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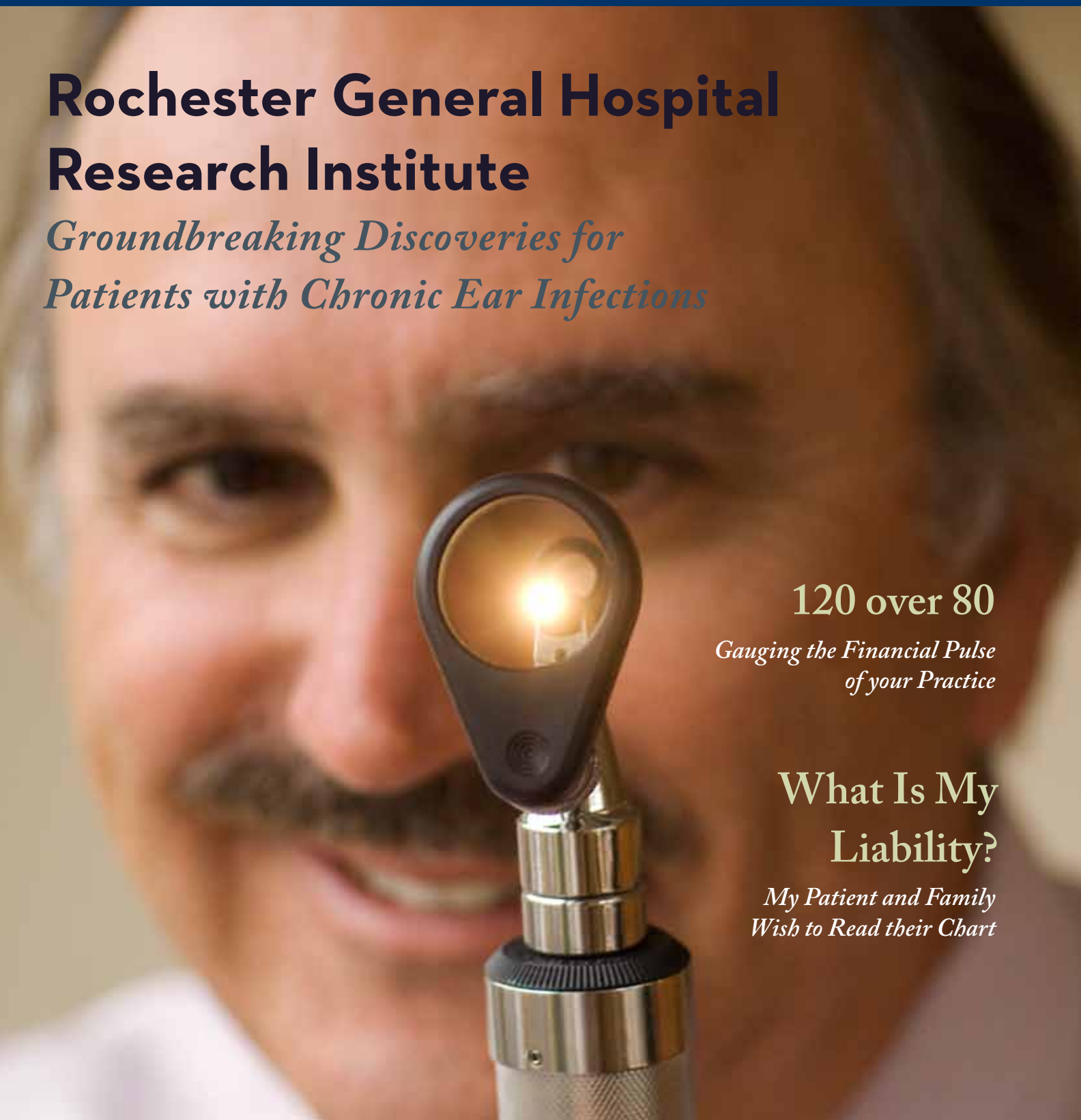

Rochester General Hospital Research Institute

Groundbreaking Discoveries for Patients with Chronic Ear Infections

120 over 80

Gauging the Financial Pulse of your Practice

What Is My Liability?

My Patient and Family Wish to Read their Chart

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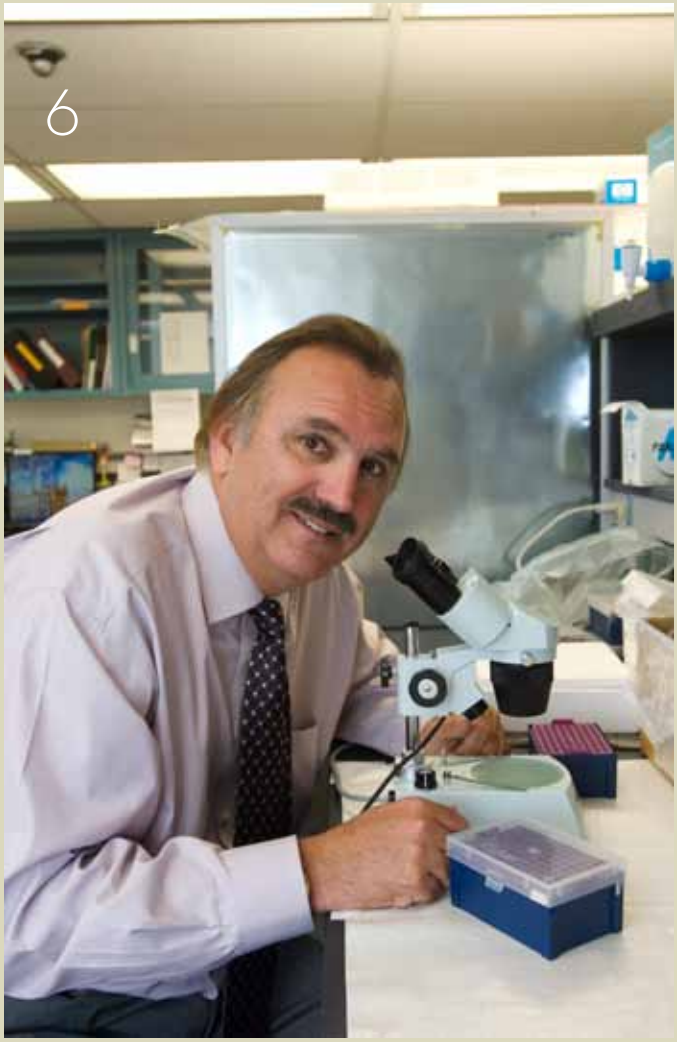

FROM THE PUBLISHER

Welcome to the August Issue

Another month filled with discovery. Knowing a little about some of the schedules you all keep, I would venture that many of you start your day with coffee. My coffee maker ceased one day and replacing it became my top priority. My internet research led me to a company site called *Whole Latte Love* – they had precisely what I was looking for - great price, in-stock and surprisingly – right here in town. I was making coffee the next day – a great little find.

Learning more about the research underway at **Rochester General Hospital Research Institute (RGHRI)**, was another great discovery. This month we sit down with **Dr. Michael Pichichero**, the Director of the Institute, and discuss the most common ailment that children suffer - recurrent and chronic ear infections. Dr. Pichichero shares some startling statistics, the latest discoveries and the future promise of the vaccine research to benefit children worldwide.

Also in this issue, our medical legal expert, James Szalados, MD, MBA, Esq discusses liability issues regarding *My Patient's Family Wants to Read the Medical Record* in the *What is My Liability?* column. For those you wear the hats of physician and business owner – Steven Terrigino, a partner and CPA specializing in health care at **The Bonadio Group** offers perspective in *120 over 80 - Gauging the Financial Pulse of your Practice*.

Whether through an in-depth cover story, a profile or as a contributing author, I thank you for sharing your time and expertise with all of your colleagues through the pages of *Western New York Physician*.

My continued thanks to advertisers! Your presence in the magazine sets you apart – positioning your practice and your business as invested leaders in health care in Western New York. Your continued trust and support ensures that all physicians in our region benefit from this collaborative sharing of information.

