ROCHESTER | JUNE ISSUE

Western New York PHYSICIAN

THE LOCAL VOICE OF PRACTICE MANAGEMENT AND THE BUSINESS OF MEDICINE

M. Gordon Whitbeck, Jr., M.D., LLC

Boutique Spinal Care

A Choice for PCPs and their Patients

Maximizing Recovery From Stroke

New Advances in Restorative Neurology and Rehabilitation

Plantar Fascitis: A Common Problem

Differential Diagnosis and Treatment Options

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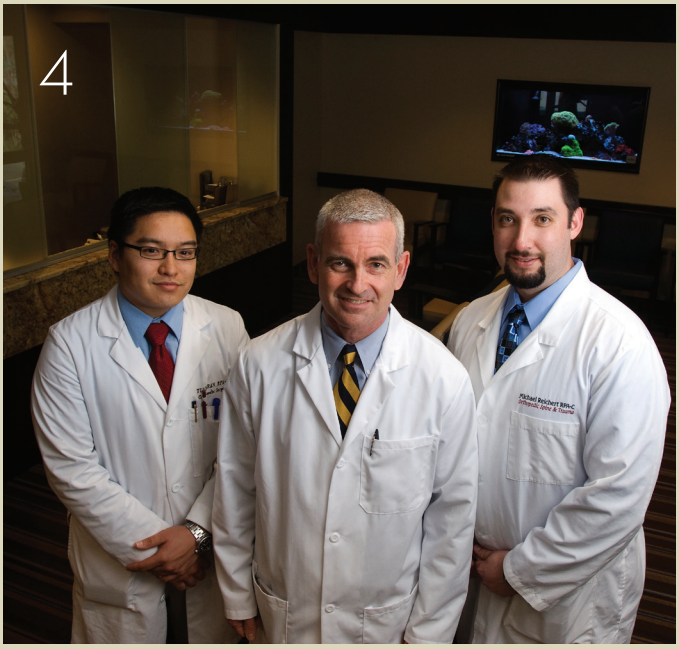

Photographer: Lisa Hughes

"We pay meticulous attention to the entire patient experience, from customer service to patient care," says Dr. Whitbeck, pictured in the reception room with his PA's.

Oral cancer survivor Lou Iovoli, right, accepts the Inspiration Award from Richard I. Fisher, MD, director of the Wilmot Cancer Center, during the 11th annual Discovery Ball.

Welcome to the June Issue of Western New York Physician

This month's cover story highlights Whitbeck Spinal Associates, a boutique-styled practice dedicated exclusively to spinal disorders – from back pain management to complex surgery of the spine. The design of this small practice is uniquely poised to deliver highly personalized and comprehensive care complimented by convenient co-located access to supporting services.

Also in this issue, hear from one of our region's thought leaders in Stroke Care and Management, Mary L. Dombovy, M.D., M.H.S.A. of the Unity Health System. Stroke remains the leading cause of adult disability in the United States; this article highlights some of the latest thinking on restorative neurology and rehabilitation.

Many Stroke patients fall into the "senior" category – a patient group who often has less home care support. Whether recovering from stroke or another post acute health condition, the role of transitional care and rehabilitation can impact the quality of recovery. Amanda Brown, Executive VP and Administrator of Kirkhaven shares insight on the value of evaluating and selecting appropriate transitional care.

Join us in July for a comprehensive look at Women's Health. Hear from local experts as they discuss some of the various health-related complaints affecting this patient group. To contribute editorial or advertising to this issue, please call (585) 721-5238 to discuss.

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

Thank you for reading.

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Western New York
PHYSICIAN

THE LOCAL VOICE OF PRACTICE MANAGEMENT AND THE BUSINESS OF MEDICINE

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Vitamin D

ARE YOUR PATIENTS GETTING ENOUGH?

Everyone needs Vitamin D, and Daniel Mendelson, M.D., is on a mission to make sure his patients get what they need. He's one of the geriatricians who practices at Highland Hospital, and he wants everyone – especially older adults – to know about this essential vitamin and what it does.

Here's what he has to say about its benefits:

"Vitamin D helps the body absorb calcium, which enables us to form and maintain strong bones.

