistant professor of



Neurosurgery. He specializes in open and interventional neurosurgical procedures for cerebrovascular disease. He is also the surgical co-director of the Neuromedicine Critical Care Program.

He earned his MD at University of Wisconsin-Madison Medical School where he completed residency training in neurosurgery and a fellowship in endovascular neurosurgery. Most recently, he was at Medical University of South Carolina completing a fellowship in neuro-interventional surgery.

UNITY

Suzan Saber, MD joins the Unity Diabetes and Endocrinology Services team



Dr. Saber is Board certified in Internal Medicine, specializing in Endocrinology. She completed residencies at the American University of Beirut and the Cleveland Clinic

Foundation; as well as a fellowship in Endocrinology, Diabetes and Metabolism at the URMC.

Unity Health System to Open Foot and Ankle Center in February

Unity Health System will launch the Unity Foot and Ankle Center in February 2014.

The first of its kind in the area, the Center includes a multidisciplinary team of specialists who provide comprehensive services for the treatment of foot and ankle conditions.

NEWARK-WAYNE

Newark-Wayne Community Hospital Welcomes Two New Pediatric Practitioners to the Medical Staff



Raissa Ong, MD, a Pediatrician, is now accepting patients at Newark Pediatrics, a Rochester General Medical Group practice. Dr. Ong earned her Medical

Doctorate at the University of Santo Tomas in Manila, Philippines and completed her residency in Pediatrics at the Geisinger Medical Center, Danville, PA. She is a member of the American academy of Pediatrics and has a special interest in newborn medicine and immunizations.



Meghan Green, NP, a Pediatric Nurse Practitioner, is also now seeing patients at Newark Pediatrics. She earned her BS in Nursing at St. John Fisher College and her Masters in Science as a Pediatric Nurse from

the University of Rochester. Previously, she worked in the Neonatal Intensive care Unit at the URMC Golisano Children's Hospital and at Finger Lakes Medical Associates in Geneva.

More Enhancements at Newark-Wayne Hospital - Pre-admission Testing Opens and MRI Temporarily Moves

To provide excellent patient care, pre-surgical patients and patients requiring MRIs will now be receiving those services at different locations at Newark-Wayne Community Hospital (NWCH).

Pre-surgical patients will now be

scheduled at the newly enhanced Pre-Admission Testing Department (in the former Emergency Department) for a two hour appointment that will include all of their pre-surgical requirements (a physical/health screen, lab work, X-Rays, EKG and other tests). Previously, patients might have had to make two or three separate appointments to accomplish all of the requirements. The Pre-Admission services will be provided by Nurse Practitioners,



Hope Monje, NP and Florence Ndongwa, NP.

As part of the continuing Major Modernization project, Newark-Wayne is also replacing its mobile MRI with a new, permanent "wide bore" MRI this spring. This will require temporarily moving the current mobile MRI to a different location while the new MRI structure is being built and the MRI is installed. Patients requiring an MRI should still report



to the Radiology Department on the 1st floor of the hospital for registration; they will then be escorted to the mobile MRI for their appointment.

"We are continuing to provide enhancements and new services to provide the best care possible to our patients," said Mark Klyczek, president of Newark-Wayne Community Hospital. "The goal is always to provide the safest, highest quality, most efficient customer-focused services for our patients," he added.

Notice Requirements Under the ACA

Question: I'm confused. What are the notice requirements for medical practices to their employees under the Affordable Care Act? What happens if I don't comply?

Answer: You are right to be confused. The U.S. Department of Labor ("DOL") has issued guidance outlining how employers must inform employees about their rights under the Affordable Care Act ("ACA").

The DOL requires that employers who have \$500,000 or more in gross sales for the year provide notice to their current employees by October 1, 2013 of the availability of coverage through the private Health Insurance Marketplace ("Marketplace"). New

hires must be notified as they start work.

The notice must include the following information:

- Information on the existence of the Marketplace, including services provided by the Marketplace and contact information
- That the employee may be eligible for a premium tax credit if the employee purchases a qualified health plan through the Marketplace under certain circumstances; and
- If the employee purchases health insurance through the Marketplace, they may not be eligible for the employer contribution to any health care benefits provided by the employer.