All the best,
Andrea

Western New York
PHYSICIAN

THE LOCAL VOICE OF PRACTICE MANAGEMENT AND THE BUSINESS OF MEDICINE

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Rochester Colon and Rectal Surgeons


Claudia Hriesik, MD


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Facts about Fecal Incontinence

According to the National Institute of Health, more than 18 million Americans suffer from fecal incontinence (FI). Patients with FI experience the unexpected leakage of gas, liquid or solid material. Some people experience a combination of these symptoms. Fifteen percent of women over age 50 experience FI. Men are affected but less often than women.

What are the causes of FI?

- Injury during childbirth
- Anal operations, anoreceptive sex or traumatic injury to the tissue surrounding the anal region
- Aging and loss of muscle strength
- Stroke
- Diseases like Diabetes, Parkinson's disease, and multiple sclerosis
- Inflammatory bowel disease and irritable bowel syndrome
- Congenital disorders

Testing for FI

For most patients with FI, there is little need for significant Colon Physiology type testing such as anal manometry, anal ultrasound or x-rays. After excluding other causes, health care resources can be directed at *solutions* rather than on expensive tests which only confirm what the symptomatic FI patient already knows so well. A history, physical exam and symptom diary suffices most of the time.

What options are available to treat FI?

Traditional management for FI includes behavioral techniques such as diet modification, bowel retraining, Kegel exercises, biofeedback, etc. Outcomes are poor and incontinence often persists. Sphincter repair surgery has been used with limited success. Colostomy is more common than most clinicians realize.

Sacral nerve stimulation (SNS) is a novel minimally invasive outpatient option, proven effective to improve or restore bowel control.

Facts about Sacral Nerve Stimulation (SNS)

Originally approved by the FDA in 1997 for urinary urge incontinence, SNS (commercially known as InterStim Therapy) now can be used for both urinary and or bowel control. To date, more than 85,000 people have received SNS in Europe, Canada and Australia.

Rochester Colon and Rectal Surgeons treat selected patients who suffer from FI with SNS. The implantable InterStim system uses mild electrical stimulation of the sacral nerves to influence the behavior of the pelvic floor muscles. As a result, the therapy significantly reduces fecal incontinent episodes for a significant number of patients.

InterStim Therapy is the only fecal incontinence treatment option that *allows patients and physicians to determine probable success of the therapy* through a test stimulation procedure prior to committing to long- term therapy. After a short trial phase, the patient will be able to determine if SNS was successful and can elect to proceed or forego permanent implantation of the InterStim device.

Living with SNS

SNS may help patients avoid frustrating experiences associated with bowel incontinence. Patients may be able to do things they were not able to do before receiving SNS – like taking long walks or travel without interruption. While it may take a while to adjust to SNS, patients should feel comfortable participating in the daily activities of living.

Due to the debilitating and often embarrassing nature of FI physicians are often unaware their patient suffers from FI.

What options are available if SNS fails?

Severe injuries to the anal muscles may occasionally be repaired with surgery. In certain individuals that have nerve damage or anal muscles that are damaged beyond repair, an artificial sphincter may be implanted. In extreme cases, patients may find that an ostomy (creation of an opening on the abdomen for exit of stool into an appliance) is the best option for improving their quality of life.

Conclusion

Fecal Incontinence is a problem that affects millions of Americans. Due to the debilitating and often embarrassing nature of FI physicians are often unaware their patient suffers from FI. Help and treatment are available and can be tailored to the degree of symptoms. Rochester Colon & Rectal Surgeons are ready to help patients with FI. This novel approach offers the most benefit and the least risk of any surgical approach; which equates to superior value and outcomes for your patients.

ICE vs Heat

When and What to Use

Quick Tip

Mixing one cup of alcohol and two cups of water makes a good ice pack because it freezes at a lower temperature but remains slushy for good ice pack consistency!

Reference: Therapeutic Modalities in Sports Medicine 4th edition, William E. Prentice; Copyright 1999, pages 173 – 206.

Two of the most commonly used modalities of rehabilitation clinicians, professional athletes and recreational athletes are ice and heat. However, there is a great deal of confusion and misunderstanding when it comes to using ice or heat.

Cold therapy (or cryotherapy) is the use of a cold modality in the event of an acute trauma and subacute injury. The important use of cold therapy is to lower the temperature in the injured area reducing the metabolic rate and decreasing the production of metabolites and metabolic heat. Thus, cold therapy reduces additional damage to the injured tissue from the inflammatory response of the body.

Other benefits of cold therapy include reducing muscle spasms and pain. Cold therapy includes ice packs, cold and ice whirlpools, ice massage, commercial chemical cold sprays and contrast baths.

With an acute trauma or subacute injury only cold treatments should be applied in the first 72 hours to reduce the accumulation of swelling (edema), pain, muscle spasm or guarding. Treatment times vary depending on several factors including the size of the treatment area, type of cold therapy applied and the size of the individual being treated. For example, a thin person requires less treatment time because the cold does not need to penetrate through as much tissue to lower the intramuscular temperature, thus producing the desired therapeutic effect.

There are four stages of cold that assist in determining the appropriate treatment time. First stage of cold therapy is an uncomfortable feeling. Second, stinging. Third, burning or aching.

Fourth, numbness. It takes between five to fifteen minutes to reach all four stages.

As a result, treatment time should be a minimum of fifteen minutes to achieve the important therapeutic effect of the treatment.

On the other spectrum, heat for the most part is the opposite of cold. Heat treatment (or thermotherapy) is recommended in subacute and chronic conditions for reducing pain and inflammation. The principal reasons for heat therapy application is to increase tissue temperatures, increasing blood flow, therefore drawing extra nutrients into the injured area to assist in the recovery and healing process.

Because of this, heat should never be used on an acute trauma or injury until swelling is controlled. The most common use of heat therapy is a moist or dry hot pack. Treatment time for heat is between fifteen and twenty minutes. Just like when using cold therapy, it takes heat a minimum of fifteen minutes to penetrate tissue to reach and raise temperatures. Other heat therapy applications include diathermy, ultrasound, warm whirlpool, paraffin bath, infrared lamps and fluidotherapy.

When patients understand the basics, cold and heat therapies can be safe, simple and inexpensive. The proper use of these modalities can assist the body during the healing process and help make the trauma or injury less stressful.

Rochester General Hospital Research Institute (RGHRI)

Groundbreaking Discoveries for Patients with Chronic Ear Infections

Julie Van Benthuysen

The Pichichero LabResearch Team:
From 5 countries, 10 PhD's and 3 MDs joined by 8 technicians and 7 students work on vaccine development and respirator disease immunology with a goal of improving care for children worldwide.

A young child suffering from recurrent or chronic ear infections typically faces surgery to implant ear tubes – the most common surgery in children beyond the neonatal period. Yet clinical studies being conducted here in Western New York hold great promise for preventing, diagnosing and managing future onsets without such measures. Customized antibiotics are already being used, and a better vaccine may be less than 10 years away. In short order, these remarkable strides are becoming music to the ears of patients and their families, physicians and the health care industry at large.

A leading group of physicians at **The Rochester General Hospital Research Institute (RGHRI)** is driving this groundbreaking research in pediatric immunology. Over the past several years, a clinical research trial has been underway to identify the immunology surrounding childhood ear infections. Led by Principal Investigator Dr. Michael E. Pichichero in collaboration with Dr. Janet Casey, Clinical Trial Director at Legacy Pediatrics, the research has shown tremendous progress in more successful treatment and potential prevention of recurrent and chronic ear infections.

In the U.S. alone, 25 million episodes of ear infections occur every year – one of the most common reasons for a child to visit a pediatrician, and the most common reason antibiotics are prescribed. Children six months to three years are the prime candidates, due to their immature immunity and an underdeveloped middle ear drainage tube (the Eustachian tube). About 10% of American children – about 580,000 annually – ultimately receive ear tubes for recurrent or chronic ear infections as early as one year of age. These startlingly high numbers translate to considerable emotional and financial impact on the patients' family, including time away from work to care for the child, and an astounding cost to our nation's health care system – exceeding $5 billion per year.