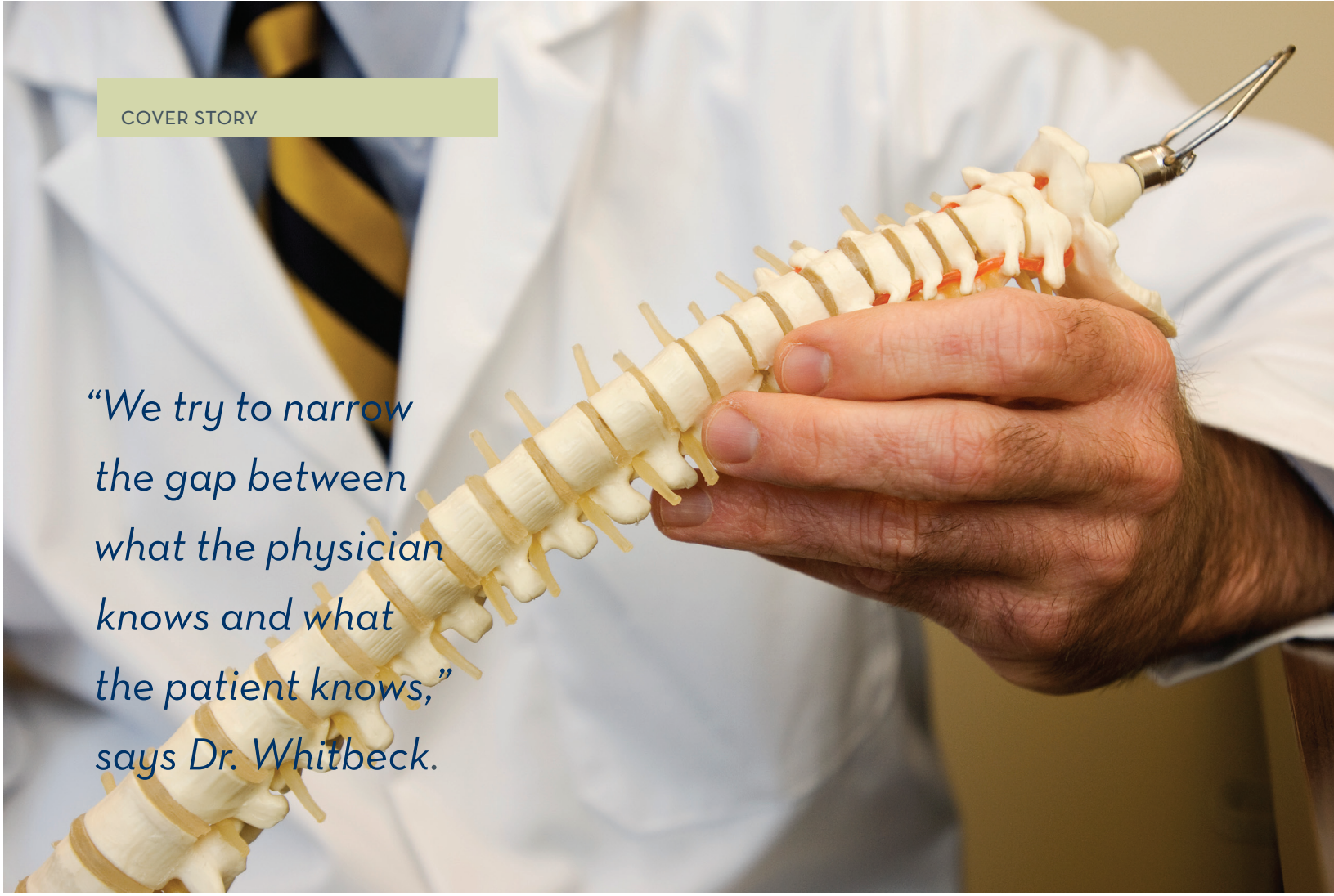
Recent research suggests Vitamin D may have other benefits, such as protecting against osteoporosis, high blood pressure, cancer and several autoimmune diseases.

It is also found to decrease falls, improve muscle tone and reduce chronic pain in the elderly."

Unfortunately, Vitamin D deficiency is very common in this country, particularly in regions like ours that aren't famous for year-round sunshine. (Exposure to ultraviolet rays helps the body use Vitamin D.) A shortage of Vitamin D has major implications for a person's bone strength and overall health, but no obvious symptoms. "Often, an older person's first symptom of this deficiency is a bone fracture," Dr. Mendelson says.

Dr. Mendelson and orthopaedic surgeon Stephen Kates, M.D., co-founded the Geriatric Fracture Center at Highland. Virtually every patient they treat for geriatric fracture is found to have a Vitamin D deficiency. That's why they routinely order a Vitamin D check and treatment of deficiency for their patients.

While Vitamin D deficiency is common, it's easily corrected. "Fortunately," says Dr. Mendelson, "there are no side effects to treatment, Vitamin D supplements are very well tolerated by patients and very inexpensive."



"We try to narrow the gap between what the physician knows and what the patient knows," says Dr. Whitbeck.

M. Gordon Whitbeck, Jr., MD, LLC

Boutique Spinal Care

A Choice for PCPs and Their Patients

Julie Van Benthuysen

The tranquil reception room in Dr. Whitbeck's practice sets the tone for the kind of visit patients can expect from this group of highly-trained spine experts. From the soothing sights and sounds of a wall-length, saltwater fish tank – to spa music and large flat screen TVs in every exam room – Dr. M. Gordon Whitbeck, Jr. and his team have created a warm, relaxed environment in which to deliver the best in customer service and patient care.

"I wanted to bring light and color into the equation to help lower the stress level patients often feel in a healthcare setting," says Dr. Whitbeck. "We pay meticulous attention to the entire patient experience, from customer service to patient care," says Dr. Whitbeck. As a smaller practice, he promotes a more personalized patient experience, with a more accessible staff who knows every patient well. From caring for patients with low back pain to performing complex surgery for patients whose spinal conditions require it, Dr. Whitbeck takes a comprehensive approach to diagnosing and treating the entire range of spinal disorders – all in a manner in which patients come first.