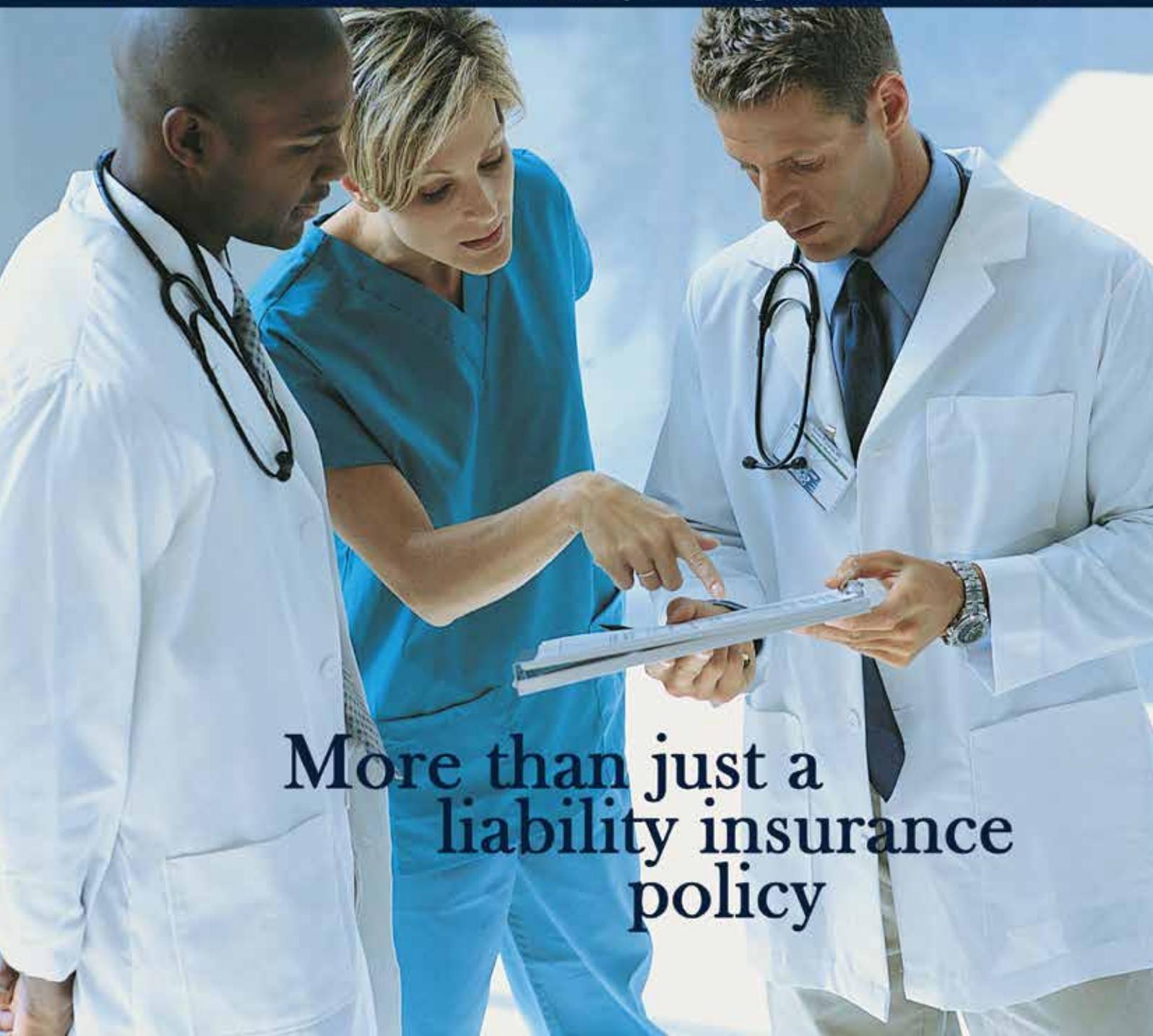
There are two model notices on the DOL's website at <http://ow.ly/p9TXE>.

Though the DOL requires that employers notify employees by October 1, 2013, the FAQ section of the DOL website advises that there will not be immediate penalties for failure to provide this notice in a timely fashion. However, the law specifies that this is a mandatory notice, so it is likely that penalties will be put in place for failure to comply.

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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585.922.3458

www.rochestergeneral.org/sports-medicine