The RGHRI team recognized the enormous potential to study the factors involved in ear infections to determine alternate solutions. "The point of the study is to better understand the immunology of an ear infection – when do bacteria colonize in the nose, what bacteria cause it, and what's the basis of protection

for kids," says Dr. Casey.

In 2006, the study began at Legacy Pediatrics where Dr. Casey practices. Patients are enrolled as early as six months of age, depending on eligibility, and study samples are procured and reviewed on-site during several consecutive sick or well visits over a two year period. "Because participants can either be prone to ear infections or not, the study is helping to identify not only what causes them, but how some kids are able to avoid them."

Nearly 500 children currently participate in the study. The patients' nose and throats are swabbed and blood is drawn. For those identified with an ear infection, the eardrum is numbed and Tympanocentesis (an ear tap) is performed by poking a needle through the eardrum under magnification to drain and collect the pus out of the middle ear space. Once the pus and blood are lab-tested to determine what's causing the ear infection, the doctors can determine which antibiotics should be used to tailor therapy to the individual patient. In 2007, the doctors were credited with discovering an ear infection "superbug" resistant to all 18 of the typical antibiotics used to treat ear infections. "We're looking at this in a much more scientific way," says Dr. Pichichero. "These bacteria continue to evolve, making some cases far more challenging to cure."

The level of clinical expertise within this research team runs deep. Dr. Pichichero was a member of the discovery team at the University of Rochester that invented, tested and licensed a Haemophilus influenzae b (Hib) conjugate vaccine (HibTITER®) now universally given to children in the U.S. He also was part of the further application of this "conjugate" vaccine technology in the subsequent development of another universally given vaccine – the pnuemococcal conjugate vaccine (Prevnar®). In her role as Clinical Associate Professor of Pediatrics at the U of R and as Director of Research at Legacy, Dr. Casey acts as Principle Investigator for this and many other notable clinical research grants.

With such world-renowned credentials, the RGHRI research team is working to develop a multi-component vaccine to prevent ear, sinus and lung infections caused by pneumococci and non-typeable H. influenzae. The approach is multi-focused and includes the study of natural infection and asymptomatic colonization with these bacteria in children, evaluation of serum and mucosal antibody; generation of B memory cell and T cell responses to disease, colonization and vaccine candidates, and molecular epidemiology and vaccine antigen discovery.

"We're asking the questions -- does the child's body create an immunity to these key bacteria, and what vaccine ingredients might work for all individuals," says Dr. Pichichero. "So far we've identified four ingredients and have filed patents."

Individualized care for study of children involves obtaining strains of bacteria from the middle ear by a tympanocentesis procedure at the Legacy Pediatrics office, then isolating and testing the causative bacteria in order to understand the best antibiotic treatment for the child.

Vital Parent Support

Drs. Casey and Pichichero concur that studying young children has its challenges. Parents are sometimes concerned with blood draws and pain from an ear tap; however, the children actually experience no pain, even when pus is drawn out of the ear, because EMLA is applied to the vein and 8% tetracaine is instilled into the ear canal prior to the procedures. "The child actually feels immediately better after an ear tap, so speed is key," says Dr. Casey. "No child likes to be held down."

Jennifer Hinton praises the opportunity her two children have been given through the clinical trials. At 15 months, her daughter Paige had suffered numerous ear infections with only short-term relief from antibiotics. During a well visit with Dr. Pichichero, another ear infection was discovered. Learning of Paige's long history of infections, he expressed dismay and frustration that more had not been done to address the issue. "He performed an ear tap, and it was instantaneous how fast the pain disappeared," she says. In the nearly five years since, Paige has averaged only one ear infection a year.

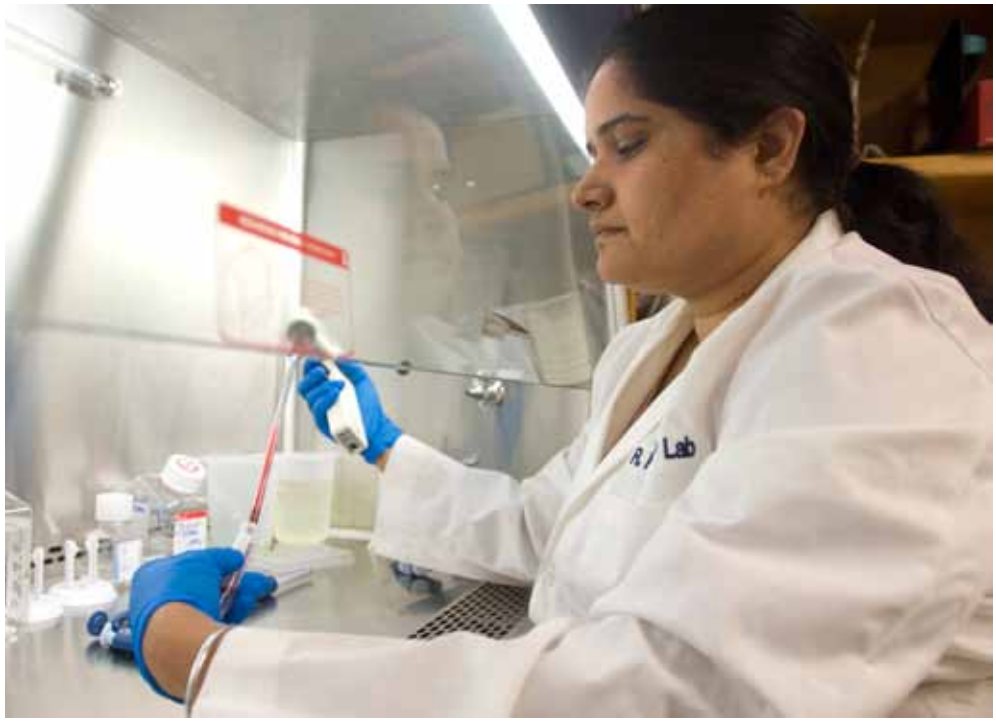
Ms. Hinton's younger son, Daniel, has faced a more difficult road. His ear infections began at five months, and would come and go over to the point where ear tubes were introduced, allowing the middle ear fluid to drain and helping prevent it from accumulating again. Ear taps only offered short-term relief. "Even though Daniel still had two surgeries, it was so worth it to be involved in this study," she says. "We joke that we saw Dr. Pichichero more than our own family, but we learned so much. Throughout the study, having the ear tap and the nasal wash helped get the right prescription for Daniel, even though he ultimately needed ear tubes."

Despite the emotional and financial strain these chronic infections placed on Ms. Hinton's family, she insists the study has been a blessing. "The takeaway from all this is that if going through this helps another child get rid of infection faster or avoid ear tubes, then it's just a small way for us to thank the doctors."

Pediatricians Lead the Way

While Legacy has been leading the charge, several other pediatric practices have enrolled patients. "With other groups collaborating, we get yet another perspective," says Dr. Casey. Dr. Alice Taylor at Sunrise Pediatrics was approached to help incorporate more patients into the study, as were Long Pond Pediatrics, Lewis Pediatrics and Westfall Pediatrics. "I already had a great deal of respect for them," says Dr. Taylor, "so I was happy to participate."

Reception within her practice has been positive. "Parents really want to be involved in the research and make a contribution," she says, "particularly those who suffered from ear infections as children and don't want to see their kids suffer the same fate." Her patients with ear infections are referred conveniently down the road to Legacy, where its study nurse Sally Thomas initiates the process and prepares the child for the ear tap. "Sally is wonderful with patients and gets the blood drawn quickly. Children are like new children after an ear tap."



The individualized care also involves collecting blood from each child to test for immunity responses that might be protective for the child and to assess the promise of future vaccine candidates to prevent bacterial infections.

The collaborating physicians hope more area pediatricians will become open to performing ear taps. While it's considered a very minor surgical procedure, a learning curve is involved, says Dr. Casey. The procedure can easily be integrated into office flow, but some doctors are deterred by the time commitment required for the ear numbing to take effect, and the need to restrain the child. "We've trained many to do this procedure, but few still actually do."