Dr. Whitbeck moved into private practice 10 years ago after serving as Chief of Orthopaedic Spinal Surgery at the University of Rochester Medical Center (URMC). "My goal was to practice in a setting in which I had control over the entire patient experience. We don't try to compete with larger practices any more than a fine dining establishment tries to compete with a restaurant chain. We offer a boutique experience without the boutique expense," he says. Whatever the issue, Dr. Whitbeck and his staff work closely with each patient to assure a smooth transition from one stage of their treatment process to the next. This begins with the patient's initial consult with a Dr. Whitbeck or one of his two Physician Assistants and continues every step of the way to a successful outcome – whether or not surgery is required.

The Experience & Expertise

As the only private practice within a nine-county area focused solely on patients with spinal disorders, Dr. Whitbeck has worked to develop the expertise of his long-standing team of PAs to ensure their knowledge base is far broader than that of the ordinary orthopaedic Physician Assistant. Michael S. Reichert, RPA-C, and Tuan T. Tran, RPA-C, are both licensed in the State of New York, hold national certification, and collectively have been with the practice for 13 years. "The atmosphere we've created here is reflected in our staff attitudes," says Dr. Whitbeck. Everyone is committed to consistency and continuity of care. To that end, only Dr. Whitbeck's PAs assist in the OR and assist with the majority of post-op care.

The team sees patients with the entire range of spinal disorders: *low back and neck pain, muscle strain, whiplash, compression fractures, spinal stenosis, disc herniations, spondylolisthesis, sciatica, complex spinal fractures with or without neurologic deficits, tumors, and infections*. For many patients, surgery is not required.

Dr. Whitbeck performs a lumbar spinal fusion with the assistance of Michael Reichert, RPA-C at Rochester General Hospital. (Courtesy RGH)

For some, surgery is not even an option. Dr. Whitbeck and his Physician Assistants manage the nonsurgical treatment of such patients; physical therapy, chiropractic treatment, massage therapy, spinal injections, pharmacologic treatment and acupuncture may be recommended and response to treatment monitored. For those patients who require surgery, Dr. Whitbeck performs the entire range of surgical procedures from minimal access discectomy to complex decompressive and reconstructive procedures.

Using the latest technology, he often employs biologic substitutes for bone grafting, providing results that are comparable to those observed with traditional bone grafting, but without donor site morbidity. Surgery is rarely the only option presented to most patients. "We never talk a patient into surgery," says Dr. Whitbeck. "We take a much more thoughtful approach. We educate the patient about the specific condition and present the entire range of options for treatment. Our goal is to minimize the knowledge gap that exists between us and the patient so that the patient can make a truly informed decision."

"As an orthopaedic spine surgeon, I don't make the artificial distinction between mechanical and neurologic issues, because there's so much overlap between them," he says. Addressing the entire range of spinal disorders, he and his staff are familiar with and can recommend a broad spectrum of surgical and non-surgical treatments. Regardless of what patients might need, they are uniquely positioned to manage patients through the entire process. "We offer spine care, not just spine surgery," emphasizes Dr. Whitbeck.

Dr. Whitbeck performs all spinal surgeries at Rochester General Hospital (RGH). His training has been extensive. After completing an orthopaedic surgery residency at the URMC in 1991 and a fellowship in orthopaedic traumatology at the MIEMSS Shock Trauma Center in Baltimore in 1992 – focusing largely on polytrauma and spinal cord injury – he completed a fellowship in orthopaedic spine surgery at the University Hospitals of Cleveland in 1993.

Over his extensive career, which includes training nine orthopaedic spine surgeons, Dr. Whitbeck has integrated cutting edge technology into a practice already recognized for its considerable surgical expertise. Most notably, he performed the area's first minimal access lumbar discectomy, minimal access cervical foraminotomy, minimal access spinal instrumentation, and cervical disc arthoplasty. He says, "My extensive traditional training and experience with a variety of surgical options have given me the knowledge, wisdom and judgment to better assess the value of new technology to my patient population. New is not always better."

Collaboration = Full-Service Care

To enhance customer service and patient care, Dr. Whitbeck made a strategic decision to co-locate the array of services commonly required to provide convenient and comprehensive care to patients with spinal disorders.

In recognition of the critical role physical therapy plays in successful patient outcomes, Dr. Whitbeck opened Culver Road Physical Therapy in the same building in 2009. This includes an expansive gym, free parking and massage therapy, appealing features to everyone whether they're patients of Dr. Whitbeck or simply referred there by their PCP. "Our patient-centric philosophy is mirrored in our PT practice, where we can be even more responsive with appointments and access," he says. "Our patients have the option of using our on-site facility where they're supervised by the same doctor and PAs who prescribed PT," says Dr. Whitbeck, "or going elsewhere if it's more convenient." Significant demand for PT – which among other benefits improves a patient's flexibility, strength, and knowledge of ergonomic principles that can be applied on a daily basis – means an additional PT will soon join Frank J. Mikloucich, D.P.T., an experienced PT who holds a doctorate from Duke University. "I trust Frank to handle patients sooner postoperatively than if they went elsewhere," says Dr. Whitbeck, who emphasizes the importance of aftercare in restoring function in patients who have undergone surgery.

Dr. Whitbeck also refers many patients to pain management specialists. Since their days together at the Pain and Symptom Management Center at RGH, Dr. Whitbeck has been sending patients to Dr. Ajai Nemani. Six years ago, Dr. Nemani opened Pain Interventions in Penfield, NY, and more recently a second facility next door to Dr. Whitbeck's practice. Fellowship-trained and board certified in pain management, Dr. Nemani is also an experienced anesthesiologist, having worked alongside Dr. Whitbeck in the OR for many years.

