Western New York
PHYSICIAN
VOLUME 1 / 2014
THE LOCAL VOICE OF PRACTICE MANAGEMENT AND THE BUSINESS OF MEDICINE

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Thinkers, Evaluators and Coordinators of Patient Care

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Cover Story

Neurology Associates of Rochester

Thinkers, Evaluators and Coordinators of Patient Care

This unique group of board-certified and fellowship-trained neurologists redefine the idea of patient-centric comprehensive care. From the very moment each patient is greeted by their doctor in the waiting room, the detective work begins. These specialists use each opportunity to observe, assess and better understand their patients, resulting in an unparalleled level of care for their patients.

From L to R: Anne Moss, MD, Ryan Evans, MD, Erica Patrick, MD, and Ashanthi Gajaweera, MD. Not pictured is founding partner Andrew Stern, MD. Cover photo credit: Lisa Hughes Photography

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www.WNYPhysician.com

Welcome to Volume 1 - 2014 of *Western New York Physician* where you will find informative stories and articles *about and for* physicians in western NY.

Our cover story this issue visits Neurology Associates of Rochester, a private boutique practice of five impassioned neurologists whose patient-centric focus provides expert diagnosis, coordinated care and disease management for patients suffering with neurological disease. These specialists often serve as principal care providers for those living with chronic neurological impairment and their unique approach to patient care makes all the difference for their patients.

2014 will prove to be an historic year for the healthcare delivery system. Of particular significance is how healthcare systems and providers will be reimbursed. With a continued shift towards value-based health-care, we take a look at how one community hospital, RGHS proactively leads the charge.

With a focus on Cardiovascular Health & Wellness, the RGHS continues to expand access between affiliates, RGH and NWCH, to excellence in specialized cardiac care services to patients in Wayne County and well beyond. Through a thoughtfully designed and seamless delivery model, patients throughout the region are ensured convenient access to the world-class cardiac care synonymous with the Sands-Constellation Heart Institute right at their own community hospital in Newark-Wayne.

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

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

In good health –

Andrea

Andrea Sperry

Western New York
PHYSICIAN

THE LOCAL VOICE OF
PRACTICE MANAGEMENT AND
THE BUSINESS OF MEDICINE

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Bringing Hemodialysis to "a Different Kind of Home"

With the introduction of home dialysis to Hill Haven residents, RGHS is at the leading edge of patient-focused care

The ongoing evolution of skilled nursing facilities and senior care. The increasing need for dialysis services, driven by diabetes and other chronic conditions. And the migration of outpatient care from hospitals to more convenient community locations.

These three distinct health care trends converged with the recent opening of an on-site home hemodialysis unit at Hill Haven Transitional Care Center in Webster, an affiliate of Rochester General Health System (RGHS). Home hemodialysis services are growing in and of themselves, but Hill Haven is the first long-term care facility in New York State to make such a program available to its resident patients.

"It's still home hemodialysis – just in a different kind of home," says Marie Wade, director of dialysis services for RGHS. "This level of service isn't commonly offered in nursing homes, but we're doing all we can to expand how we can help our patients in need."

In the past, many Hill Haven residents with renal disease would receive peritoneal dialysis services, usually delivered every night while the patients were sleeping. But for those who preferred the three-days-a-week routine of hemodialysis, or whose underlying medical conditions made peritoneal treatments impossible, receiving hemodialysis meant being transported to an off-site outpatient facility. This would often require a stretcher or chairmobile, due to the patients' degrees of infirmity.

"For frail elderly patients, that transportation could be uncomfortable and even carry risks," says Terence Klinetob, administrator at Hill Haven. "And for rehab and short-stay patients – more of whom are coming to Hill Haven – traveling to another facility for dialysis means giving up valuable time that could be better spent on activities that would speed up their discharge.

"In both cases," Klinetob adds, "transporting them to the third-floor suite here at Hill Haven is naturally a lot quicker, easier and less stressful than taking them across town."

The rising demand for dialysis services has led RGHS to launch new service centers in various regional locations including Newark, Hill Haven in Webster and (pictured) Bay Creek Dialysis in Penfield.

The launch of this program is just one link in a larger chain of changes throughout RGHS. Driven by such external factors as the federal Affordable Care Act and reliable studies by leading industry analysts, a need has been identified to ensure that patients receive exactly the right level of care to address their specific issues, no matter what those issues may be. Patients who might previously have needed to stay in a hospital bed for

weeks or months are now increasingly able to move earlier to a facility like Hill Haven. Meanwhile, many patients who could once have stayed at Hill Haven for years are now able to return to their homes, where programs like RGHS's ElderONE can provide them with comprehensive medical services while they live independently.

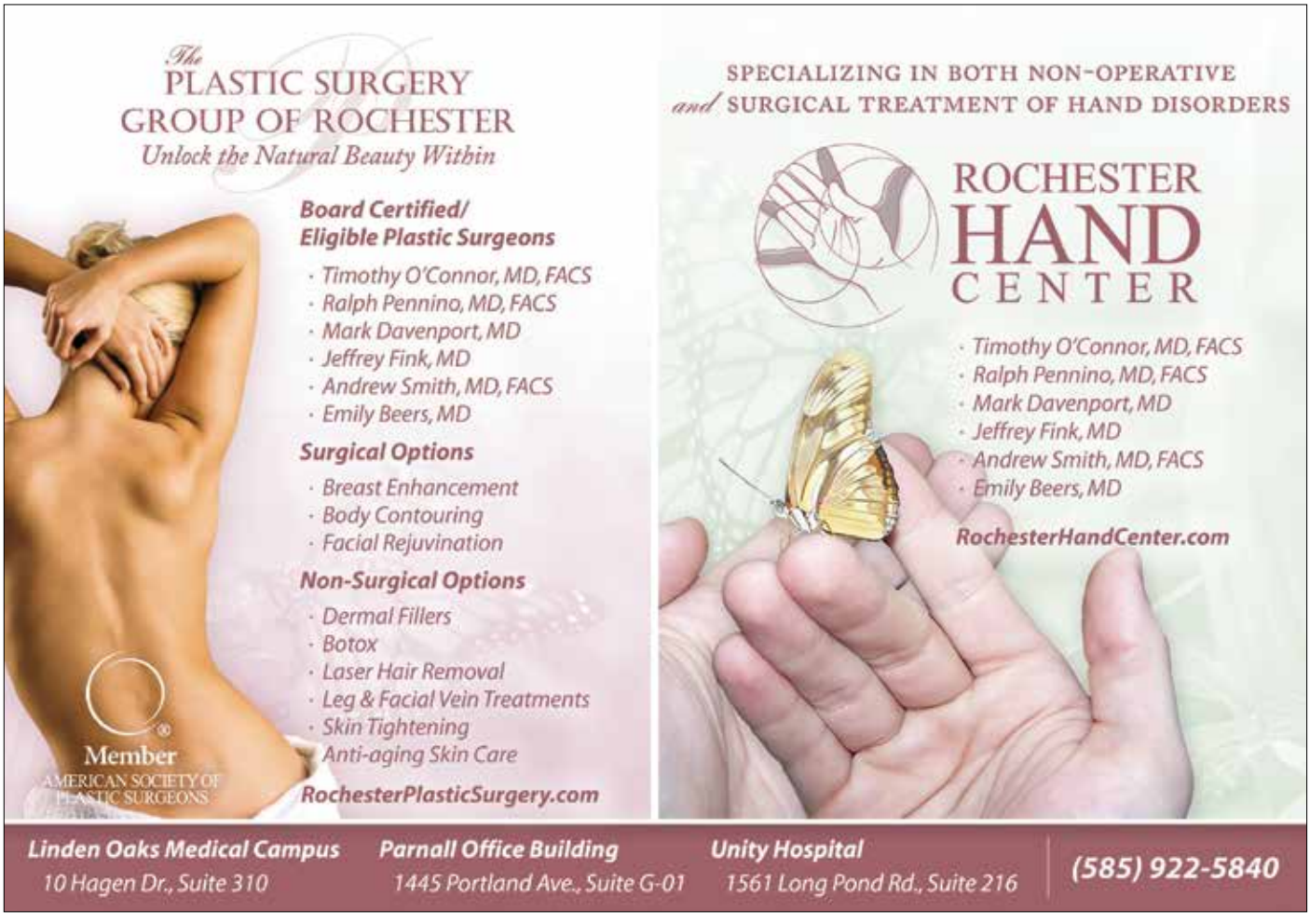
These shifts in the delivery of care are more economical than the former models, driving costs down without compromising care quality. And as patients naturally tend to prefer moving further away from a traditional hospital environment, their satisfaction increases with this new system-wide paradigm.

In addition to peritoneal and home hemodialysis, other advanced post-acute care services offered at Hill Haven include wound care, delivered with the aid of telehealth technology that remotely connects patients with surgical specialists; and round-the-clock respiratory therapist coverage. "Given the acuity of our patients, we know it's important to make sure they get the care they need, no matter when they need it," Klinetob says.

The growing demand for dialysis care isn't only reflected at Hill Haven. In 2013, the community's increasing need for this specific outpatient service led to RGHS opening new ambulatory dialysis facilities in Penfield and Newark, in addition to the Seneca Ridge dialysis station in Irondequoit.

Beyond the much-needed expanded availability of dialysis, these facilities are examples of a new industry-wide focus on ambulatory care that brings essential medical services – also including physical therapy, surgery, imaging and more – out into more diverse community locations.

"These services keep people healthier overall, so it's only logical to make patient access as convenient and cost-effective as possible," says Katherine Rogala, RGHS vice president of ambulatory care. "In the case of Hill Haven, the introduction of home hemodialysis represents a big step in improving the quality of life for some very frail individuals, and in helping rehab patients recover more quickly so they can return to active, healthy lives. It's a win-win for our health system, and for the community."



NEUROLOGY ASSOCIATES OF ROCHESTER

Thinkers, Evaluators and Coordinators of Patient Care

By Julie Van Benthuysen

Photo: Lisa Hughes Photography

"Neurology tends to be a very cerebral field, without a lot of fancy technology or procedures." It's about seeing and understanding the many nuances of each patient," says Dr. Ashanthi Gajaweera.

Since opening its doors more than 30 years ago, Neurology Associates of Rochester has maintained its guiding principle. "We are all of the mindset that patient-centric care works best for our patients," says founding neurologist Dr. Andrew Stern.

Over the years as the practice has grown, Dr. Stern has recruited his colleagues based on their special combination of smarts and personality. "Understanding the central nervous system is what excites us," says Dr. Ashanthi Gajaweera, one of the practice's five physicians who joined in 2003. "Neurology tends to be a very cerebral field, without a lot of fancy technology or procedures." It's about seeing and understanding the many nuances of each patient. "We have a reflex hammer," she jokes, "but that's not very sexy or glamorous. The tools we use tend to be our senses and our intuition."