Nationwide Support Grows

In just five years, the RGHRI clinical trial has shown remarkable results with this new approach to management. The researchers have found that 300% fewer ear tube surgeries can occur by providing an ear tap, as well as through personal-

ized testing for the antibiotic that suits the individual patient. Study results also project a reduced rate of repeated infections of between 600-800%. Reducing the need for surgery, which requires anesthesia, could represent a huge health care cost savings to our region alone. The doctors project the U.S. could save about $3.5 billion annually from this approach to ear infection care. "Moreover, if we can ultimately prevent the majority of these infections from occurring in the first place with a vaccine, the possibilities are tremendous," says Dr. Pichichero.

A study of this significance has already received widespread national and international attention. The National Institutes of Health have been notably supportive. Research at RGHRI enjoys funding from federal, state and local organizations, foundations and private organizations and support from international scientists. Dr. Pichichero is an advisor to the U.S. Food and Drug Administration, the U.S. Centers for Disease Control and the World Health Organization regarding antibiotic use and vaccines for children.

"Funding has been highly successful," he says. "The National Institute for Deafness and Communication Disorders at NIH has funded our research since 2007 and we just received our renewal score to continue at least through 2017, with a $4 million grant specifically used to research ear infections." Pfizer, the pharmaceutical company responsible for the pneumococcal conjugate disease vaccine, has provided $7.1 million in funding for five years to evaluate the impact of its new Prevnar 13 vaccine on ear infections. Sanofi Pasteur has also been funding the research into new vaccine ingredients for pneumococci. "Since the same bacteria causing ear infections also cause bronchitis, pneumonia and sinus infections, they all require immunity protection – so a vaccine for one disease would likely be effective for all four."

Dr. Pichichero credits Dr. Howard Faden and Dr. Tim Murphy of the University of Buffalo. "Their pioneering ear infection research through the 1970s and 1980s was foundational to our study. We're now using modern tools to completely understand the immunity of ear infections first addressed decades ago."

Regional Commitment to Research

It has only been through a concerted joint effort between Rochester General Hospital and The Rochester Institute of Technology with support from the University of Rochester that the study has reached this benchmark status.

When Dr. Pichichero was recruited in 2009 to rejuvenate the research mission of RGH, he recognized these alliances in biotechnology, bioengineering and human immunology would suit the institutions well. In his former role at the U of R, his lab specialized in bacteria and viral infections in children, so this professional move and this study proved to be a logical next step.

"The RIT alliance has flourished," he says. More than a dozen RIT scientists are working with RGH scientists using state-of-the art technology in renovated and expanded facilities. A major recruitment effort has already resulted in 12 new research tech jobs and 7 PhD scientists.

"We're successfully recruiting from all over the U.S. We represent a new kind of research institute, not affiliated with a university, yet with tremendous support from both RIT and the U of R. To have our research facility and two universities within the same region is something amazing. There are tremendous opportunities for collaborations that could lead to spin-off companies from the kind of research we're doing."

It's clear that the Research Institute as part of Rochester General Hospital has brought together expert, dedicated researchers to pursue vital clinical and translational work in Vaccine Immunology. This incredible research opportunity is helping to impact the health of human beings worldwide.

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One 20 Over 80

Steven M. Terrigino, CPA

"To study the abnormal is the best way of understanding the normal." ~ William James

Typically, when people hear the term 120/80 they may deem it as a "normal or ideal" reading for one's blood pressure. There are several vital signs or test results that may define a person's range in any number of medical categories as being "normal or ideal". Yet, as physicians well know, some measures or medical test results may be out of a normal range but still be deemed acceptable, due to certain individual circumstances. Since I am a CPA, I will leave it to the physicians to define what is normal or ideal in terms of medicine. In this article, I will instead try to help you monitor your financial normalcies to gauge the pulse of your practice. I will offer you some suggestions to help you determine where your practice falls with respect to "normal or ideal." However, it is important to note, that financial benchmarks may vary for different specialties, practice sizes, etc.

1. PREPARE AN ANNUAL BUDGET

Annually, a practice should develop a financial budget. Many expenses and operational costs can be predicted with some level of certainty. While some costs remain fixed each year, other variable expenses can be estimated based upon a percentage of revenue or historical trends. On a monthly, or at a minimum on a quarterly basis, actual results should be compared to budget. Any major variances between the two should be identified and explained. There may be expenses which initially appear to be out of range, but when investigated, there may be a logical justification, deeming this variance "normal". For example, payroll costs may have risen considerably from a prior year. While at first glance this can be alarming, a logical explanation may be a considerable rise in revenue from the prior year, resulting in the hiring of additional staff for the practice. Conversely, do not ignore expenses which are in line with budgeted amounts, if revenues are down significantly from budget. The sooner variances falling out of a normal range can be identified; the quicker steps can be taken to get back on track. This will help the practice mitigate unnecessary costs and ultimately enhance profits. The utilization of an annual budget will assist you in this regard.

2. BENCHMARK YOUR PRACTICE

Benchmarking provides a methodology to analyze your metrics against industry norms. One of the most common questions I receive from a practice relates to their total overhead percentage. Most physician groups are anxious to know how it compares to others. Physician practices are much like individuals in that they are unique and have individual characteristics that make them who they are. Sometimes certain metrics of your practice may not be like the metrics from other practices. Nevertheless, they may be deemed "normal" for your circumstances. Practices in similar specialties will generally have similar expenses as a percentage of revenue. For example, major expense categories such as salaries and wages, occupancy and insurance should be compared with similar sized practices. There are various statistical publications which provide these numbers. As you compare your practice with others and certain metrics appear to be out of a normal range, determine why that is. If you are satisfied with the explanation, great. If not, it may be time to consider some changes.

3. REVIEW TRENDS AND RATIOS

When you analyze a practice's operations, past results, trends and ratios are generally reviewed and compared to current operations. There should be some level of consistency from year to year amongst a practice's financial metrics. A prime example of this relates to revenue, accounts receivables and accounts receivable write offs. Periodically, revenue should be compared to prior year's revenue for the same time period then ended. Generally trends exist with respect to revenue cycles for each practice. Moreover and most especially, accounts receivable write offs should be compared to total billings. While it is important to have a level of comfort with respect to this trend, a careful watch should always be maintained as the existence of why any write offs occurred. Variations in the above metrics may indicate a possible billing, coding or collection issue. If revenue has declined or accounts receivable write offs are higher as a percentage of revenue when compared to prior years, it is time to investigate the reason and take corrective action. Keep in mind that if your practice has undergone major changes from prior years, these trends should be changing as well. For example, if you added a type of service and/or a number of practitioners, analyze the increase in revenue to determine if these changes are showing the improved financial results you anticipated.

4. REVIEW OPERATIONAL EFFICIENCIES

Finally, another way to compare your practice to others and to see if you are falling within a "normal" range is to determine if you have implemented some of the best practices other groups have. Many organizations such as the Monroe County Medical Society or the Medical Group Management Association provide peer group forums both for physicians and practice administrators alike. Sharing information in these forums may provide you with ideas on how to better manage your practice. Banking practices is a great example. Today many banks will offer plenty of efficiencies at little to no additional cost to the practice. Is your practice making the most out of on-line banking? A remote check deposit scanner allows you to make checking deposits without physically going to the bank daily. Are you using this? Are credit cards for large purchases being utilized on a regular basis to maximize rebates such as frequent flyer miles? Is your payroll and time reporting automated? Are you fully utilizing the capabilities of your software systems? Implementing many of these features saves a practice both time and money.

In summary falling within a "normal" range with respect to financial and operational metrics may mean different things for different practices. Similar to medical procedures and tests, the above suggestions should be performed on a regular, pro-active basis to determine if your practice is in an acceptable range. I have assisted many physician groups to assess the range they fall in, under multiple metrics, as well as comparing these metrics to local and national averages. Moreover I have reviewed with them where they can save money or enhance efficiencies as a result of these analyses. Ultimately, when the results are not falling within the prescribed range, an action plan on how to get there should be developed. Again, the best way to understand the normal is to study the abnormal, doing so may enhance your practice and profits.