Like his colleague, Dr. Nemani recognized the obvious benefits of collaborating to enhance the patient experience, address-

Michael Reichert, RPA-C and Tuan Tran, RPA-C confer about a patient.

ing customer service and patient care concurrently. Co-location, a commitment to provide timely, convenient access to important nonsurgical treatment options, and effective communication between practices have been invaluable. "Our practices truly complement each other," says Dr. Nemani.

While Dr. Nemani treats numerous patients with spinal disorders, he also treats patients with other musculoskeletal disorders, cancer, and diabetes using a combination of injections, analgesics, muscle relaxants and coordinated physical therapy.

Through collaboration with Dr. Whitbeck, Dr. Nemani's practice continues to thrive. "We've developed a mutual respect for each other's practices," he says. "I trust his opinion and judgment, and he trusts mine. If I needed surgery or someone in my family did, I would trust him over anyone else." Dr. Nemani recently added Dr. Chirag Patel, another pain management specialist, to the practice. As the country's aging population increases in size and spinal disorders become more prevalent, Dr. Nemani anticipates further growth for his practice.

Dr. Whitbeck reviews an MRI and discusses options with a patient. "We offer spine care not just spine surgery" he states. Patient education comprises a large component of Dr. Whitbeck's practice.

Dr. Whitbeck has also enlisted the expertise of Borg & Ide Imaging, now located on-site. "This radiology group has a long tradition of providing superb customer service and patient care, and serves as a tremendous community resource," he says. As one of the largest imaging providers in the region with nine other outpatient locations, Borg & Ide Imaging offers a complete range of imaging services to support the practice, including X-Ray, MRI/MRA, CT/CTA, PET/CT, nuclear medicine, and DEXA for bone density measurement. "It is of the utmost importance that that those practices with whom we collaborate share our patient-centric philosophy, and Borg & Ide Imaging certainly does," he adds.

Happy Patients

Patients coming to Dr. Whitbeck's practice arrive largely through referrals from proactive primary care physicians and the word of mouth of satisfied patients and their families, as well as from neurologists, other orthopaedic surgeons and chiropractors. "A happy patient is our best referral source," says Dr. Whitbeck.

Marty Finkel, 58, of Rochester, speaks with gratitude about his experience with the practice. Five years ago, he began to experience excruciating neck and shoulder pain, severely restricting movement in either direction. He consulted several area physicians who were unable to determine the cause of the problem, despite an MRI and a number of other tests.

He ultimately consulted with Dr. Whitbeck, who recommended a stepwise approach to treatment. Finkel underwent a series of PT treatments, massage and pain management therapies (pain medications and injections) – with negligible improvement. "After several years of pain and one entire year just figuring it all out, my quality of life was not all that good," says Mr. Finkel.

"We discussed all of the options for patients with cervical spondylosis with radiculitis," says Dr. Whitbeck. "I didn't recommend a multi-level fusion because I was concerned that this might hasten the development of symptomatic degenerative changes at adjacent levels. I instead recommended foraminotomies at several levels."

The surgery involved an enlargement of the holes through which the nerve routes exit. For Mr. Finkel, the slow recovery led him to sometimes question if he'd made the right decision. "I encouraged him to be patient," says Dr. Whitbeck. Within two weeks post-op, Mr. Finkel was undergoing PT which would continue for an entire year, with routine follow-ups for an additional year. "For us, it's especially important to over-

see the management of ongoing patient symptoms during the sometimes prolonged recovery period."

Despite an arduous recovery, Mr. Finkel insists he was in good hands throughout the entire process. "Dr. Whitbeck is an amazing surgeon," he says. "It's clear he doesn't rush patients into the OR – he takes a much more conservative approach – and I trusted his diagnosis implicitly. He always made time for me, monitored the case closely and provided thoughtful reassurance."

Frank Miklouich, D.P.T., a member of the multidisciplinary team, consults with a patient at Culver Road Physical Therapy. Dr. Whitbeck's patients benefit from the enhanced communication afforded by on-site physical therapy.

For Mr. Finkel and patients like him, quality of life becomes a barometer by which they measure their health. "You don't realize what you have until you don't have it anymore," says Mr. Finkel. "With spinal pain, people can't see it, so they don't appreciate it until they personally suffer through it. The bottom line is, I'm pain free today," he says. "One day I got up and the pain had completed its course."

In all his cases, Dr. Whitbeck insists that the communication between doctor and patient is invaluable. It entails developing a thorough understanding of patient expectations and educating the patient regarding the condition and treatment options. "Our philosophy is to narrow the gap between what the doctor knows and what the patient knows," he says.