Successfully managing neurologic disorders demands a comprehensive approach. As such, these five neurologists have advanced training in specific neurological conditions such as neuromuscular disorders, epilepsy and movement disorders. "Our patients benefit from this collective body of knowledge on a daily basis, because we often knock on the door of another doctor's exam room, and ask for a second opinion about a patient presenting with a challenging problem," says Dr. Stern.

All board-certified and fellowship-trained, this impassioned group strives to uphold a superior level of care by knowing each patient at a much deeper level. "We're highly trained, but at the same time we want our patients to experience a down-to-earth approach with which they can feel comfortable while confident that they are getting the best care possible," says Dr. Gajaweera. "This means that we don't use ancillary care providers, because we think it's important that all patients are managed exclusively by a physician." Every opportunity for interaction brings information that can be helpful in the diagnostic phase, treatment planning and thorough ongoing care. This begins with something as seemingly simple as the doctors greeting their own patients in the reception room and escorting them to a consultation room. For each of these doctor detectives, every detail is a valued and vital clue.

"We love the nervous system, and we bring that same approach to addressing patient needs compassionately," she says. From the moment a patient checks into the waiting room, the analysis begins. "As you shake the patient's hand, there is already much to be evaluated. Everything is considered, from the patient's eye contact, to how he or she gets up from a chair, even the appearance of their posture. "We can recognize subtle signs before the patient even enters the exam room," adds Dr. Anne Moss, who joined the practice in 1995 after co-directing the Neuromuscular Disease Center at the University of Rochester. "We can observe a tremor, recognize back pain or even the symptoms of migraine. We WATCH."

Initial patient interviews might last from 30 to 60 minutes, depending on the complexity of the issues involved. "How they stand up and sit down, how they navigate the turns on the way to the exam rooms, even how they speak, helps determine the diagnosis." The doctors pay special attention to the patient's current condition through a comprehensive neurologic exam of almost all new patients.

"It's like playing Sherlock Holmes," says Dr. Gajaweera. "We love to be masters of observation, gathering clues by asking questions in different ways to get a better understanding of the problem." Most patients, she acknowledges, don't realize what's important in the line of questioning. It takes time and patience to elicit all the right clues. "In today's pressured medical environment, we realize these are rare commodities for doctors to provide but that's what we aim to do."

Photo: Lisa Hughes Photography

"As you shake the patient's hand, there is already much to be evaluated. Everything is considered, from the patient's eye contact, to how he or she gets up from a chair, even the appearance of their posture. "We can recognize subtle signs before the patient even enters the exam room," says Dr. Anne Moss.

Treatment as Partnership

"Neurologic illness is so multi-faceted that Primary Care physicians look for us to help manage their patients' needs," says Dr. Stern. "We recognize the necessity of a solid working relationship with each patient's PCP." Disorders like Parkinson's or Alzheimer's disease and Multiple Sclerosis, for example, are not managed optimally by a PCP alone, he adds. "There are bound to be complications of disorders and their treatments that are more familiar to us than to non-neurologists"

These conditions often involve complex treatments difficult to alone by a Primary Care doctor. "One of our jobs is to demystify neurology," says Dr. Moss. "We try to go out of our way to communicate our availability in case of any questions. There may be signs that we can detect sooner and faster, so having that strong relationship is critical."

Neurologic symptoms tend to be scary," she adds. "Many patients have already Googled their symptoms and they might be terrified to even see a neurologist. Patients are reassured when they have a greater understanding of their symptoms. They

"Neurologic illness is so multi-faceted that Primary Care physicians look for us to help manage their patients' needs," says Dr. Andrew Stern.

typically feel much better when they leave our office than when they arrive. Because of our commitment to flexibility and accessibility, we're seeing more and more patients coming through our doors."

Dr. Erica Patrick, who joined the practice in 2012 with an emphasis on the use of EMG to diagnose neuromuscular disorders, also emphasizes the importance of collaboration. "Our aim is to assist our primary care referrers," she says. They might be with a patient, and can easily just pick up the phone and ask me what I think. If I believe it's a more pressing need, I can see the patient the same day. It's not about just sending a patient to a lab for blood work or an MRI. Collectively, we can address our patients' needs in the most individualized and efficient way."

once a month. The traditional medications which were available then were often associated with serious side effects. "This is often not acceptable these days. Similarly, we now know that MS care needs to start early in order to slow down disability and disease progression."

By taking a comprehensive approach, these doctors help patients find the optimal medication regimen. Within the past 15 years, conditions like these are being treated more effectively than ever before with better choices available. "Our job is to have a complete understanding of what novel treatments are available to our patients and share this information with patients and their primary care doctors so that these decisions can be made together."

Movement disorders and conditions like migraine also present opportunities for improved treatment. "These conditions are very burdensome to patients," he says, "but fortunately treatment options have also grown in recent years." The use of botulinum toxin injections has been shown to be very effective in treating a variety of neurological disorders such as chronic migraines, which affect about 20% of women and 10% of men. Patients who have at least 15 days a month with headache and have failed preventative medications are using Botox and are typically seeing about a 50% reduction in headaches over the course of a given month. While the cost of injections is relatively expensive, he adds, the short- and long-term benefits can far outweigh the price. "Otherwise, patients are relying on frequent use of triptans and other analgesics which often lead to exacerbation of headaches and more negative side effects." The lower quality of life and impact on job productivity can also be greatly improved through Botox injections.

Photo: Lisa Hughes Photography

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More Successful Treatment Options

Two serious neurologic illnesses – Multiple Sclerosis and Epilepsy -- continue to be under-referred, despite encouraging new treatments. "We make ourselves very accessible to patients who undergo a seizure or have an MS flareup because prompt care is vital to their health and prognosis," says Rochester native Dr. Ryan Evans. As recent as the 1990s, he says, it was considered normal for an adult onset epileptic patient to have a seizure

Botulinum toxin injections are also an invaluable aid for patients with dystonia or spasticity. Limb spasticity that limits daily function is relatively common after strokes or in diseases like MS. "A big portion of our population could benefit, but it remains significantly under-utilized. Blepharospasm and hemifacial spasm cause eye closure and facial twitching that can be significantly disabling but effectively treated with Botox. "Torticollis and other forms of dystonia lead to functional im-

pairments and social embarrassment," he adds. "Oral medications for these treatments are often ineffective and cause somnolence and other side effects. All of these conditions respond very well to botulinum toxin injections, but frequently go unrecognized, undiagnosed and untreated."

Parkinson's Disease patients are also benefiting considerably. "We often see patients five to eight years into their disease," he says. "They either have not been diagnosed, not told or simply not managed in any specific way." In some instances, the patient might have a sleep disorder or other non-motor Parkinson's related symptoms that have gone undiagnosed and untreated. "The encouraging thing is that Parkinson's is fairly treatable once it's diagnosed, which is incredibly empowering to patients if they know why they have been experiencing certain symptoms. Especially in the case of early-stage Parkinson's, he adds. "We can evaluate how much they sleep, what they eat and even how high their bed is off the floor. We have to learn the nitty gritty of their lives in order to best diagnose and treat them."

Adding Medical Acupuncture to Treatment Options

In keeping with the practice's comprehensive patient centered approach, Dr. Gajaweera recently trained with the Helms Medical Institute – the oldest Medical Acupuncture training program in the country and the program chosen by the U.S. Military to train its physicians. Dr. Gajaweera is trained in body, scalp and auricular acupuncture as well a neuroanatomical approach, which is relatively unique to her training.

"Training in acupuncture has added so much to the understanding of my patients," she says. "Being trained alongside military physicians who have used it on and off the battlefield was a tremendous opportunity to see the value of acupuncture. The elegant complexity of the nervous system is complemented by the non-linear understanding that acupuncture and Chinese Medicine provide. One does not contradict the other. When pharmacologic treatments prove limiting, acupuncture can often help."

Dr. Gajaweera's acupuncture practice focuses on pain management, neurologic issues and their associated symptoms. This includes treatment of facial pain and headache, lower back and neck pain, joint pain, neuralgias and neuropathy, promoting well being and stability in degenerative conditions such as MS or Parkinson's Disease and post-stroke rehabilitation. "I think I offer a very unique understanding of a patient's neurologic condition and can hence combine these two approaches to optimize their care and overall well being."

The Path of Neurology

The doctors express concern about the decreasing number of neurologists and decreasing reimbursements to neurology just as the demands in the population increase for neurologic services. As one of the "cognitive fields" of Medicine (Rheumatology and Endocrinology being the other two), it's their job to listen, examine and talk to their patients. "It's hard to increase our productivity without affecting our quality of care. That's just not something we are willing to compromise," says Dr. Gajaweera.

Moving forward, this dynamic group of neurologists hopes to see more focus on prevention and a more comprehensive view of patient care across all medical disciplines. "Our practice is blessed in that we have a strong academic interest in the field of neurology, yet share the guiding principles that Andy Stern set forth when he started the practice – to put patient care first. We feel quite passionately about the elegance and intricacy of the nervous system, but because we genuinely care about our patients' wellness, we appreciate and respect that they have entrusted us with their health," she says. "We take this responsibility very seriously, and our patients know it. I think most patients and referring doctors who work with us know that we love what we do – and we know we are a lucky bunch."

Photo: Lisa Hughes Photography

Patients who have at least 15 days a month with headache and have failed preventative medications are using Botox and are typically seeing about a 50% reductionin headaches over the course of a given month.

Telemedicine Brings Parkinson's Care to "Anyone, Anywhere"

A new study shows that a neurologist in an office thousands of miles away can deliver effective specialized care to people with Parkinson's disease. For individuals with the condition – many of whom have never seen a specialist – these "virtual house calls" could allow them to live independently while effectively managing the symptoms of the disease.

"The idea that we can provide care to individuals with Parkinson's disease regardless of where they live is both a simple and revolutionary concept," said URMC neurologist Ray Dorsey, MD, MBA, senior author of a study which appeared in the journal Neurology: Clinical Practice. "This study demonstrates that, by employing essentially the same technology that grandparents use to talk to their grandchildren, we can expand access to the specialized care that we know will improve patients' quality of life and health."

"Dr. Dorsey's work with Parkinson's disease patients exemplifies the type of forward-thinking, technology-driven innovation that the Verizon Foundation seeks to support," said Anthony A. Lewis, Verizon's mid-Atlantic region vice president of state government affairs. "Technology can equalize access to quality health care and bring much-needed services to chronically ill patients who may not otherwise receive such care because of geographic or financial reasons."

Ray Dorsey, MD

More than 40 percent of people with Parkinson's disease do not see a neurologist, placing these individuals at greater risk for poor health outcomes. For example, people with the disease who do not see a specialist are 20 percent more likely to fall and fracture a hip, 20 percent more likely to end up in a skilled nursing facility, and 20 percent more likely to die.