Is it Mental Illness, Chemical Dependency ***or both?***

Co-morbidity in Behavioral Health

Stephanie Rago, MEd, NCC

Michael McGrath, MD

Adolescence is a difficult time. Not only for teens, but also for families and health care providers. The average teen has many ups-and-downs, fueled by hormones, as well as personal and cultural expectations. In the midst of this turmoil one must prepare to become an adult. Most make the transition to adulthood without major difficulty. However, a sizable minority of adolescents are sidetracked by mental illness, some by substance abuse - and some by both. The signs of substance abuse can mimic mental illness, and vice versa. When both illnesses are present, it is known as co-morbidity.

Studies consistently show that teens choose alcohol as a mood altering chemical most often, followed by marijuana, but there are other dangerous options. Many have access to prescription drugs such as narcotic analgesics and stimulant medications. Many dangerous drugs are also available to them on the street, in stores, and on the Internet. For example, substances like salvia divinorum, and synthetic tetrahydrocannabinol (THC) also known as "spice" have been the source of local concern recently. And so-called "bath salts", which can have effects like cocaine and Methylenedioxymethamphetamine (MDMA) are being used by teens. Until recently, many of these substances were legal and easily accessible.

In 2009, a study was conducted in Western New York in which teens surveyed reported the following information

- 37% had an alcoholic drink in the past month
- 32% of high school seniors reported binging on alcohol in the past month
- 22% had used marijuana in the past month.

These findings provide some alarming concerns, because the age at which an adolescent begins using substances helps us determine the risk of developing a substance abuse disorder. The National Institutes of Health estimates that adolescents who begin drinking alcohol before the age of 15 are four times more likely to develop alcoholism than those who begin at age 21. The use of substances greatly affects the developing adolescent brain, which does not mature until around age 25. Beyond developmental issues, teen substance use can be linked to school related issues such as: higher drop-out rates and suspensions, legal involvement, risky sexual behavior, and acts of violence.

Diagnosing substance abuse and/or mental illness in teens is often challenging because the warning signs can be very similar. Often warning-sign behavior can be consistent with normal teenage angst and acting out. Key parameters to watch for are social role functioning and mood. Teens struggling with substance abuse and/or mental illness will frequently fail to maintain prior levels of functioning. They may withdraw from family and (non-using) friends and exhibit irritability or hostility when questioned about their behavior. Energy level may vary. Sleep can be affected (either too little or too much), as well as personal hygiene. School performance can suffer. Often it is difficult to get a clear picture of substance abuse because many tend to lie about, or hide their behavior. To further complicate

matters, some mental illnesses (such as Schizophrenia) generally have onset during late adolescence or early adulthood, and some illnesses (for example, Bipolar Disorder and Schizophrenia) can be exacerbated during substance use. Ongoing use of stimulants such as cocaine can make the teen very paranoid and even psychotic.

Determining the severity of substance use and the level of impairment may be difficult, as many people see drinking and drug use as a teenager's "right of passage". While for many young people that may be true, others will over-rely on mood altering substances to self medicate feelings of anxiety and/or depression.

Things to consider in determining when it is appropriate to intervene are a noticeable decrease in meeting one's social role expectations, arrests (especially, shoplifting for easily sold items like infant formula), violent or risky behaviors, and unexpected poor school performance in the context of suspected substance use.

When referring a patient to a mental health or chemical dependency professional it is helpful to tell the provider that you would like to receive a report on evaluation findings, any medication prescribed or changed and ongoing feedback about how your patient is responding. Depending on your evaluation you may want to refer to a provider that has experience in treating co-morbid patients.

Unity Chemical Dependency is the largest and most experienced adolescent treatment provider in Western New York. Our trained experts understand teenagers and know how to reach them effectively. Programs range from educationally-based outpatient programs to more intense outpatient programs to residential treatment. All programs include individual and group treatment and place a special emphasis on family education and engagement to foster relationships that support recovery. While Unity does not provide mental health treatment to children and adolescents, if a mental disorder is suspected appropriate recommendations can be made. Stephanie Rago, MEd, NCC, Coordinator, Chemical Dependency Outreach, Unity Behavioral Health; Michael McGrath, MD, Medical Director and Chair, Department of Psychiatry, Unity Behavioral Health.

2011 EDITORIAL CALENDAR AUGUST–DECEMBER

SEPTEMBER
Chronic Diseases
Prostate Cancer Awareness
Latest Advances in Wound Care

OCTOBER
Oncology Issue
Breast Cancer Awareness
Advances in Physical Therapy

NOVEMBER
Geriatrics - Caring for Older Patients
Diabetes and Related Health Issues
Lung Cancer Update

DECEMBER
Sleep Medicine
Pain Management
Infectious Disease

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Special Columns

Healthcare Reform Update
Invited experts offer perspective on the impact of healthcare reform – what it means, what it might cost, and the impact to the healthcare system and patients in western New York.

Primary Care Perspective
A forum created to share insights from the physicians who deliver primary care to area patients.

Medical Innovation
Learn about the latest developments in technology to improve practice management, patient care and the delivery of medicine.

Electronic Health Records
Area experts and practitioners share valuable expertise in managing the implementation process, avoiding pitfalls and guiding your practice into the through the transition.

Long-Term Health Effects of Environmental Factors Is Focus of New $1.75-Million Study

How exposure to chemicals and other environmental factors from the earliest months of life – even before we are born – affect our long-term health is the subject of a new five-year study by a scientist at the **University of Rochester Medical Center.**
B. Paige Lawrence, Ph.D., associate professor of **Environmental Medicine and of**

Microbiology and Immunology, has been awarded $1.75 million by the **National Institutes of Health** to study how early exposure to factors in the environment affect our immune system.

While chemicals like solvents, pesticides or bisphenol A (BPA) quickly come to mind when discussing "environment exposures," substances in the environment that affect our health come in many forms. Cigarette smoke is a gaseous brew of noxious substances that more than one in five people subject themselves and their loved ones to. The chemicals that line the insides of our food and beverage containers provide a whole set of exposures that most people rarely consider. Even the foods we eat release chemicals whose effects on health are being explored. Lawrence is leading an effort to learn more about how environmental factors wield the influence they do over our immune system, an impact that sometimes lasts for decades after just a brief early exposure. For instance, scientists know that children who are born in heavily polluted areas are less able to shake respiratory infections and have a poorer response to vaccines for many years. Lawrence is trying to understand why, by working in the laboratory to re-create the effects in mice, where the processes can be studied more thoroughly.

"Although we are exposed daily to many different chemicals from our environment, we really don't know much about how most of these substances affect the immune system," said Lawrence.

"When people have concerns about the environment and ask my advice about how to best protect themselves, the first thing I say is that they should know where their food comes from. The major source of human exposure to many chemicals is through what we eat and drink. That's the best starting point. I also recommend not microwaving food in plastic containers. But, ultimately, we need to conduct more research into these questions, and funding for biomedical research is crucial," she added.

In the new five-year study, Lawrence will look at how maternal exposure to a common pollutant, dioxin, alters the immune system of the offspring. Such chemicals oftentimes don't directly damage our DNA; rather, they modify how the immune system responds to germs and other pathogens in some other way – which is what she and members of her research team intend to figure out.

Greater Rochester Obesity Collaborative Part of National Health Initiative

Rochester's team selected as one of 10 to help nation reduce obesity rate

The Greater Rochester Obesity Collaborative has been selected to serve as a national model for obesity prevention and treatment. The Rochester team was among 10 teams chosen to participate in the **Healthy Weight Collaborative (HWC)**, a partnership between the **Health Resources and Services Administration (HRSA)** and the **National Initiative for Children's Healthcare Quality (NICHQ)**, aimed at curbing the obesity rate in the U.S.

Obesity is the leading preventable cause of death nationwide. Monroe County's overall childhood obesity rate is a little more than 15 percent, which is just below the national average of 17 percent, according to a study conducted by **Golisano Children's Hospital** at URMC. **Stephen R. Cook, MD, MPH**, assistant professor of **Pediatrics at Golisano Children's Hospital**, was principal investigator of the study and is the team leader for GROC.