Overcoming Barriers to Referral–Working with PCPs

"Our patient-centric philosophy stresses timely, convenient access to comprehensive spine care," says Dr. Whitbeck. The co-location of collaborating practices such as Culver Road Physical Therapy, Pain Interventions, and Borg & Ide Imaging, which share this philosophy, creates this access and enhances the entire patient experience. "This is what people deserve as patients and what they desire as customers," he adds. Free parking is located immediately adjacent to the building at 2619 Culver Road where the collaborating practices are located. With the assistance of two experienced PAs, Dr. Whitbeck is able to accommodate all requests for consultation within three weeks and requests for urgent/emergent consultation immediately. He does not require patients to have undergone advanced imaging studies – such as MRI – prior to consultation. The office staff coordinates and facilitates arrangements for further diagnostic testing and treatment, referring to a network of on-site or off-site providers that share the same commitment to a patient-centric philosophy. Prompt communication with PCPs following consultation enhances customer satisfaction – patients and their PCPs are customers – and improves patient care.

Thriving Practice, Expanding its Reach

As a native of Waterloo, NY, Dr. Whitbeck understands the Western New York region well, particularly its outlying communities where access to spine care is limited. To better serve these areas, Dr. Whitbeck's practice maintains satellite locations at Life Care Medical Associates in Seneca Falls, Wayne Regional Orthopaedics in Williamson, and at Finger Lakes Bone and Joint Clinic in Newark. He will soon perform spinal surgery at Newark-Wayne Community Hospital.

Culver Road Physical Therapy offers state of the art PT care in a tranquil setting for patients with the entire range of musculoskeletal disorders. On-site massage therapy complements these services.

For Dr. Whitbeck and his staff, boutique spine care implies a focus on the entire patient experience, and embracing a patient-centric philosophy that provides PCPs and their patients with the care they need and the customer service they desire. "It represents a choice for PCPs and their patients who seek an attentive, personalized, comprehensive approach to spine care with one-stop shopping – whether or not surgery is required."

CLINICAL FEATURE

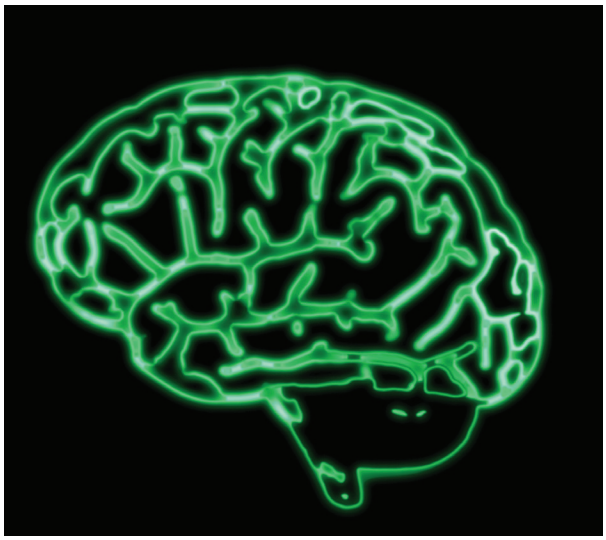
Maximizing Recovery From Stroke

New Advances in Restorative Neurology and Rehabilitation

Mary L. Dombovy, MD

Mary L. Dombovy, M.D., MHSA

Stroke remains the leading cause of adult disability in the United States. The long-term care and management of disabled stroke survivors costs over $34.5 billion per year. Despite receiving considerable public attention and research funding, new treatments for acute stroke have had little impact on these numbers. Lack of access to coordinated care and late arrival at the emergency room currently limit use of these therapies to 3-10% of all stroke cases. The stroke providers in the Rochester area have worked together over the past 2 years to develop standard protocols as well as potential venues for much-needed public education on signs, symptoms and treatment of stroke.



Despite these efforts, many stroke patients will be left with speech impairment, weakness, incoordination, cognitive impairment to the degree that they will need assistance with simple tasks such as walking, dressing, eating – that we all take for granted. As a result, attention is shifting to post-stroke outcome, including the mechanisms of neural repair and the pharmacologic and rehabilitative therapies that may influence recovery.

Over the past 20 years our understanding of how the brain reacts to stroke and other injuries has expanded exponentially. We have progressed from thinking that neurons in the brain have no potential for regeneration or recovery to an understanding that the brain has enormous potential to recover given the correct stimulus and environment. A number of promising therapies are emerging in the treatment of stroke, some of which may soon be paired with cell infusions, trophic factors, and other pharmacologic agents. Animal research has repetitively shown that activity (rehabilitation) is required to facilitate incorporation of these elements, promote neuronal growth, and dendritic sprouting that is ultimately associated with enhanced clinical recovery.

Mounting evidence supports the concept that high-intensity training programs with multiple repetitions not only produce improved clinical recovery, but also cause reorganization of the brain as seen on functional MRI (fMRI). Two of these approaches are Constraint Induced Movement Therapy (CIMT) and Body Weight Supported Treadmill Training (BWST). In CIMT, the unaffected arm is restrained while the patient is required to use the affected arm, at times with an assist device, to complete repetitive and daily tasks. In BWST, part of the patient's weight is lifted via a harness, while the patient walks repetitively over a treadmill, with or without some additional assistance. These approaches have been shown to produce both clinical improvement and activity changes on fMRI, even in chronic stroke patients who

have "plateaued."

Yet, these approaches are slow to achieve widespread implementation: *They are time and therapist-intensive.* They can be physically and mentally demanding for stroke patients, as well as tedious. Pressure to shorten length of stay often results in a fall-back to techniques that use substitution, as they are quicker and easier to implement, even though they may actually hinder recovery by reducing input to the brain from the involved extremities.