Geography is often a determining factor in whether a person with Parkinson's sees a specialist. Neurologists with training in movement disorders like Parkinson's disease tend to be concentrated in major academic medical centers. Additionally, the nature of the disease – particularly the impact on movement, balance, and coordination – can make a long trip to the doctor's office unfeasible.

"We have an ample supply of neurologists in the country to take care of people with Parkinson's, but because of distance, disability, and the distribution of doctors, many patients have a difficult time seeing a specialist," said Dorsey.

Working with PatientsLikeMe, the study invited individuals with Parkinson's who lived in the five states where Dorsey is licensed to practice medicine – California, Delaware, Florida, Maryland, and New York – to receive one free telemedicine consultation in the comfort of their own home.

The participants downloaded secure web-based video conferencing software developed by California-based Vidyo. The technology, which is akin to Skype, only requires an Internet connected computer and a webcam.

Using this system, Dorsey saw more than 50 people with Parkinson's disease, ranging from individuals who were getting a third opinion to those that were seeing a neurologist for the very first time. Virtually all of the visits resulted in treatment recommendations, including increasing exercise (86 percent), changes in current medications (63 percent), the addition of new medications (53 percent), and discussions about potential surgical options (10 percent). Patient satisfaction with the telemedicine care exceeded 90 percent.

Parkinson's disease particularly lends itself to telemedicine because many aspects of the diagnosis and treatment of the disease are "visual" – meaning that the interaction with the doctor primarily consists of observing the patient perform certain tasks such as holding their hands out and walking and listening to the patient's history.

"James Parkinson wrote the seminal description of the condition in 1817 by watching people walk in the park," said Dorsey. "This is just a 21st century application of that principal of observation."

The authors contend that this approach could also be ap-

plied to a number of other chronic conditions, from autism to Alzheimer's disease, from diabetes to congestive heart failure. Collectively, chronic conditions affect over 140 million Americans and are responsible for 84 percent of health care expenditures.

While demonstrably effective, one of the key barriers to the wider adoption of this approach is the fact that Medicare does not pay for telemedicine care provided to people in their homes. Also, out-of-state physicians are barred from providing remote care to patients in many states.

These barriers prevent the potential savings – both in terms of cost and time – that can be realized by care delivered via telemedicine. A previous URMC study showed that not only did telemedicine visits cost less than providing care in a traditional setting such as a clinic or a hospital, but the virtual house calls saved patients an average of more than three hours and 100 miles of travel per visit when factoring in travel to and from the doctor's office.

Dorsey and his colleagues are now extending the program with the support of the National Parkinson's Foundation and support from the Patient Centered Outcomes Research Institute. The new study, called Connect plans to enroll approximately 200 individuals with Parkinson's disease beginning next year. Participants will either receive their usual care from a physician in their community or additional remotely-delivered care from a Parkinson's disease center of excellence in their state.

"This research demonstrates that we can reach anyone, anywhere with a given condition," said Dorsey. "If we can successfully remove the barriers to telemedicine, this approach will ultimately allow more patients with Parkinson's disease to live independently in their homes, while getting the care they need."

Making Changes to the Medical Record

Question: My practice manager and I disagree on how I should make changes to the patient chart. How do I determine the correct method?

Answer: Besides being important for patient care, and to defend against legal challenges, using the right method when making changes to the patient chart is critical should your records be subject to subsequent audit. The Centers for Medicare & Medicaid Services (CMS) earlier this year published information about amendments, corrections and "delayed entries" into the medical record. CMS acknowledged that, occasionally, upon review a physician may discover that certain entries, related to actions that were actually performed at the time of service but not properly documented, need to be amended, corrected, or entered after rendering the service. CMS goes on to say that, when making review determinations, the MACs, RACs, ZPICs and CERT will consider all submitted entries that comply with what CMS refers to as "widely accepted recordkeeping principles." (If the above acronyms are unfamiliar to you, see: http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html and click on your state.)

What are those widely accepted recordkeeping principles, according to CMS? Whether the document is a paper record or an electronic health record, documents submitted to CMS containing amendments, corrections or addenda must:

1. Clearly and permanently identify any amendment, correction or delayed entry as such;
2. Clearly indicate the date and author of any amendment, correction or delayed entry; and
3. Not delete but instead clearly identify all original content.

Paper Medical Records: When correcting a paper medical record, these principles are generally accomplished by using a single line strike through so that the original content is still readable. Further, the author of the alteration must sign and date the revision. Similarly, amendments or delayed entries to paper records must be clearly signed and dated upon entry into the record.

Electronic Health Records (EHR): Medical record keeping within an EHR deserves special considerations; however, records sourced from electronic systems containing amendments, corrections or delayed entries must:

- **a.** Distinctly identify any amendment, correction or delayed entry; and
- **b.** Provide a reliable means to clearly identify the original content, the modified content, and the date and authorship of each modification of the record.

The MACs, RACs, ZPICs and CERT will not consider any entries that don't comply with the above principles, even if excluding the entry would lead to a claim denial. For example, they will exclude from consideration any undated or unsigned entries handwritten in the margin of a document. If they identify medical documentation containing what they consider to be potentially fraudulent entries, the reviewers shall refer the case for further scrutiny.

If you are concerned about a document request from any payor, please contact our Managing Partner, Michael J. Schoppmann, Esq at 1-800-445-0954 or via email at MSchoppmann@DrLaw.com.

THYROID NODULES

Identification and Treatment

K. K. Rajamani, MD

Thyroid nodules may be found in approximately 30 percent of adults; however, fewer than 10 percent of nodules are cancerous. The incidence of thyroid cancer in the United States has been increasing by more than 6 percent annually. This increase is probably due to a combination of improved detection and environmental factors. In 2013, it was expected that more than 60,000 people in the United States would be diagnosed with thyroid cancer.

Many thyroid nodules are discovered by a patient's primary care provider or gynecologist, or occasionally by a patient's dentist during the course of a neck examination. Nodules are often detected when a patient undergoes a diagnostic test such as a CT or MRI scan of the neck for an unrelated condition. These are often small nodules that are not felt at the time of a routine examination of the neck.

The usual evaluation of a thyroid nodule starts with neck ultrasonography. An experienced radiologist can evaluate features of the nodule and also see how many nodules there are in the thyroid gland. The nodules are then sampled through a procedure known as a fine needle biopsy, in which a tiny needle is introduced into the nodule and a sample of material is obtained for evaluation. An experienced pathologist then examines this material and the pathology report is used to differentiate benign from cancerous thyroid nodules.

The time from the discovery of a thyroid nodule to a definitive diagnosis is often measured in weeks or months.

The time from the discovery of a thyroid nodule to a definitive diagnosis is often measured in weeks or months. This waiting period can be anxiety-provoking for many patients. The Unity Thyroid Center can reduce this time by coordinating the services of an endocrinologist, radiologist, and pathologist. Patients seen at the center usually know the same day or the next day if their nodules are benign or require further evaluation or surgery.

In spite of the expertise and experience of the medical team evaluating patients with thyroid nodules, the diagnosis may not be definitive in some patients. Treatment of thyroid cancer involves neck surgery followed possibly with radioactive iodine treatment. Neck surgery carries risks including injury to the nerves that control vocal cords and the voice. The ability to accurately determine whether a nodule is benign or malignant is therefore very important. The Unity Thyroid Center uses additional genetic and molecular testing to see if a particular nodule carries changes suggesting that the nodule may be cancerous. Patients evaluated in this way could potentially avoid surgery and its possible risks. If testing detects the presence of genetic or molecular changes suggestive of cancer, this information can guide appropriate treatment of the thyroid cancer. For patients with a definite or possible diagnosis of thyroid cancer, coordination between the endocrinologist and an experienced surgeon ensures timely management, with surgical consultation in one to two days, and scheduling of surgery within one to two weeks, or as the patient's schedule allows.

The Unity Thyroid Center brings together a team of experienced specialists including radiologists, pathologists, endocrinologists, surgeons, and radiation oncologists. This team of specialists works with the patient's primary care provider to create a personalized treatment plan for each patient.

Most patients with thyroid nodules and thyroid cancer, with appropriate treatment and follow up, are able to lead normal lives. The Unity Thyroid Center's aim is to help them do just that.

Unity Diabetes & Endocrinology Services is led by Dr. Rajamani is an Endocrinology specialist certified by the American Board of Internal Medicine with a subspecialty in Endocrine-Diabetes-Metabolism. He received his MD from Christian Medical College in India and completed residencies at Christian Medical College and Cleveland Metropolitan General Hospital. Dr. Rajamani is affiliated with the American Diabetes Organization and has been with Unity since 1994.

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The St. Luke's Health System Case

Is this the Death Knell of Integrated Care?

Carol Maue, Esq,
Boylan Code, LLP

JUDE B. LYNN WINMILL, CHIEF UNITED STATES DISTRICT JUDGE for the U.S. District Court for the District of Idaho, rendered a controversial decision on January 24, 2014 that has broad implications for the integration of medical services in the United States as health care payors and providers attempt, in the wake of the Affordable Care Act's directives and in Judge Winmill's words:

> **"[to move] away from the "fee-for-service health insurance reimbursement system that rewards providers , not for keeping their patients healthy, but for billing high volumes of expensive medical procedures" and instead to "focus on maintaining a patient's health and quality of life" by "rewarding successful patient outcomes and innovation and encouraging less expensive means of providing critical medical care. Such a system would move the focus of health care back to the patient where it belongs."**

The facts of the case are straightforward. Like many other hospital systems across the United States, St. Luke's Health System began systematically purchasing independent physician groups to assemble a team of professionals committed to practicing integrated medicine, where compensation depended on patient outcomes rather than the revenue generated from fees charged for particular services. St. Lukes is a large hospital system that operates several hospitals and health care clinics throughout the Treasure Valley area in Idaho.

In Nampa, Idaho, St. Luke's acquired the Salzer Medical Group, a primary care physician practice group with 40 primary care doctors on staff, the largest local primary care medical practice. At issue was whether the acquisition was anti-competitive and violated the Clayton Act and the Idaho Competition Act, anti-trust statutes enacted to prevent monopolies.

"anti-trust laws " require the Court to predict whether the deal under scrutiny will have anticompetitive effects"

The action was commenced by the Federal Trade Commission and several of St. Luke's competitors, all of whom asserted that the acquisition would have a chilling effect on competition among primary care doctors while providing St. Luke's with increased bargaining power to demand higher payments from health insurance plans, resulting in higher insurance costs and higher costs to patients. Accordingly, the FTC and the hospital Plaintiffs requested the Court "to unwind the deal."

However, St. Luke's and Salzer contended that the "intended goal" of the acquisition was not to squelch competition. Rather, its primary purpose was to allow the combined entity to provide integrated health care, improving not only the delivery of health care in the area, but patient outcomes as well.

To the surprise of many familiar with this rapidly changing health care arena, Judge Winmill agreed with the FTC and the hospital Plaintiffs and ordered St. Luke's to unwind the transaction and to divest itself of the Salzer Medical Group.