"This project will focus on working closely with our partners in the community – something we've been able to do very well in this community for years. Our partners include community groups, such as local non-profits and government agencies, along with individuals, including parents, pediatricians, nurses, office managers and insurance agents," said Cook.

"We're very proud to share our experience and are very excited to see what we'll learn from the other teams from across the U.S.

The teams will partner with proponents from primary care, public health and community-based organizations. Organizations partnering with the Rochester team include the **Finger Lakes Health System Agency, the Monroe Plan, the YMCA, Cornell Cooperative Extension, the Children's Institute, WXXI** broadcasting and the **Monroe County** and **NYS Departments of Health**.

For more information on the project, and to access tools and resources available to help families and communities improve obesity rates, **visit http://www.collaborateforhealthyweight.org**.

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BE AWARE AND BE INVOLVED!

What to Consider When Your Employer Purchases Professional Liability Insurance on Your Behalf

Stephanie Waxman
Vice President
MLMIC Underwriting

If you are deciding to become an employee of a hospital or physician group, and your new employer is purchasing professional liability insurance on your behalf, there are potential risks that can arise if you are not an active partner in the choices being made. You need to find out, "What kind of insurance is being purchased to protect me?" This article will assist you in your due diligence process by offering a list of questions you should ask, as well as potential scenarios to consider.

Is the insurance coverage limited to the professional services I perform on behalf of my new employer?

When you are insured under a hospital's policy, coverage is typically limited to professional services you perform within the scope of employment in the conduct of the hospital's business. Should you perform professional services outside of your employment, your coverage may not extend to those situations.

What are my limits of coverage?

Are they sufficient? Are they being shared with other physicians and/or an institution, or are you being provided with individual limits of insurance coverage dedicated solely to your protection? If you are insured by a New York State admitted insurance carrier and have primary policy limits of liability in the amount of $1,300,000/$3,900,000 (Each Person/Total), then you satisfy one of the basic requirements for the New York State Section 18 "free" excess limit of coverage, which provides an additional $1,000,000/$3,000,000 limit of coverage. Although a risk retention group (RRG) or a non-admitted insurance carrier may provide an individual limit of coverage, you will not be eligible for this additional limit of coverage.

What is the form of coverage being purchased?

If you are currently insured on an occurrence basis, you should understand the differences between the occurrence and the claims made forms of coverage, particularly if your employer chooses to purchase claims made coverage on your behalf. A reporting endorsement or "tail" is required to cover any claims that are reported after the termination of coverage for incidents or allegations that occurred between the "retroactive date" of the claims made policy (may be the date of employment) and the termination of coverage (may be the date employment ceases). It is important to know from the beginning whether it is you or your employer who will be responsible for the purchase of the tail, should the relationship cease. All too often, a physician is left unprotected for this tail exposure.

(For more information about claims made vs. occurrence coverage, go to our Web site at www.mlmic.com and click on Underwriting – Physicians and Surgeons – Claims Made vs. Occurrence.)

Who makes decisions about the continuation of my insurance coverage?

Are there any underwriting requirements to remain eligible for insurance coverage with your new employer? What if you incur

losses and/or defense costs in the new insurance program? Under what circumstances may you be cancelled or non-renewed? Will you be given adequate notice? Is there a peer review process? Are there any limiting endorsements, deductibles, or unusual exclusions in the coverage being provided of which you should be aware? Do you have the right to consent to the settlement of a claim against you? You should ask for a copy of the insurance policy and have a professional review it carefully.

Is my new insurer regulated? What is my insurance company's current financial condition and its plan for long term stability? Will my insurance company be there when I need it?

You and your employer should understand that there are disadvantages to being insured by an RRG or an insurance company that is not admitted in New York State. Those companies are not subject to the New York Insurance Department's regulation of insurance rates, rules, or policy forms. As such, their premium costs may be low initially, but they can become substantially higher at future renewals when compared with the premium rates of a New York State admitted insurance company. Further, with non- admitted carriers, the cost of the tail, or reporting endorsement, is not regulated and, therefore, there are no limits on what may be charged for such protection. Since policy terms and conditions are also not regulated, provisions contained in the policy may not be as protective as those offered by an admitted carrier, particularly as they relate to the claims made provisions in the policy.

In the event of insolvency of a non-admitted insurance carrier, or an RRG, there is no protection afforded to you or your employer by New York State's Insurance Security Fund, a/k/a the Guaranty Fund. Some insurance carriers require a capital investment and/or assessments should their loss experience and financial condition deteriorate. You need to know, in advance, what your liabilities will be, in the event that your insurance carrier becomes bankrupt or insolvent.

(For more information about Risk Retention Groups, go to our Web site at www.mlmic.com and click on Dateline Newsletter, Winter 2008, Underwriting Update RRGs: Weighing the Risks)

How does my employer's financial condition affect my medical professional liability?"

Aside from the obvious outcomes, should your employer become insolvent or cease operations, your employer may be unable or unwilling to purchase the appropriate tail protection for you, if your coverage is written on a claims made basis. Whether you have an individual policy, or are covered under the institution's policy, a tail or reporting endorsement is required to insure your liability for future claims and suits that may be brought after a claims made policy is cancelled or terminated.

Some other important insurance considerations:

Ask your new employer if you have the option of continuing your current coverage with MLMIC. As an admitted carrier in the state of New York, MLMIC's rates, rules, and forms are regulated by the New York State Department of Insurance, and MLMIC is protected by the state's Guaranty Fund.

Your current individual professional liability policy may remain in force and be managed and paid for by your new employer, subject to underwriting review of any changes in the professional services you may be providing for your new employer. With an individual policy, you can retain your right to consent to settle a claim made against you. You will also be eligible for the additional Section 18 Excess Insurance limit, provided the basic program requirements are met.

You have the option of continuing your current mature claims made policy, whereby your new employer agrees to maintain the years already invested in the claims made program, so that you will remain eligible for a free tail when you retire, or if you become disabled (subject to the terms and conditions of the policy).

For answers to any of your other questions, please contact one of our Underwriting Managers at the following locations: Syracuse Office - Ms. Amy Herendeen at 315-703- 7218; NYC Office - Mr. Robert Pedrazzi at 212-576-9893 or Latham Office - Ms. Stephanie Waxman at 518-786-2740.

What is My Liability?

My Patient's Family Wants to Read the Medical Record

James E. Szalados, MD, MBA, Esq.

Issue

Your patient is hospitalized and unable to communicate. Family members have requested to read the chart. Do the family members have a right to do so? Do you have the right to withhold the information?

There are two aspects of medical records:

(1) the physical chart, and

(2) the information contained in them. The physical chart is the property of the medical provider. Frequently, the actual possession or property right to the physical chart is contractually assigned by providers, to an office or hospital, which then, as custodian of the record, assumes the responsibility for its safekeeping. On the other hand, the information contained within the medical record is the clearly the property of the patient.

Patients have reasonable expectations that the information entered into their record is treated professionally and confidentially; and, that the information will be safely maintained within the healthcare system in case it must be referenced in the future. Under New York law, healthcare providers must maintain medical records for a statutorily designated minimum period of time: physicians must retained medical records for at least 6 years; obstetrical records and records about minor patients must be retained at least six 6 years, or until one year after the minor patient reaches 18, whichever is longer. Hospitals must retain medical records at least 6 years from the date of last discharge.

Thus, the patient entrusts the custodian of his or her medical record with its safekeeping. The patient then also enjoys two types of legal rights to his or her medical information:

(a) a right of confidentiality, and

(b) a right of possession. Of course, patients may legally assign their medical record confidentiality and possession rights to others, such as, for example, their healthcare proxies.