Although much has occurred to facilitate stroke recovery, much more needs to be done: *Creative methods of care delivery and reimbursement combined are needed to facilitate implementation of treatments that we already know produce a benefit.* This will require leadership from physicians both on the policy end as well as in the day-to-day management of rehabilitation programs. Rehabilitation or restorative approaches and prevention do not attract the type of research funding afforded to acute interventions. Yet, rehabilitation, education, and secondary stroke prevention have a much greater impact on stroke and the resulting economic burden than all current acute treatments combined.

While cell transplantation techniques combined with various growth factors hold promise for the future, it remains clear that they will only facilitate neuronal reconnection if conducted in concert with repetitive rehabilitation activity. Physicians need to take the lead in addressing the barriers to additional research and clinical implementation.

Dr. Dombovy is the Vice President of the Department of Rehabilitation and Neurology, Chair of the Acute Rehabilitation and Brain Injury Program, Medical Director of The Stroke Center and Medical Director of The Spine Center at Unity Health System.

EDITORIAL OUTLOOK

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JULY

Cover Story: West Ridge OB GYN

Clinical Focus: Women's Health

An in-depth look at the diseases and medical issues affecting women. Hear from local physicians on current trends and treatments for issues relating to lung and colon cancer, periodontal health and cardiovascular risk, thyroid related eye disease.

AUGUST

Cover Story: TBD

Clinical Focus: Pediatrics

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

Special Focus: *Obesity- Breaking the Cycle*
Sports Medicine for Kids
Imaging the Pediatric Patient
Advances in Asthma and Allergy
Medical Talk with Teenage Patients

SEPTEMBER

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Clinical Focus: High Tech Medicine

Opthalmology / Outpatient Care

Reports on significant advances in how care is delivered, trends in treatment, testing and research on diseases of the eye and the impact of outpatient care on the patient and the system.

Special Focus: *Medical Innovators*
Telemedicine

CLINICAL FEATURE

An Update on Bariatric Surgery

Alok Gandhi, DO

Alec Gandhi, DO

The last few months have been an exciting time for Bariatric (Weight-Loss) Surgery. Studies continue to validate the safety and efficacy of bariatric surgery as the most effective medical intervention for durable weight loss and significant resolution of many medical conditions associated with being overweight.

OBESITY AND CO-MORBITIDITIES

Patients with significant medical conditions associated with obesity such as Type 2 diabetes, high blood pressure, heart disease, high cholesterol, sleep apnea, degenerative joint disease, depression, urinary incontinence and infertility are seeking bariatric surgery to improve and resolve these problems. These diseases are often called co-morbid conditions because they are a consequence of being severely overweight.

Patients are empowering themselves through bariatric surgery to regain control of their lives by losing weight and significantly improving their health. Bariatric surgery allows patients to break free from the invisible handcuffs of disease so they can live an active and healthy life.

Many insurance carriers are now covering a procedure known as "Sleeve Gastrectomy" which is an option for many patients in addition to the Gastric Bypass and the Lap Band procedure. The Sleeve Gastrectomy may potentially be better suited for some patients than the conventional bypass or band and it allows us to customize the perfect operation for each patient.

QUICKER RECOVERY AND REDUCED PAIN

At Rochester General Hospital, bariatric surgeries are performed using advanced minimally invasive techniques. This allows us to perform the operation with small incisions allowing the patient a quick recovery and less pain compared to an open or conventional operation. In addition to the Gastric Bypass and the Lap Band, the Sleeve Gastrectomy is also performed with a laparoscopic minimally invasive technique. Patients are often amazed how such procedures are performed through such small incision.

WEIGHT

HEIGHT	120	130	140	150	160	170	180	190	200	210	220	230	240	250	260	270	280	290	300
5'0"	23	25	27	29	31	33	35	37	39	41	43	45	47	49	51	53	55	57	59
5'2"	22	24	26	27	29	31	33	35	37	38	40	42	44	46	48	49	51	53	55
5'4"	21	22	24	26	28	29	31	33	34	36	38	40	41	43	45	46	48	50	52
5'6"	19	21	23	24	26	27	29	31	32	34	36	37	39	40	42	44	45	47	49
5'8"	18	20	21	23	24	26	27	29	30	32	34	35	37	38	40	41	43	44	46
5'10"	17	19	20	22	23	24	26	27	29	30	32	33	35	36	37	39	40	42	43
6'0"	16	18	19	20	22	23	24	26	27	29	30	31	33	34	35	37	38	39	41
6'2"	15	17	18	19	21	22	23	24	26	27	28	30	31	32	33	35	36	37	39
6'4"	15	16	17	18	20	21	22	23	24	26	27	28	29	30	32	33	34	35	37

Patients interested in any bariatric surgery procedure qualify based on a height/weight ratio known as BMI or body mass index. Patients who qualify for bariatric surgery:

Have a BMI of 40 or above or **have a BMI of 35 or above with a serious health condition related to obesity.**

METABOLIC WOMAN

Bariatric & Metabolic Surgery is known to be one of the most effective and longest lasting treatments for morbid obesity. It can positively affect the following obesity related conditions indicated by the diagram on the right.