Judge Winmill noted that the anti-trust laws "require the Court to predict whether the deal under scrutiny will have anticompetitive effects, stating, "[t]he Court predicts that it will." While the Court praised St. Luke's for its "foresight and vision" in anticipating the "major shift some time ago … away from our fragmented delivery system and toward a more integrated system where primary care physicians supervise the work of a team of specialists, all committed to a common goal of improving a patient's health," he none the less held that the likely outcome of the merger was that "health care costs will rise as the combined entity obtains a dominant market position that will enable it to

(1) negotiate higher reimbursement rates from health insurance plans that will be passed on to the consumer and

(2) raise rates for ancillary services (like x-rays) to the higher hospital billing rates."

The Court also noted that if the merger were left intact, it no doubt would have the salutary effect of improving patient outcomes given St. Luke's "sterling reputation" and applauded St. Luke's for its "efforts to improve delivery of health care in Treasure Valley" but ultimately held that "there are other ways to achieve the same effects that do not run afoul of the anti-trust laws and that do not run such a risk of increased costs."

Presumably Judge Winmill was referring to the use of other, contractual strategies such as joint ventures that do not result in a combined entity with single ownership. The decision does seem to suggest, however, that an "accountable care" model for the delivery of health care services may not pass judicial muster, at least not in Idaho, notwithstanding the directives of the Affordable Care Act. Indeed, given the recent spate of acquisitions by Tenet Healthcare Corp. that to date have raised no anti-trust eyebrows, it remains to be seen if this decision will stand. Last October, Tenet, a Dallas Texas hospital conglomerate, acquired Vanguard Health Systems and its 28 hospitals in Nashville, Tennessee and Chicago Health Systems Inc., a hospital system with 1,000 affiliated physicians and 100 physician-employees in a deal with a multi-billion dollar price tag. St. Lukes and Salzer have stated that they will appeal.

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[1]See, *St. Alphonsus Medical Center, Nampa, Inc. et al v. St. Luke's Health System, Ltd.*, Salzer Medical Group, P.A., 2014 U.S. Dist. LEXIS 9264 (D. Idaho January 24, 2014)
[2]St. Alphonsus Medical Center v. St. Luke's Health System, Ltd, page 5
[3]St. Alphonsus Medical Center v. St. Luke's Health System, Ltd, page 5
[4]St. Alphonsus Medical Center v. St. Luke's Health System, Ltd, page 6
[5]St. Alphonsus Medical Center v. St. Luke's Health System, Ltd, page 6

Address Change?

If you are a new doctor in town or have recently moved your office - Email the change of address to continue receiving your copy of Western New York Physician.

WNYPhysician@Gmail.com

Computers, Software and Related Expenses Can be a Sales and Use Tax Nightmare

Eileen C. Semmler, CPA

From computerized medical imaging and diagnostic tools to practice management solutions, the practice of medicine has become increasingly dependent on computer hardware, software and support services. These products and services have many benefits in the delivery of quality care and efficient practice management but they may also create a serious headache in a New York state sales tax audit. Many vendors are not located in New York State so they may not be required to collect sales tax here. Others may not be fully aware of the rules and so may not charge sales tax correctly. That leaves the customer, your practice, with the obligation to calculate and pay use tax on taxable property and services purchased. Sales tax audits have increased dramatically in recent years and interest can add thousands of dollars to an assessment. Penalties may also be assessed so it is important to learn the rules to protect your practice.

In general, prewritten computer software ("canned" software) is considered tangible personal property subject to sales tax regardless of the means by which it is conveyed to a purchaser. An outright purchase of canned software is clearly taxable but the right to access and use a vendor's software online has also been ruled taxable by Commissioner of Taxation and Finance in numerous advisory opinions. With respect to a license to use software, a transfer of possession has occurred if the customer obtains actual or constructive possession, or if there has been "a transfer of the right to use, or control or direct the use of the software". Any right to alter content, by entering data for example, is considered constructive possession so the fees charged for the right to use the software are subject to sales tax.

Prewritten computer software is software that is not designed to the specifications of a specific purchaser. Computer software that is designed to user specifications (custom software) is not subject to sales tax.

Your software provider may provide additional services along with the software, such as training, consulting and customer support. These services are not subject to sales tax. However, if these services are not separately billed, sales tax will be assessed on them. The charges must be reasonable and separately stated to be exempt from sales tax. Since many vendors bundle their services into one lump sum, you will need to request itemized billing to avoid paying sales tax on nontaxable services.

In addition, services that would otherwise be taxable, such as installation or maintenance are exempt from tax where performed on computer software. However, where such services are sold in conjunction with the sale of prewritten software or other tangible personal property, the charge for such services is exempt only if it is reasonable and separately stated on the invoice or billing statement. Again, request itemized billing from your vendors.

Monthly or periodic charges for software maintenance and support are also exempt from sales tax. However, if software updates are included in the fee charged, the entire fee will be subject to tax. Your vendors need to separately state the price for exempt services.

Of course, computer hardware and related installation, servicing and repairs are subject to sales tax. However, charges for the initial installation, configuring and servicing of network operating software are not subject to sales tax if separately stated on the invoice.

A sales tax audit looks at three general areas; sales, purchases and capital items. Generally a medical practice audit will focus on purchases and capital items. Some areas besides computers, software and support where auditors have been particularly successful are; purchases of equipment outside of New York State and the purchase of medical equipment and supplies for use in the office of a provider who receives compensation for medical services provided (yes, those bandages are taxable.). In both cases vendors may not charge sales tax so the purchaser is responsible for use tax on the purchase.

If you receive notice of a planned sales tax audit by the Department of Taxation and Finance, I recommend you contact your accountant for assistance. They can help you to navigate the complex sales tax rules and avoid costly misunderstandings between you and the auditor. For now, have your office staff review your purchase invoices and request the necessary detail from software vendors where they have not provided it on their invoices to reduce your potential liability, ask medical supply vendors to charge you sales tax to simplify your internal accounting and file your sales and use tax returns paying any use tax still outstanding. The sales tax audit then goes from nightmare to annoying dream!

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Italian-Style Meatballs?

Understanding and Removing Hoax Viruses

by Marc-Anthony Arena

Like those wholesale packages of Italian-Style Meatballs, today's topic is Nigerian-Style Hoax Viruses. They're not always from Nigeria, but they're different from the traditional viruses Mama used to make.

Traditional viruses were tiny pieces of malicious software code that replicated themselves from machine to machine. Customers who call me with a slow PC (mistakenly) think they have a virus, when most of the time it's their antivirus program acting paranoid. Indeed, even your average computer guys still think a virus is the only threat, when in reality there's so much more out there. (Imagine if one of your colleagues blindly prescribed antibiotics to everyone, including those with influenza or a broken bone.)

The Internet has always been plagued by scams. The first style of scam was the 419 scam, where you receive an email allegedly from a Nigerian prince, asking if you could take some loot off his hands. Wasting the scammers' time has also become an art form, and web sites like 419 Eater document the fun.

Other scams include "Help I'm trapped on vacation please wire me some money", as well as Phishing, where an email leads you to an impostor banking website that records your username and password.

Nigerian-Style Hoax Viruses, also known as scareware, rogue security software, or hostageware. These are structurally different from regular viruses. EVERY Microsoft Windows user is vulnerable to them, and there is NO KNOWN SOFTWARE to prevent these attacks.

You start out by either:

- using Google Image Search
- clicking on a link within an email that imitates a bank or shipping company
- clicking on a window that claims you need a Flash plugin to play pirated content on the Web

Then, something goes wrong: A window pops up claiming you have 12,000 viruses and must type in your credit card number to be rid of them…

You have received a Hoax Virus. 99% of the time, they only affect ONE user account on your PC. (If you have Sally and Bobby and Jimmy accounts, only one is affected.)

Antivirus software is completely helpless. (That's why I believe ALL antivirus, antispyware, and cleaning programs are unnecessary, with exception of Microsoft Security Essentials.)

Examples

Again, a fake virus scan window shows up, then scares you into paying them money. Note how they look eerily similar to popular programs (or Windows itself).

Most of the time they'll:

- include misspelled words
- "detect" an outlandish number of viruses, and
- won't let you launch ANY PROGRAM.

They usually have pretty shady names, like:

- XP Antivirus 2012
- Vista Security Pro 2010
- Spyware Protect 2009
- Internet Security 2010
- Antivirus Security 2013
- Win 7 Defender 2013

These things hold your computer hostage and promise to clean the nonexistent viruses if you type in your credit card number. If you do this, they will steal your credit card number, and subsequently your identity. In that case, call your credit card company and tell them you've been scammed. Even the police can't do much.

The first generation also HIDES your files, leading you to believe they're gone, when in reality they're not. The second generation doesn't cause as much damage, for whatever reason.

The THIRD generation is a whole different ball game. These don't pose as antivirus programs, but rather as THE FBI ITSELF:

- They take over your whole screen and you can't get out
- they claim they've caught you looking at pornographic content
- and that the FBI wants you to pay them some sort of indulgence:

Regardless of what you were doing when they catch you, these guys are out to scare you, and they want your money.

They're a bit smarter than the credit-card-seeking ones, because these ask for a Moneygram or similar service as opposed to a credit card.

Many of these will also TURN ON YOUR WEBCAM (they probably don't record you) just to scare you even more.

Again, DO NOT PAY THESE PEOPLE.

It's all poker, really. There's nothing to be afraid of. These babies can't spread and everything they claim (you have 12,000 viruses, or the FBI wants you) is false.

Removal

Let's say you get one of these and realize it's not legitimate. You call your aunt's uncle's cousin's neighbor's pastor's ex-wife's goldfish's golf partner. They come over and spend the next 3 days trying to install some cleaning software, which won't work. Maybe you then brought it to a computer store, and those guys erase your entire machine because they don't know any better. (Worse yet, one customer brought hers to an office supply store, whose geeks started replacing parts in her machine! Have you ever given someone with the sniffles a liver transplant?)

There are also sites out there that claim to offer free downloads or "certified" telephone support, all of which are scams.

This isn't a simple issue to fix. Mine is the only shop I know of that employs highly advanced Mint technology to deracinate these things, and one of the very few in town that can do so while preserving your data.

Why they do it

Why not? It's extremely cheap to cast a net out onto the Internet and grab one or two identities.

It's also absurdly easy. Microsoft Windows is innately vulnerable to Hoax Viruses, antivirus companies cannot prevent them, average computer professionals don't know much about them, and consumers are fooled by them.

Prevention

The answer's the same as usual: Only users of Microsoft computers are vulerable. If you must use one, browsing with Firefox is remarkably safer than Internet Explorer. Ask me about my Mint software for bulletproof home computing.

About the author: Marc-Anthony Arena is founder and President of Teknosophy, LLC in Rochester. His company focuses on on protecting its customers from viruses, toolbars, online scams, and nag-ware. He is also the host of "The Computer Exorcist Show" on WYSL radio 92.1FM, and teaches computer self-defense classes at Perinton Community Center. You can reach him at 789-1856.