Many doctrines, laws, regulations, and policies address the confidentiality of medical information. The common law concept of the 'physician-patient relationship' dictates that medical information revealed by patients during the medical encounter, objective findings and laboratory data, and also impressions and conclusions made by the treating are 'privileged.' Privilege is a legally protected privacy right: privileged information cannot be released unless the holder of the privilege – the patient – choses to disclose it. Privacy is also a constitutionally protected right: the Supreme Court noted in Roe v. Wade that the medical information within the patient-physician relationship was of the sort that the Constitution sought to protect. More recently, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the subsequent Privacy Rule ("Standards for Privacy of Individually Identifiable Health Information", 65 Fed. Reg. 82462) which became legally effective as of April 14, 2001, made the unauthorized release of confidential medical information punishable under federal law. The Office for Civil Rights of the U.S. Department of Health and Human Services (OCR) is the agency charged with enforcing the HIPAA and prosecuting violators. Finally, state statute, Department of Health regulations, and hospital policies strictly prohibit unauthorized disclosure of medical information. New York State has enacted legislation, very similar to HIPAA, in order to provide an additional state-level of confidentiality to medical informa-

tion; moreover, where HIPAA and the NY State confidentiality conflict, it is the stricter (more protective) of the two that applies . Therefore, intentionally or negligently allowing access to confidential medical information can result in criminal, civil, and disciplinary actions which may be sufficiently serious as to be career-ending.

Authorization for the release of medical information must generally be in writing – rare exceptions may include, for example, where a person is physically incapable of signing a form, and must give a properly documented, and witnessed verbal consent. The authorization for release of information may be unlimited such as for release of all medical records; or, may be limited in scope so as to exclude psychiatric or HIV-related information.

In New York, providers must allow patients to inspect their medical record within 10 days; and, must be prepared to provide a patient with a copy of his or her medical record within 30 days of receiving a properly executed written request. The provider may charge a reasonable fee, not to exceed 75¢ per page for paper copies, and also charge for the costs of postage but may not withhold copies of the chart if a patient is unable to pay for it. Once again, patients have two separate legal rights: the right to obtain, and the right to amend, their medical records. Thus, after reviewing the medical record, patients have a legally – protected right to amend their medical record – to request corrections or additions to ensure completeness or accuracy.

In some cases, the patient loses the capacity to make decisions regarding his or her medical care. Often, this may occur after a catastrophic brain injury, or may be related to an acute severe illness requiring hospitalization and life support. Patients may designate health care proxies to make decisions on their behalf while they are incapacitated, so as to assure that their previously expressed wishes are carried out. In New York, where there is no designated healthcare proxy, state statute establishes a hierarchy of surrogates who are then statutorily authorized to speak on behalf of the incapacitated patient.

In New York State, the right to obtain and amend and patient's medical record may be transferred to a patient's designated 'personal representative' such as a proxy or power of attorney for healthcare. Although the release of confidential medical information may result in misuse or abuse of such information, the presumed intent of transferring legal control over medical information to authorized third-parties is to maximize the potential for personal representatives to understand the context in which they are making their decisions, and thereby, to make decisions that best reflect the incapacitated patient's wishes. Failure to release the information, after a proper request has been obtained, is grounds for a civil cause of action against the custodian of the record. In the case of patients who are minors, the law is somewhat more complex, but similar.

In conclusion, withholding an adult patient's medical record from either the patient or their personal representative can expose the provider and the practice to legal liability. On the other hand, unauthorized release of confidential medical information represents a potentially greater risk. Thus, hospitals and medical practices should have policies, procedures, and specific forms available when patients, proxies, or designated personal representatives request copies of their medical record. In general, it is considered good practice to offer to review the material with the patient or their representative, in order to minimize misunderstanding that may stem from the chart's format, the terminology, and to clarify handwriting; however, such a formal translation may not be requested and is not mandatory.

WHAT'S NEW IN Area Healthcare

Rochester General Reaches Milestone in Minimally-Invasive Robotic Surgery

Program ranks among the busiest in U.S. and serves as a global observation center

Rochester General Hospital's Robotics program, the largest in the region, recently reached its 4000th case. The robust volume of procedures places RGH among the top 3% in the nation for robotic urological procedures; the top 5% in the nation for robotic GYN procedures; and, among the top 5 institutions in the nation performing colorectal procedures with the robotic system.

"This is a truly remarkable milestone for Rochester General Hospital," said John Valvo MD, Director of the RGH Robotics Program. "It is testimony to the dedication of a committed administration and an expert staff."

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

Geneva General Hospital's Nuclear Lab Receives Accreditation

Geneva General Hospital was granted accreditation by the Intersocietal Commission for the Accreditation of Nuclear Medicine Laboratories (ICANL). The laboratory is one of a growing number of nuclear cardiology laboratories in the United States, Canada and Puerto Rico to be so recognized for its commitment to high quality patient care and its provision of quality diagnostic testing.

Participation in the accreditation process is voluntary. Accreditation status signifies that the facility has been reviewed by an independent agency that recognizes the laboratory's commitment to quality testing for the diagnosis of heart disease. Jeff Fultz, director of diagnostics comments "obtaining this type of accreditation is evidence of the commitment our staff has for ensuring our community is offered the best service available. This is yet another step along our path of becoming the best health system of our size in the United States."

Titan Medical Inc. appoints John R. Valvo, MD, FACS Vice President of Medical Affairs

John Valvo, MD

"Dr. Valvo joins Titan Medical at a vital point in our Company's stage of development," said Craig Leon, Titan Medical CEO. "His wealth of knowledge and expertise in robotic surgery will be an important asset in building a novel robotic surgical platform, leading our world-class medical affairs team, and supporting the clinical launch and commercialization of Amadeus. Since his appointment to our medical advisory board nearly a year ago, he has provided innovative thought and leadership, and I am pleased to welcome him to the Titan Medical management team."

"I look forward to working as an integral member of the Titan core team, preparing Amadeus for scientific and clinical trials, future commercialisation, and helping to expand Titan Medical's portfolio," commented Dr. Valvo.

Geneva General Hospital and Soldiers & Sailors Memorial Hospital

Medical Staffs Welcome New Physicians

Ronald D. Spurling, MD

Tamara A. Prull, MD

Tamara A. Prull, MD and Ronald D. Spurling, MD recently joined the medical staff of Geneva General Hospital and Soldiers & Sailors Memorial Hospital.

Dr. Prull is board certified in the fields of Internal Medicine and General Pediatrics. She attended medical school at SUNY Upstate Medical University in Syracuse, NY and completed her residency and internship at Saint Vincent's Hospital and Medical Center of Manhattan. Dr. Prull is assigned in the Emergency Departments at both hospitals.

Dr. Spurling is board certified by the American Board of Psychiatry and Neurology and specializes in Psychiatry. He attended the Medical University of South Carolina in Charleston, SC and completed a combined Internal Medicine and Psychiatry residency program at URMC.

Bariatric Center at RGH Receives Center of Excellence Designation


Anthony DiBenedetto, MD

Rochester General Hospital's bariatric center, Bariatrics of Western New York, has been named a Center of Excellence by the Surgical Review Committee (SRC) in conjunction with the American Society for Metabolic and Bariatric Surgery (ASMBS). ASMBS is the largest organization for bariatric surgeons in the world.

This prestigious, international recognition follows months of review by the SRC to make certain the RGH program consistently delivers the safest, high-quality care to bariatric patients. Ten research-based, comprehensive standards were required to be met before the designation was awarded.

"We are proud to provide the highest standard of bariatric care as evidenced by our being named as a Center of Excellence," said Anthony DiBenedetto MD, Medical Director of the Bariatric Program at Rochester General. Our focus is to provide patients with the best evidence-based preoperative, surgical and postoperative care."

Obesity is a major health issue not only in the United States, but worldwide. In the US, it is estimated at 55% of adults and 25% of children are overweight. Medical conditions related to obesity account for 6% of all healthcare expenses.

"Scientific studies show that patients who have bariatric surgery have a better quality of life" said Dr. DiBenedetto. "And, in addition to increased confidence and improved self-esteem, many medical conditions associated with obesity, such as type-2 diabetes, high blood-pressure/cholesterol and sleep apnea improve or eliminated."

It is important to note that the Center of Excellence designation applies to both the facility and to the practicing bariatric surgeons. At RGH, there are two surgeons specializing in the field: Anthony DiBenedetto MD and Alok Gandhi DO. They regularly perform three bariatric procedures; Laparoscopic Adjustable Gastric Banding, Roux-en-Y-Gastric Bypass and the Gastric Sleeve.