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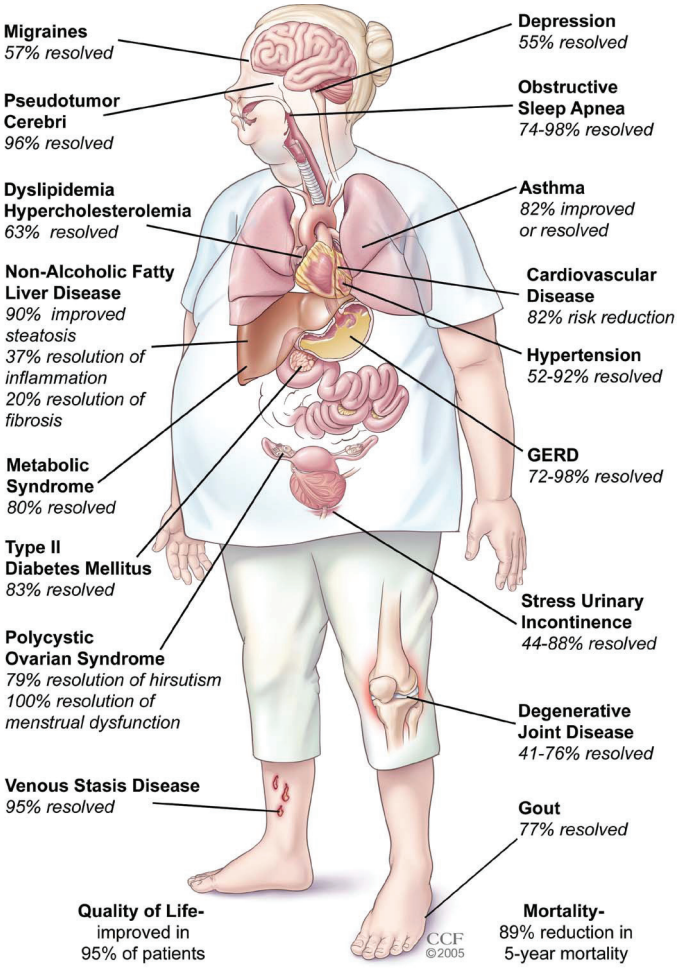

Patients interested in Bariatric Surgery should seek consultation with a Bariatric Surgeon to discuss their case and surgical options. Bariatrics of Western New York at Rochester General Hospital offers free patient seminars in Rochester, Newark-Wayne and Lockport. Registration for these seminars can be made by calling 585-922-LINK (5465).

Plantar Fascitis
A Common Problem

Differential Diagnosis and Treatment Options

Joseph L. Carbone

Joseph L. Carbone, DPM, FACFAOM

Plantar fascitis, often referred to as heel spur syndrome, is a very painful debilitating condition that affects approximately 2-3% of the adult population. Men and women are affected equally regardless of their weight or work/leisure activities. The condition can be more prevalent in those who participate in strenuous sports activities, since plantar fascitis is an overuse syndrome. Plantar fascitis usually strikes individuals in mid-life and later. A proper diagnosis, careful history, and comprehensive treatment regime will usually allow for a complete recovery from symptoms, and will minimize the long-term risk of injury.

UNIVERSAL SYMPTOMS

Most symptoms of plantar fascitis are universally described by the patient and will usually sound familiar to the practitioner. Patient will often talk about excruciating pain during the first 20 steps when they get out of bed in the morning. The pain then eases until the next time the patient sits/rests for a while and then stands. It is cylical during the day as one rests and then steps down again. Plantar fascitis usually does not hurt during prolonged standing or walking as the day progresses or after certain activities. If this is the case a secondary diagnosis of Achilles tendonitis should be considered. Quite often, Achilles tendonitis and plantar fascitis are present concurrently. Pain is usually elicited at the point of maximum fascia stress, which is at the medial calcaneal tubercle. This area is plantar medial at the calcaneus and is easily palpable.

PLANTAR FASCIA

The plantar fascia is a unique band of strong, fibrous tissue that courses the plantar aspect of the feet and is a basis of support. Unlike muscles, tendons and ligaments, the fascia cannot stretch. It begins as three bands (medial, central, and lateral) that originate at the base of the calcaneus. The medial band is the strongest and thickest and is almost always the portion affected by plantar fascitis. As the band progresses distally towards the toes, it becomes much thinner and then joins the area of the toes. Tears in the plantar fascia are commonly situated at the heel area but can also appear further distally in the arch or mid-foot area.

OVER-PRONATION CREATES HAVOC

Over-pronation refers to a hereditary imbalance in patients' feet that causes the feet to roll towards the medial arch and the 1st metatarsal phalangeal joint, when walking or standing. An overabundance of individuals in any population possess this inherent imbalance that create havoc in the foot. Consequently, poor mechanics and an improper weight/stress imbalance in the feet ensue.

Many symptoms manifest themselves because of over-pronation including plantar fascitis, bunions, ankle pain, knee pain, shin splints, and low back pain. When feet over-pronate, they lengthen.

Since the plantar fascia is not a muscle, tendon or ligaments, but a very strong fibrous band, it cannot stretch to keep up with foot lengthening. Therefore, the fascia pulls at its insertion on the calcaneus. Eventually, the fascia pulls long enough to tear away at its insertion.