Clinical Integration Success

NWCH and RGHS Expanding Cardiac Expertise

by Julie Van Benthuysen

As the government and insurance companies continue to shift reimbursement to value-based healthcare, Rochester General Health System is proving once again that clinical integration across an entire health system works. In recent years, Newark-Wayne Community Hospital (NWCH) has increased its commitment to providing a wider breadth of specialized services to its rural patient base. As affiliates of Rochester General Health System, NWCH and Rochester General Hospital have been working in continued partnership to ensure quality, efficient and affordable delivery is being realized through thoughtful integration and seamless access to specialized services across Wayne County and beyond.

Photo: Jeff Blackman

The power of clinical integration. Dr. Ronald Kirshner and Dr. Senthil Natarajan working together to provide the best care to patients.

Since 2007, NWCH has been integrating its health care delivery system with RGHS through the steady expansion of key clinical services. More than 150 physicians have been added at the community hospital during these past seven years. This month, NWCH formally celebrates the renaming of its clinically integrated cardiac program. Established several years ago, its cardiac facility will now be considered an extension of the Sands-Constellation Heart Institute founded at RGH in 2011 and since integrated within the entire health system. NWCH's cardiac patients have been receiving the expertise of the system's nationally-recognized programs and providers, including RGHS's state-of-the-art clinical and EMR Technology.

"The Affordable Care Act is demanding consistent standards of care throughout entire regions, regardless of what specific hospital you go to," says Dr. Senthil K. Natarajan, Chief of Cardiology at NWCH and a RGH cardiologist. "RGHS has already been following this path for years. By clinically integrating our cardiac services at NWCH, we've expanded the population of patients that can benefit from an outstanding heart program." By committing RGH's same level of exceptional care at NWCH, he says, patients can now receive cardiac care at their own community hospital. Care is informed by the same training, policies processes and in many cases, the same physicians as are used at RGH. From East to West towards RGH, patients in Williamson, Macedon and other towns within a reasonable small town distance can come now come to NWCH with their cardiac needs.

The Emergency Department cardiac processes and process times at RGHS have been consistently exceptional, making it the logical choice for emergency cardiac cases — even for patients located at the fringes of its traditional patient area. The Heart Institute's approach to cardiac care has been proven to result in fewer complications, faster recoveries and longer, healthier lives for its patients. The Sand-Constellation Heart Institute's highly skilled cardiologists and heart surgeons have an expert understanding of leading-edge cardiac care including cardiac tests and heart screenings, cardiac catheterization, heart

and thoracic surgery and cardiac rehabilitation. With heart disease remaining the nation's number one killer, having localized heart health care that might require specialized services is critical – whether its high blood pressure, coronary artery disease, stroke, angina, heart attack, congestive heart failure or congenital heart defects.

This exceptional approach has not gone unnoticed. RGHS is the only area health system to be nationally rated by SDI – a premier health care analytics firm – as a TOP 100 Integrated Health Network (2007-2012). Integrated care networks are consistently recognized for delivering higher levels of quality, service, patient safety and efficiency. The Sands-Constellation Heart Institute has been recognized nine times as a Thomson/Solucient Top 100 Cardiovascular hospital. According to the 2014 report from CareChex®, a division of Comparion Medical Analytics, RGH ranks first in New York for Cardiac Care and Heart Attack Treatment and #2 in New York for Overall Medical Care.

As an electrophysiologist at Rochester General, Dr. Natarajan works closely with a patient to test if their heart's electrical signals are working and checking for abnormal heartbeats or heart rhythms. Maintaining a private practice at Westfall Cardiology with offices both in Newark and close to the city, Dr. Natarajan sees the clinical integration of cardiac services as a critical element in delivering consistent, high-quality care to the regional community. "Our goal is to bring the same standard level of care to our patients at NWCH. By integrating the SCHI model to include hospitals like Newark-Wayne as well as Rochester General, patients from the farther reaches of our region greatly benefit."

Having the same physicians available at both hospitals is an important way of delivering consistent care to Newark-Wayne patients. "Our pulmonary doctors are here every day," he says. RGHS has also strongly supported the recruitment of physicians to the area in targeted service lines and provides direct support and access to services in key areas that will strengthen the hospital's ability to deliver the highest-quality, most compassionate care. "We're adding more subspecialties all the time out here, which makes for a stronger local community as well."

Particularly with non-urgent issues, the comfort level associated with having the same doctors is considerable. Since the SCHI program was integrated throughout RGHS, "patients who are not critically ill have more options. They can have their follow-up handled locally, eliminating the need to travel to the city and the stress that sometimes goes along with that." Since integration began, Emergency Room volume at NWCH has also grown. "We have a large base of referring physicians, and we're adding new patients from as far east as Syracuse," he says.

RGHS has also strongly supported the recruitment of physicians to the area in targeted service lines and provides direct support and access to services in key areas

Another important component to clinical integration is the recognition of the needs of the region's aging population. "God forbid if an 85-year-old patient can't get to the hospital promptly for a cardiac issue," he adds. Being far closer to home means easy access, with convenient, free parking. In Newark, many patients live within walking distance of the hospital.

From a facility standpoint, everything has become more consistent with RGH. The hospital has renovated an entire floor to model that of RGH. "It's the continuity of the brand — having everything look and feel the same – with far more amenities and a more inviting environment," he says. "We want patients to feel like they are in the cardiac unit of a large hospital, with all the benefits that go along with it."

For those in Cardiac Rehabilitation, the Sands-Constellation Heart Institute makes for a far better healing process and supports longer-term, positive results. NWCH's Cardiac Rehab program is an exercise and education program designed to assist people who have recently experienced a heart attack, angioplasty, bypass surgery or who have been repeatedly diagnosed with stable angina, lower their risk factors for another cardiac event.

Maintaining consistent standards of care across the Western New York region will continue to be a top priority for RGHS. Its dedicated approach addresses the economic realities that hospitals face under the demands of health care reform, while ensuring patients have an immediate gateway to the best clinical care, regardless of where they live.

The Doctor as Proctor

Considering the Legal Implications

John R. Valvo, MD

By Dr. John R. Valvo, Director of Robotic Surgery, Rochester General Hospital and Dennis Gruttadaro, Attorney for Brown, Gruttadaro

Technology has come late to healthcare. Even as incredible new techniques and instruments have been introduced in recent years, patient safety and physician experience dictate when these new approaches can be introduced most effectively. Third-party insurers have been notoriously slow to reimburse for state-of the-art treatment, even when clearly the "new" state-of-art far exceeds the "old."

Robotic surgery represents a striking example of the introduction of new technology introduced into the medical field. Back in 2000, only 1,000 robotic surgeries were performed worldwide. (1) By 2011, that number soared to 36,000, and by 2012 to 450,000. Despite overwhelming growth, most surgeons today still need to retool their skills to learn robotic surgery. With the simultaneous emergence of enabling technologies and surgeons capable of utilizing them for better patient care, re-education is critical.

In some respects, physicians have themselves to blame for being slow to adopt new skills required to treat old conditions better. Surgeons have often approached teaching with a "see one, do one, teach one" philosophy. Not so today. Hospital credentialing committees and patients require physicians to demonstrate proficiency in their surgical approaches. Unfortunately, few experienced surgeons are available to teach new procedures. The learning curve for many new surgical skills is varied due to the task and instruments involved, and acceptable results may also vary. In most cases, the transition goes successfully but occasionally untoward complications develop, which put everyone in the operating room at risk.

Credentialing a new skill for hospital privileges often requires a Proctor experienced in the surgical procedure or instrument the novice wishes to employ. While proctors are relied upon to advance technology, they unwittingly put themselves in the crosshairs of a physician-patient relationship.

Are You Covered?

Consider this typical scenario. A local representative from Brazen Technologies contacts you. The company recognizes you as an expert in the use of one of its devices. You agree to proctoring for a colleague, Dr. White. The rep asks you to review the patients' records and speak to them about the upcoming surgeries. He asks you to be prepared to scrub in if necessary and to expect Dr. White to contact you to discuss the approach and any recommendations. He confirms that reimbursement will come directly from Dr. White, not Brazen. All necessary contacts will also be emailed to you.

In this scenario, your actual medical malpractice policy may not cover you as the Proctor. Similarly, the physician who hires you as Proctor may not be covered for the acts of Proctor in this case. For review are two medical malpractice policies with some prevalence in the Rochester community that provide coverage for acts involving "Professional Services." One policy describes Professional Services to include among other things, medical, surgical, dental, osteopathic, podiatry, psychological or nursing treatment or services. (2) Another policy describes Professional Services as "acts which an Insured performs in the course of treatment of a patient in your or the professional entity's medical or surgical practice." (3)

The potential issue for the Proctor is the physician-patient relationship. As noted, the first policy suggests the need for medical or surgical treatment or services in order to be covered as a Proctor. The other suggests the need to perform treatment on a patient in your own or your entity's medical or surgical practice. Conversely with the Proctor, coverage could become an issue, especially where it can be said the Proctor is not providing surgical services. More typically, the patient case in need of Proctoring falls outside the Proctor's own practice. Taking the position that coverage is necessary because medical or surgical treatment was being provided clearly suggests that the Proctor's role is beyond that of observer and more in line with treatment.

What to Do?

As with other aspects of medicine, communication is critical before undertaking the role of Proctor. If asked to Proctor outside your typical hospital system, it is routine to establish to the hospital that you have medical malpractice coverage before being allowed into the OR as a Proctor.

In this scenario, the Proctor should not just confirm coverage, but confirm coverage for a proctored case. Simply calling and receiving a letter that you have malpractice coverage with the limits requested may not be enough. It's important to fully explain to your carrier why that letter certifying coverage is necessary and communicating that it is to act as Proctor. By doing so prior to the case, you can safely proceed knowing your carrier understands, should that coverage ever become necessary. In the event that your malpractice carrier doesn't provide coverage, the receiving hospital and/or surgical company may be willing to provide the necessary coverage for the Proctor case. In some, while proctoring is important to the advancement of surgery and medicine, your personal exposure needs attention and protection and you will want to ensure that you are covered should that need ever arise.

Lawsuits Involving the Proctor and the Physician-Patient Relationship

One generally thinks of a Proctor as an observer, like someone overseeing an exam. (4) In the hospital or medical setting, the Proctor is pres-

ent to observe that the proctored surgeon's approach to care and proper handling of equipment is appropriate. The Proctor is not a preceptor. Preceptorship is generally a form of training whereby an experienced physician provides expertise to a novice learning physician by supervising the procedure, providing feedback and an actual hands-on approach. A preceptor can actually provide the care and take over procedure if the situation warrants a higher level of expertise.