"Every patient has different needs and expectations," said Dr. DiBenedetto. "We not only discuss the appropriate surgical options, but our comprehensive care program is designed to make the patient experience as stress free as possible"

RGH Launches Palliative Care Consult Service

Rochester General Hospital is pleased to announce the development of a specially-trained medical consult service to help patients facing serious and life-threatening illness. Working within the Department of Medicine at Rochester General, members of the new Palliative Care Consult Service will focus on creating a well-coordinated, integrated treatment plan for patients based on the patient's wishes and in collaboration with the patient's primary care provider(s).

"The goal of Palliative care is to relieve suffering and provide the best possible quality of life," said Adam Herman MD, Director of the Palliative Care Program at RGH. Dr. Herman is Board Certified in Hospice and Palliative Care Medicine; Gerontology, and Internal Medicine. "It is our job to maximize care for patients facing the pain, symptoms and stresses of serious illness, as well as facilitate understanding of treatment choices, and provide the support needed to make difficult decisions about their medical care."

Joining Dr. Herman on the Rochester General Hospital Palliative Care Consult Service are Jessica Moore MS, PA-C; Cheryl Pipkin CHE MSW LMSW; Kimberly Stampone MSW LMSW, and Christine Baker, MDiv.

Ralph Pennino, MD Named Chief of Surgery at Rochester General Health System


Ralph Pennino, MD

Dr. Pennino has held the role of Interim Chief of Surgery since January of this year when Ralph Doerr, MD retired from his administrative responsibilities as Chief of Surgery.

"As Chief of Surgery of our System, Dr. Pennino will lead the work currently underway to make RGHS the highest quality and safest surgical program anywhere in the country," said Mark C. Clement, president and CEO of RGHS. "He will also help lead continued clinical integration of surgical services across the system and advancement of clinical partnerships with affiliated providers in the secondary service area."

URMC Surgeon Becomes President of National Orthopaedics Society


Judith Baumhauer, MD, MPH

Judith F. Baumhauer, MD, MPH, has been a trailblazer for years in the field of foot and ankle orthopaedics and today is no different: She was recently installed as president of the American Orthopaedic Foot and Ankle Society (AOFAS), the first time in its 42-year history that a woman will lead the professional organization.

The latest honor follows several other leadership roles. In 2008 she was elected the first woman president of the Eastern Orthopaedic Association, a regional professional organization. Before that, Baumhauer was the first female faculty member appointed to the URMC Orthopaedics and Rehabilitation, and she is one of the nation's few female professors of foot and ankle surgery.

Baumhauer treats patients, conducts research, and directs a busy laboratory, the Strong Foot and Ankle Institute, a joint venture in clinical care and research with the Ithaca College Physical Therapy Department. Physicians and scientists at the Institute study a variety of problems including plantar fasciitis, amputation, arthritis of the foot and ankle, painful flatfoot, and the most cost-effective ways to treat common ailments such as bunions and hammertoes.

Her focus has been to help people function as normally as possible, whether they have a life-altering degenerative disease, a serious injury, or a chronic condition.

"We tend to take our feet and our ability to move for granted," Baumhauer said. "However, about half of all Americans will face a problem with a foot or ankle at some point in their lifetime. Due to a growing population of older people who want to stay active, we have a great need to continue to conduct research that guides evidence-based, cost-effective treatment."

Baumhauer received her MD from the University of Vermont College of Medicine, completed her orthopaedic surgery residency at the Residency Medical Center Hospital of Vermont, and a fellowship at the Foot and Ankle Surgery Medical College of Wisconsin., joining the URMC faculty in 1995.

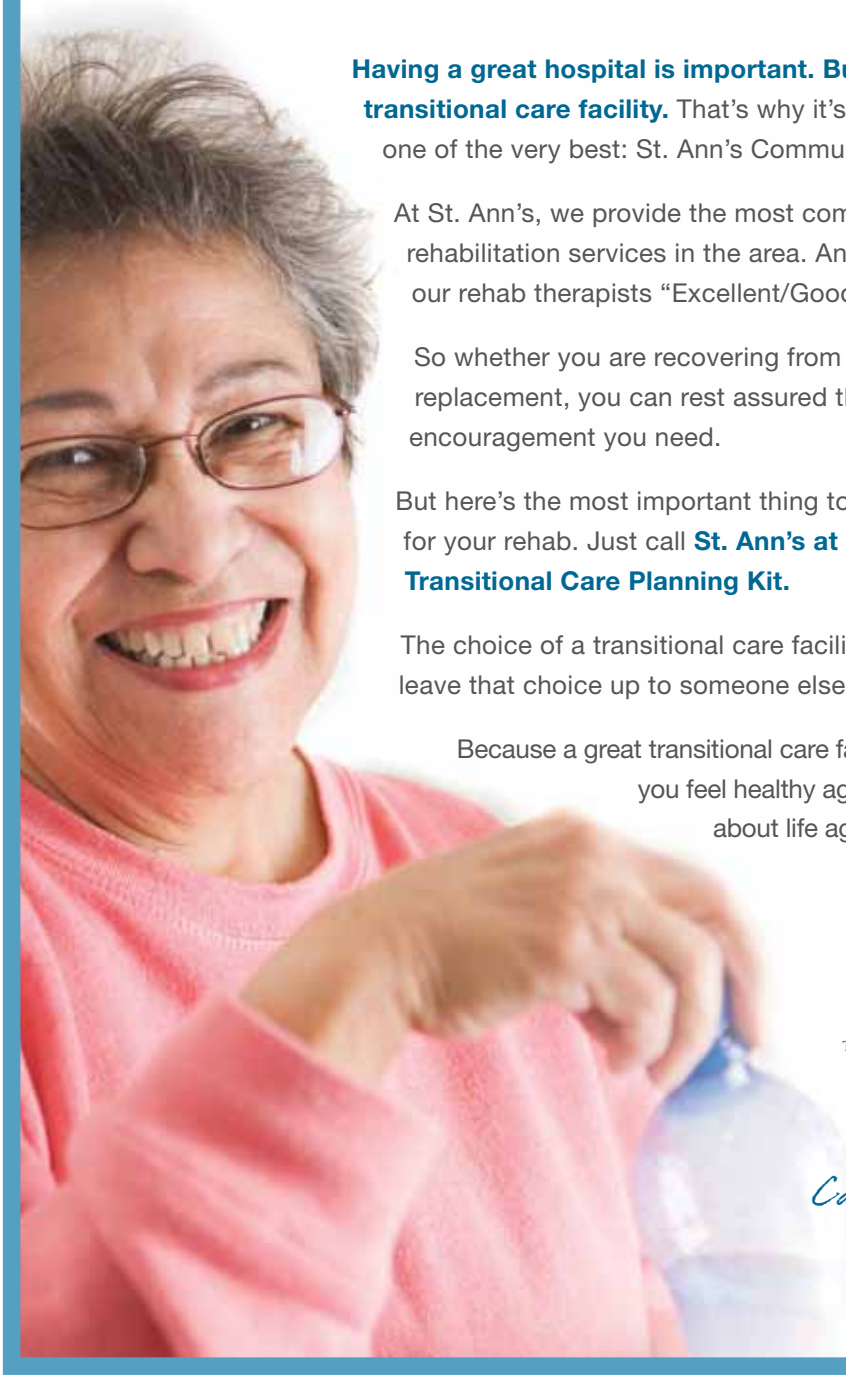
West Ridge OB/GYN is pleased to announce the addition of Dr. Rachel Paulino

Dr. Paulino, born in the Philippines, attended medical school at the University of Santo Tomas and completed her residency in Obstetrics & Gynecology at RGH in 2011. Receiving an award from the RGH Residency program in 2009 or "being kind, honest, generous and especially skilled." She worked with all of our doctors and was felt to be all of these things and an excellent surgeon."

Rachel Paulino, MD

Advertiser Index

They rehabilitated my hip.
And my belief in the kindness of others.



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