That's not generally the case as it as relates to the Proctor. However, as with other aspects of medical surgical treatment and care, not all Proctors are the same and just observe. Some Proctors may be actively involved from as early as the patient consent process through post anesthesia care. Others may not see the patient until the patient is anesthetized, and leave before the patient awakes. During the procedure, the Proctor may respond to questions about the equipment use or approach without directly participating in the medical decision-making process.

Ultimately, the Proctor reports findings to the governing body that evaluates the physician or surgeon in question, and may provide recommendations for further instruction or proctoring. This can be done verbally or more commonly in written form. Because of these differences in the Proctor's role and involvement, caution is advised. The Proctor and proctor team must have sufficient knowledge of their legal exposure vis-a-vis the patient, the proctored physician, the hospital where the proctoring takes place and the manufacturer of the instrument for which proctoring is necessary.

There is a dearth of law in New York, and nationwide, in terms of the legal duty. There is no applicable New York appellate case which speaks to the relative legal responsibilities and duties of the Proctor to the patient, the Proctor-physician to be proctored or the hospital. There is one California case, Clarke v. Hoek, which provides guidance on how New York might handle a lawsuit involving a Proctor. (5) We can also look to New York's treatment of telemedicine as a means to review the role of Proctor because ultimately, in Clarke v. Hoek, the legal (5) responsibility in every situation for the Proctor is governed by the presence of lack of physician-patient relationship.

In the Clarke case, a patient brought a lawsuit against the physician who proctored two surgical procedures performed by another physician. The Proctor acted on behalf of a hospital's credentialing committee. His role was to assess and report on the competence of the proctored surgeon. Prior to both surgical procedures, the Proctor reviewed the radiologic studies and operative plan. Other than the procedure itself, the Proctor took no part in the patient's care and treatment. During the actual procedures, he did not participate in the surgery nor was he asked to do so by the proctored physician or any operating personnel in the hospital's credentialing committee. Testimony indicated that the Proctor did not believe any such intervention was warranted for either operative procedure. He was not scrubbed in for the proctored cases and simply observed them from outside the sterile field. The Proctor never met the patient until well after the proctored procedures (for unrelated reasons) and did not expect, request or receive payment from any source for the proctored procedures. The patient claimed she was injured as a result of negligence of the Proctor and the proctored surgeon.

The Proctor sought dismissal of the case on the grounds that he owed no duty of care to the patient as a medical Proctor and that no physician-patient relationship existed between them. The trial judge dismissed the case and on appeal the decision was affirmed. The California Court of Appeals stated that "proctoring plays an essential role in maintaining the professional competence of hospital medical staffs and therefore, in fulfilling the affirmative legal responsibility of hospitals to screen the competency of members of their medical staffs on a regular basis, the role of the individual Proctor is not to supervise; it is simply to observe and report." (6) The California Appellate Court essentially reviewed the factors and decided that this particular Proctor, through his actions or inactions, did not create a patient relationship for which a duty to that patient would arise.

One would expect the New York courts to also review the physician-patient relationship law to determine whether the Proctor had a duty to the patient, and hence be liable in the event of litigation. New York has likened the physician-patient relationship to a contractual one (liability for medical malpractice may not be imposed absent a physician-patient relationship, either express or implied, because there is no legal duty in the presence of such a relationship.) (7) New York broadly defines this relationship as created when the physician's professional services are rendered and accepted for purposes of medical or surgical treatment." (8) The courts have been reluctant to decide whether that physician-patient relationship exists and have generally left that determination to the jury. (9) Specifically and analogous to the role of Proctor, the New York courts have held "an implied physician-patient relationship can arise when a physician gives advice to a patient, even if the advice is communicated through another healthcare professional." (10)

Considering this, the Proctor and proctored surgeon should be mindful of how their interactions will be treated in the courts in the event of litigation. They should consider any direct contact between the Proctor and the patient, whether in person, by phone or electronically; offers of advice relating to medical and surgical judgment as opposed to advice given simply to Proctor; whether the Proctor is paid and by whom; whether the Proctor scrubbed in; whether the Proctor participated in the surgical procedure; whether the Proctor intervened, supervised, directed or in any way exerted control over the proctored case; and whether the Proctor in any way participated in care after the proctored event.

The Take Away

While our public demands the latest and best that science can provide, we cannot substitute care to a disorganized, unsupervised surgical intervention. We need to be credentialed properly and oftentimes a Proctor is necessary to observe our ability to perform new procedures. The Proctor who stays within the established guidelines shouldn't be encumbered into a medical liability arena, even if a provider performs below care standards. If a Proctor's role expands to preceptor or mentor within a physician-patient relationship, a medical malpractice case should be expected if any substandardization of care exists.

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(1) Wall Street Journal, November 17, 2013.
(2) GRACO Risk Retention Group, Inc., Policy 2012-2013.
(3) MLMIC Professional Liability Policy 2013.
(4) Merriam Webster Dictionary defines "Proctor" as one appointed to supervise students (as at an examination).
(6) Clarke, supra, 174 Cal. Rptr. at 216.
(7) Cygan v. Kaleida Health, 51 A.D. 3d 1373 (4th Dept. 2008).
(8) Glasheen v. Long Island Diagnostic Imaging, 303 A.D.2nd 365 (2nd Dept. 2003; Zimmerly v. Good Samaritan Hosp., 261 A.D. 2d 614 (2nd Dept. 1999)
(9) Hickey v. Travelers Ins. Co., 158 A.D. 2d 112 (2nd Dept. 1990); Tolisano vs. Texon, A.D. 2d, 267, 278, (1st Dept.1988), revd. on other grounds 75 N.Y. 2d 732 (1989); Twitchell vs. MacKay, 18 A.D. 2d 125 (4th Dept. 1980)
(10) Thomas v. Hermoso, 110 A.D. 3d 984 (2nd Dept. 2013) citing Raptis-Smith v.s St. Joseph's Med. Ctr., 302 A.D. 2d 246 (1st Dept. 2003); Campbell v. Haber, 274 A.D. 2d 946, 947, (4th Dept. 2000); Cogswell v. Chapman, 249 A.D. 2d 865 (3rd 1998).

URMC Introduces New Therapy to Lower Sky-High Cholesterol

URMC cardiologists are first in Upstate New York to offer a blood-cleansing therapy for people with extremely high cholesterol, including two-time heart attack survivor Bob Guesno, whose cholesterol level was nearly three times the norm.

Heart & Vascular Center doctors have introduced apheresis to filter excess cholesterol from the body, providing a potentially life-saving reduction in the risk of stroke or heart attack for people with hypercholesterolemia.

"This new therapy offers a tremendous advance for patients with familial hypercholesterolemia, which is a genetic cause of very high cholesterol and relatively rare, but can be very dangerous because standard medications are ineffective in sufficiently lowering the cholesterol levels," said Robert Block, MD, MPH, expert and director of the URMC LDL Apheresis Program.

It takes about four hours to filter the cholesterol from the blood, and patients undergo the procedure as many as four times per month.

This nonsurgical technique involves filtering a patient's blood using apheresis technology that separates the cholesterol from the plasma before returning it to the body.

Guesno, 42, started this new therapy four months ago. "By the second day after the treatment, I have more energy and I can exercise again. I didn't have the muscle stamina before, but now I can walk up to four miles on the treadmill," said the father of three sons.

He was diagnosed with familial hypercholesterolemia as a teenager. It runs in his mother's side of the family – she has it, and her father suffered a heart attack in his mid-30s, and her grandfather died after a heart attack in his late-30s.

Robert Block, MD, MPH

Within a few years, Guesno's cholesterol levels climbed up over 500 mg/dL.

When his cardiologists prescribed statin medications to manage Guesno's cholesterol levels, he suffered severe back aches, muscle weakness and pain that made it difficult to walk. He adopted a plant-based diet, to help reduce his cholesterol because he couldn't tolerate the medications.

"We tried everything we could and he couldn't tolerate any of them," said John D. Bisognano, MD, PhD, preventive cardiologist and director of outpatient cardiology. "Without a doubt, when he wasn't taking medications, he was rolling the dice."

Without therapy, Guesno's cholesterol levels continued to rise and in 2008, at 36, he suffered two heart attacks in consecutive weeks. His care team suggested LDL apheresis, but at the time, the closest center to offer it was in Pittsburgh. Guesno made the four-hour trip there, but suffered an allergic reaction to a medication necessary for the therapy.

Block urged Guesno to try again, since URMC now offers the therapy and there have been advances in the medications required. The weekly treatments have been successful in reducing his cholesterol from more than 360 mg/dL when he arrives to under 60 mg/dL after the four-hour apheresis.

"It's a constant game of trying to get the LDL out quickly and not let it rise higher and higher," Guesno said.

DISASTER PREPAREDNESS UNDER HIPAA

Question: What HIPAA precautions should a practice take to prepare for a business interruption caused by winter storms and other "disasters"?

Answer: Disasters can strike a practice of any size and there is only so much you can do to prevent them from affecting your operations. Fires, floods, snow storms, equipment failures, power outages, and vandalism are among the possible scenarios. But both the HIPAA Privacy and HIPAA Security rules require that you have a plan in place to reasonably protect both paper and electronic patient information if and when your practice does suffer a "disaster." Facility licensure, accreditation, and CMS participation impose specific disaster preparedness requirements, as well.

Focusing on electronic PHI (EPHI) and the Security Rule, you should be aware that every HIPAA Covered Entity must have a Contingency Plan in place. That Contingency Plan must include, at a minimum, a Data Backup Plan (procedures to create and maintain retrievable exact copies of EPHI) and a Disaster Recovery Plan (procedures to restore any loss of data). An Emergency Mode Operation Plan is also required, which means having procedures to enable continuation of critical business processes for protection of the security of EPHI while operating in emergency mode. In addition, you should have procedures in place for appropriate notifications to employees, patients, vendors, and business associates when the practice's operations have been interrupted, and procedures for what will be done to get the practice up and running as quickly as possible.

You should work with your EMR vendor and/or IT consultant to put these procedures in place and test them in advance. And remember that compliance with the HIPAA requirements is not a one-time goal but must be maintained over time. Conduct at least an annual review to address how well the practice has implemented its emergency measures. Documenting your Contingency Plan and your annual evaluation will help prove to regulators that you made reasonable efforts to secure your EPHI. And having a Contingency Plan in place just might help you sleep better at night when those winter winds howl.

ANNUAL REPORT OF DATA BREACHES

Question: Am I correct that the rules regarding data breach reporting apply only to major breaches involving 500 or more persons?

Answer: No. While data breaches involving large numbers of persons get media attention, the federal data breach notification law applies to all data breaches involving a HIPAA covered entity, regardless of the size of the breach or the size of the entity. If you have a data breach, you must determine whether it, in fact, meets the definition of a data breach under the federal law and what notification obligations apply. Every breach of unsecured PHI must be reported to the U.S. Department of Health & Human Services (HHS), but the timing of that notification differs depending on how many persons are affected by the breach.

If a breach affects 500 or more individuals, you must notify HHS without unreasonable delay and in no case later than 60 days following the breach. Any breach that affects fewer than 500 individuals must be reported to HHS no later than 60 days after the end of the calendar year in which the breach was discovered. Notification is made with a form found at: http://ocrnotifications.hhs.gov/ and by following the instructions at the HHS website: http://ow.ly/t4xcm. Keep in mind that most states have a data breach law that may have different definitions and notice requirements than the federal law.

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.

You are a Cardiologist.

A lifesaver
A specialist of the heart

By Julie A. Lughart

The Health of Your IT System

You give advice to patients on how to keep their heart healthy. However, try as you may, often times your efforts are in vain. You painstakingly go over the dangers of smoking, the benefits of exercise, the importance of a healthy diet, and maintaining a healthy weight. You even encourage your patients to get regular health screenings. But month after month some of these same people show up in your office in worse shape than ever before. They give you excuses like it's hard, I don't have time, I don't have money to buy good food, etc. You wonder… Why won't they help themselves? It's a bit of a quandary. There are no easy fixes, magic pills, or ways to get something for nothing.

Just as you care for the health and welfare of your patient's heart, you should also care about the health and welfare of the "heart of your business". Do you have your finger on the pulse of your business practices?

Being a doctor is about practicing medicine, but if you do not practice good business, things may be harder than they need to be.

Here are a few health tips for your business and warning signs you might not be meeting the mark.

Do not smoke

We tell patients that smoking is not good, because it does nothing good for your body – it actually harms it.

Take a look at things that may be harming your business.

EMR System – Should be easy to use and produce professional patient records. This equates to higher rate of billing and quality patient care.

WARNING SIGNS: No EMR, poor quality patient notes, delayed billing, low rate of billing.

Workflow Tools - Updated computers, echocardiogram systems, speech recognition software and other technologies to create a streamlined workflow.

WARNING SIGNS: Frustration with computer slowness, outdated equipment or paying transcriptionists.

Exercise

Exercise is important - it alleviates stress. Just like physical activity is exercise to the body, cognitive activity is exercise to the business. To help you get started get a personal coach… go to a specialist.

Software Training – Do not waste time trying to figure out how to use software when there are specialists who can show you tips and tricks or give you the answers you need to best utilize it for your workflow.

WARNING SIGNS: You don't know keyboard shortcuts, or the most efficient functionality in Dragon or your EMR. You are doing processes in 5 steps that could be done in 2 steps.

- **New Product Demos** – Taking the time to watch a product demonstration can be a difficult, but it is worse to let great technology pass you by. The purpose of new product implementation is to make processes simpler and save time.

WARNING SIGNS: Sales reps have stopped calling, your peers talk about technology you have never heard of OR are not taking advantage of.

Healthy diet

The heart is happy when it is pumping nutrients from fruits and vegetables rather than from a greasy burger or a doughnut. Your patients depend on your guidance on how to make healthy and good changes to lifestyle.

Communication – Provide quality patient notes, make things easy for the patient and update patients on latest technology and prescriptions available.

WARNING SIGNS: Patients tell you they do not understand your notes, patients are not aware of the valuable information you have.

Maintain a healthy weight

Being at ideal BMI gives you energy and confidence. Measure your weight and make adjustments.

How healthy is your business?

Do you know what your costs are? Are you getting a return on your investment? Are you incurring costs for things you do not even know about? Ask yourself these questions and get the answers!

WARNING SIGNS: You do not know the answers to these questions.

Get regular health screenings

Health screenings are preventive medicine.

Operations - Make a list of the things that are working and start looking for solutions to solve the things that do not work. This will help your office be proactive and prevent issues down the road.

WARNING SIGNS: You are always in a reactive mode.

Your work reflects who you are - so take care of the heart of your business.

Julie A. Lughart is an Applications Specialist for Mindware Connections - which specializes in Dragon Medical Software integration. For more information, please contact Mindware Connections at (585) 388-3166 or info@mindwareconnections.com.

MLMIC

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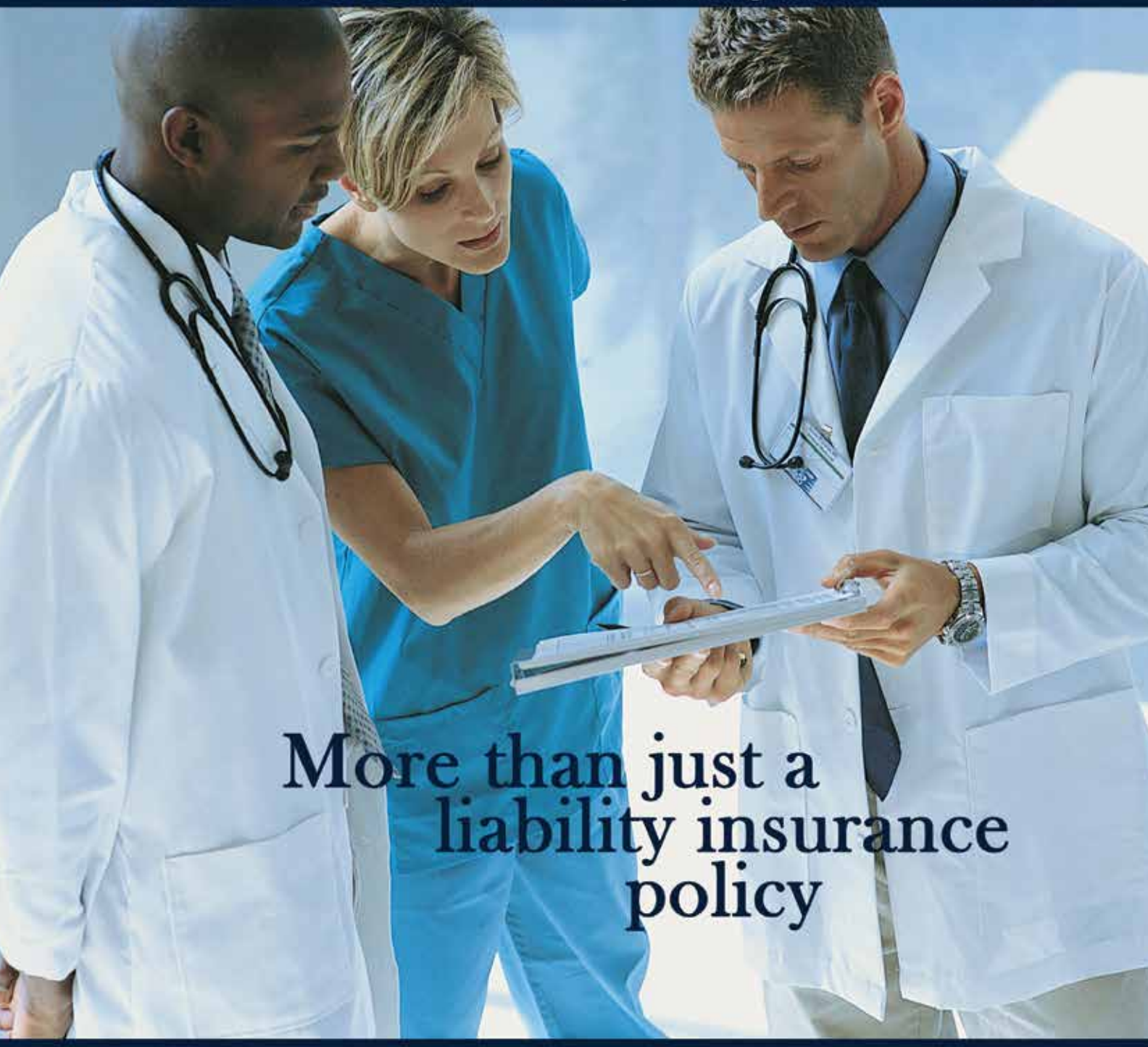

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A New Generation of Urology
Dr. Joy Michaelides

Dr. Michaelides earned her medical degree from the University of Rochester School of Medicine and Dentistry and completed her urologic residency at University of Rochester Medical Center. She has published numerous articles in peer reviewed journals on a variety of urologic conditions and has received special recognition for her patient-oriented care. Her special interests include urologic oncology and voiding dysfunction.

Q. With almost half of all urologists older than age 55 and the majority male - what guided your decision to specialize in Urology?

I was originally intending to pursue general surgery and happened to get involved in a Urology research project. Over the course of that project, I was exposed to some Urology residents who took me in the OR with them. I had a fantastic time. Not only was I interested in the procedures themselves, but also it gave me more time to consider the disease processes and get to know the patients. Urology offers a great variety of procedures and a nice mix of office and OR time. I never get bored. Because of the nature of Urology, you have to talk about very personal things with your patients. I really like making the folks feel comfortable and, very importantly, teaching them about their bodies and their disease in a way they can understand.

Q. After completing your extensive medical training in the Rochester area, how did you decide to stay in the region to practice?

Being from the area certainly contributed to my decision to stay. My family and my husband's family are still mostly in New York State. We wanted our daughter to be able to grow up near them. Also, my husband had both spent many years in the south prior to moving back to the region to train. I think it gave us a different perspective on the region. We really appreciate the natural beauty that upstate New York offers. After considering moving back to the south, and also out west, we decided that New York was home. I was very lucky to have the opportunity to move into such a nice position with Rochester General right out of residency. I love my job and the people that I work with, and that can make such a difference in one's life, health, and happiness. I'm very lucky.

Q. What is your view on the need for and accessibility of specialist healthcare in the rural regions?

Even before I knew in which geographical region I wanted to practice, I knew I wanted to be in a rural area. Having grown up in and "underserved area" I knew firsthand that there was a critical need of medical practitioners in those areas. But my decision to practice in a rural area wasn't based on altruism. I like living in the country and I hate traffic – so therefore I like working in the country too. As to the need for specialist, yes, there is a huge need. People who live in rural areas sometimes don't want to or can't travel great distances for care. I'm more than happy to cater to that need. Also, I am a supporter of telemedicine to bridge the gap in areas where there aren't specialist or the particular specialist that are needed. Telemedicine is neither perfect nor the final solution, but it's a fantastic way to offer the care that is needed to those in need.

Q. Considering the Geriatric patient group, what trends, needs and care opportunities do you foresee?

That's a big question. We all know that the population is aging. With people living longer and surviving longer with conditions such a heart disease and diabetes, we'll see more geriatric cancers. It's particularly difficult to manage some of these patients because of frailty and competing comorbidities. Therapies that are tolerated by the younger population are often unable to be used in these patients. All physicians, but especially those treating cancer, are going to have to be smarter and wiser in their therapeutic decisions. With the obvious exception of pediatricians, all practitioners are going to be taking care of more elderly persons and are going to have to educate themselves about the physiological differences that need to be considered. Also, unique social issues that are faced in the later stages of life are going to increasing impact how, and potentially where, we care for patients.

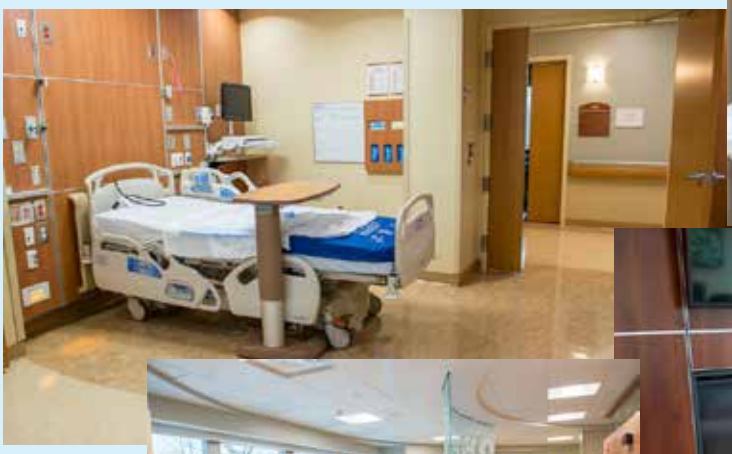
Q. How do you enjoy your time when you are not caring for patients?

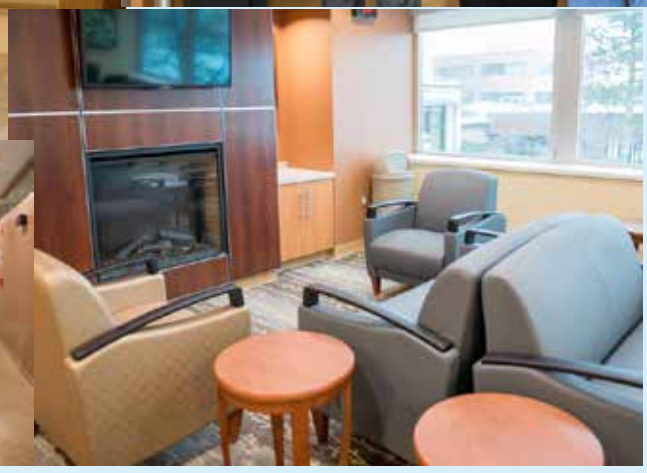
I'm a homebody. My husband and I raise honeybees so that takes up a certain amount of time in the summer. The rest of the time I'm playing with my daughter, reading, or cooking up something new in the kitchen.

RGH Cuts the Ribbon on new Surgical Short-Stay Unit

"This surgical short-stay unit is an investment in our patients and the way surgical care should be provided"

~ Mark Clement, CEO of Rochester General Health System (RGHS)





Rochester General Hospital (RGH), already ranked fourth in New York State by Delta CareChex for surgical care, celebrated the completion of a new surgical short-stay unit designed to provide patients with a unique combination of privacy, high-quality care and comforting amenities.

"This surgical short-stay unit is an investment in our patients and the way surgical care should be provided," said Mark Clement, president and CEO of Rochester General Health System (RGHS). "Advances in surgery and surgical recovery are leading to shorter hospital stays. This new unit gives patients an extraordinary healing environment that complements the nationally recognized care delivered by the teams at Rochester General Hospital to create an even greater patient experience."

Designed for patients who need to stay in the hospital for 23 hours or less after surgery, the unit is the latest example of Rochester General Health System's family-centered approach to care, featuring:

- 12 state-of-the-art private rooms.
- A private bathroom and shower for every room.
- Family-friendly furniture in each room that will allow loved ones to remain comfortable when staying with a patient.
- Telehealth capabilities in every room, allowing for more frequent rounding by offsite physicians and specialists.
- Two uniquely-equipped rooms for patients with additional needs.

"As surgeons, we know the importance of the care that comes after the patient leaves the operating room," remarked Dr. Ralph Pennino, chief of surgery for RGHS. "It is an integral piece to the puzzle and this unit will bring post-surgical care at RGH to new levels of excellence."

The 12-room surgical short-stay unit, located on the 2000 wing of the hospital will begin to see patients on Thursday, February 27. In summer of 2014, RGH will begin renovating its 2800 unit in similar fashion.

in Area Healthcare

URMC

Baumhauer Named One of North America's Top Foot and Ankle Surgeon

Judith F. Baumhauer, MD, MPH, an orthopaedic surgeon at the Orthopaedic Foot and Ankle Institute at the University of Rochester Medical Center, was named by Orthopaedics This Week as one of the top 26 foot and ankle surgeons in North America. The publication polled orthopaedic specialists in the U.S. and Canada through a phone survey conducted this fall.

A professor of Orthopaedics and associate chair of Academic Affairs, Baumhauer is a national leader in the field of orthopaedics. She served as the first female president of the Eastern Orthopaedic Association, the American Orthopaedic Foot and Ankle Society and most recently the American Board of Orthopaedic Surgery.

Wilmot Cancer Center Launches Inpatient Smoking Cessation Initiative

The James P. Wilmot Cancer Center at the University of Rochester Medical Center is helping patients navigate the complexities of quitting smoking after a cancer diagnosis with the introduction of an inpatient smoking cessation program—the first in the region to offer this comprehensive service to cancer patients admitted to the hospital.

For cancer patients, even if the cancer is not caused by tobacco use, quitting can speed recovery from surgery, improve the response to chemotherapy and radiation, and lessen the chance of developing secondary cancers and other health risks including congestive heart failure, heart disease and pulmonary disease.

"Quitting smoking is one of the most important changes a patient can make after receiving a cancer diagnosis; even recent quitters are more likely to recover from cancer than patients that smoke," said Chunkit Fung, MD, director of the in-patient smoking cessation program, Wilmot Cancer Center. "While cancer patients may be the most motivated at quitting smoking, we recognize that it can still be a struggle while also managing the stress of a serious illness."

The program aims to give smokers the tools they need to help quit while in the hospital, and then provides additional support once they go home. The patient's care team, made up of doctors and nurses, plays a key role in helping that person to successfully quit.

Once enrolled in the program, smoking cessation treatment will be integrated into the patient's cancer treatment, and will include counseling from nurse managers, the development of a quit plan, access to nicotine replacement and other tobacco cessation medications, and behavioral strategies for managing craving. At home, the patient will receive check-in phone calls from his or her care team and can schedule outpatient sessions with the Healthy Living Center.

"With tobacco cessation as a core health outcome in the Affordable Care Act, we are implementing programs and systems to incorporate the treatment of tobacco use into our daily patient services," said Jonathan Friedberg, MD, director, Wilmot Cancer Center. "A diagnosis of cancer is a 'teachable moment' for patients. This opens the door for our care team to help influence lifestyle changes that will impact the patient's overall outcome."

Strong West Surgical Center OK'd by State

UR Medicine's Strong Memorial Hospital received approval today from the state Department of Health (DOH) to proceed with plans for an ambulatory surgical center at its Strong West location, 156 West Ave., Brockport.

The DOH Public Health and Health Planning Council gave its OK this morning. A final review by the state's Bureau of Architecture and Engineering will take place over the next few weeks. Construction should begin in April on the ambulatory surgical center (ASC) project, which includes upgrades to three operating rooms and renovations to an adjacent pre- and post-op patient care area. Same-day procedures performed will include surgical and GI procedures. The ASC is expected to be open in the third quarter of the year.

"We are grateful to the state for allowing us to move forward with the ambulatory surgical center," said Bradford C. Berk, MD, PhD, CEO of UR Medicine. "Our goal is to revive specialized health care services in the Brockport community and this is another positive step in bringing some surgical options closer to home for area residents."

The University of Rochester Medical Center continues to work with the DOH to gain approval for a full-service, freestanding Emergency Department (ED), a new health care model being considered by institutions across New York that has prompted the state to develop specialized requirements. Updated design drawings and other details requested by the state were submitted this week. No timeframe has been set for approval of an ED at Strong West, although a decision by the DOH could come this spring.

URMC purchased the former Lakeside Memorial Hospital and other assets last year after Lakeside closed its doors. Strong West consists of urgent care centers in Brockport and Spencerport; Orthopaedic, Cardiology, Neurology, Urology, Oncology and Primary Care practices; as well as lab and Imaging services that support Brockport-area physicians.

RGHS

Rochester General HealthSystem Opens Dialysis Center in Newark

Rochester General Health System (RGHS), 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 Dialysis Center is now accepting patients. 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 U.S., 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."

Services provided at the new Newark-Wayne Dialysis Center include in-center hemodialysis and peritoneal dialysis. All services are provided by board-certified nephrologists and a highly skilled team.

UNITY

Unity Transforms Process for Diagnosing Thyroid Nodules

A streamlined approach speeds up the process to diagnosing the problem and developing a treatment plan.

Unity Health System has transformed the process for diagnosing and developing a treatment plan for patients who have suspected thyroid nodules.

The Unity Thyroid Center will open on October 23 on the Unity Hospital Health Care Campus in Greece.

The Center was created through a partnership among Unity Diabetes & Endocrinology Services, ACM Medical Laboratory and Borg & Ide Imaging.

Strategically aligning these partners speeds up the process to diagnosing and developing a treatment plan for patients with nodules in their thyroid gland, said K.K. Rajamani, MD, Chief of Endocrinology for Unity Medical Group.

"We've thoughtfully created a better way for patients with this need to access care in a more timely matter," Rajamani added. "This really showcases Unity's commitment to provide the absolute best possible health care experience."

Within one to two days patients will see an endocrinologist and receive necessary diagnostic tests. By the end of that day the endocrinologist will contact the patient will their test results and provide a treatment plan for follow up. This concept is unique in that the normal process can take two months or more.

David Gill, MD has been appointed to Medical Director of the Unity Memory Center

Dr. Gill joined Unity Neurosciences in September 2012 to develop the Unity Memory Center and dementia care. The Memory Center is a comprehensive, multidisciplinary approach to assessment of memory and cognitive disorders and ongoing care of both patients and families. Prior to joining Unity, Dr. Gill headed the Memory Center in Hershey, PA following his residency in Neurology and fellowship in Behavioral Neurology at the University of Rochester Medical Center.

Nathan Odom, MD has been appointed to Medical Director of Unity Acute Rehabilitation and Brain Injury Program

Dr. Odom joined Unity Neurosciences in August 2013 and has been actively involved in preparing for the upcoming move of the Acute Brain Injury and Rehabilitation Program from the Unity St. Mary's Campus to the Golisano Center on the Unity Park Ridge Health Care Campus. Prior to joining Unity, Dr. Odom completed his residency in Physical Medicine and Rehabilitation at the University of Rochester Medical Center.

Unity Health System is pleased to welcome Geetha Koushik, MD

Dr. Koushik will join Unity Geriatric Associates. She earned her Doctor of Medicine degree from M.S. Ramaiah Medical College in India. She completed her residency with Unity Internal Medicine at Unity Hospital. Dr. Koushik is a member of the American College of Physicians.

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