People will commonly describe a scenario of an activity out of the ordinary or reveal a pattern of overuse from which heel pain has followed. Overuse is common among athletes and especially runners. What essentially happens in the overuse syndrome is the feet over-pronate, which causes the feet to lengthen. The

fascia has usually been under constant pulling tension for years and can't keep up. Eventually, the fascia pulses away from its insertion at the calcaneus and develops micro-tears. The body's normal reaction to these tears is to create an inflammatory response at the site. This quarter-sized area of inflammation is ultimately the cause of pain in plantar fascitis.

Generally, plantar fascitis is most common in individuals who have rigid/inflexible body types or limited joint ranges of motion. Often paired with plantar fascitis, Achilles tendonitis brings a host of other heel symptoms that must be treated.

TREATMENT BEGINS CONSERVATIVELY

The key to resolving plantar fascitis is healing the inflammation or tear. Treatments, such as cortisone injection, nonsteroidal anti-inflammatories (NSAIDs), icing, rest, physical therapies, etc., tend to produce the temporary result of reducing inflammation but usually do not resolve the problem. Over-the-counter heel pads and adjustable splints do little to resolve the pain.

Long-term therapy involves custom prescription orthotics that limit the over-pronation, hence restrict the foot lengthening which further stops the pulling tension of the plantar fascia. Prefabricated arch supports are not recommended since all feet are not created equally. Ultrasound of the affected area combined with immobilization as a temporary measure may also be recommended.

Orthotics should be fabricated using non-weight-bearing or partial weight-bearing plaster impressions and a careful biomechanical exam. The material should be semi-flexible to bring the feet into a neutral (non-pronated) position. The heel area must be deep with a non-horseshoe pad to grip the calcaneus into neutral position at heel strike. Unfortunately, computer generated orthotics only capture foot pressure in a two-dimensional scan. Casting captures the foot in 3D, and by using this method, prescription orthotics can be fabricated with the crucial deep heel seat. Orthotics for plantar fascitis must usually be rearfoot-posted externally because they require a higher degree of rearfoot correction.

SOLUTIONS

A final solution to ending the cycle of plantar fascitis is a surgical approach. Surgery involves lengthening of the plantar fascia and can be performed pericutaneously (minimally invasive surgery). This surgery has a much shorter post-op course than conventional heel spur surgeries.

Approximately 5% of chronic cases of plantar fascitis require surgical intervention. Almost 95% of sufferers get total relief using properly constructed prescription orthotics and other conservative treatment options already mentioned. The success rate approaches 100% when orthotics are combined with physical therapy and anti-inflammatory meds. On average, it takes approximately 12 to 16 weeks for the plantar fascia tear to completely resolve itself. Individuals should limit their activity during the healing phase to avoid further tearing and wear appropriate shoe wear to accommodate the orthotics.

HEEL SPURS

The plantar fascia inserts into the hard periosteum of the calcaneus. After years of over-pronation and a consequential pulling of the fascia at its insertion, the fascia pulls away at the periosteum and forms what is commonly considered a heel spur. This spur, which is evident on x-ray, is not new bone or calcium growth but an out-pocketing of the calcaneal lining.

Heel spur presence is not a diagnosis for plantar fascitis. Heel spurs are purely an x-ray finding. Even if a heel spur is evident on x-ray there may be no evidence of pain elicited by the patient and vice versa. Heel spurs themselves do not hurt. Alternatively, periosteum abnormalities at the Achilles insertion is usually more indicative of heel pain. The tear of the plantar fascia at the vicinity of the heel spur is what causes the pain, along with inflammation. Heel spurs usually needn't be surgically removed.

ACCURATE DIAGNOSIS REQUIRED

Plantar fascitis is an incredibly debilitating condition especially in active patients because it can limit their activity/participation. One must also realize that, although plantar fascitis is the most common type of heel pain, there are other conditions that can crease heel pain such as bruised heel, entrapment neuroma, Reiters Syndrome and Achilles tendonitis. A careful history, examination with palpation, and biomechanical assessment can lead the practitioner in the right direction in making an accurate diagnosis of heel pain. Once the exact nature of the cause of heel pain has been determined, a step-by-step logical treatment regime can commence.

Dr. Carbone is in private practice with Drs. Bonavilla and Chazen at Rochester Foot Care. He is also on staff at RGH and serves on the Board of Golisano Children's Hospital at Strong Memorial.

Strategic Planning Keeps Practices Focused

Michael J. Reilly

Michael J. Reilly, CPA/ABV, CVA, CDA

If an obese patient wants to lose weight, you help him or her develop strategies to reach that optimum weight. And if you play tennis or chess, you understand the value of strategy to beat your opponent. It is only natural, then, to assume that your practice will reach its goals only if you and your partners have developed clear strategies to help it do so.

The process of strategic planning forces you to look at your practice realistically so you can identify growth opportunities, emerging practice trends, competitive strengths and weaknesses, and patient needs.

GETTING THE PROCESS ROLLING

To get started, gather your partners, key managers and financial advisors for an off-site work session during which you review and discuss financial data from the last two years. Topics to discuss include the practice's accounts receivable, charges, gross and net collection percentages, fee schedules, and charges attributable to your referral sources. You should also review expenses incurred by the practice and its key performance indicators.

Include your entire staff in the process of developing goals and strategies. They will likely have some valuable input, and doing so will help build consensus and a sense of teamwork.

In addition, make sure everyone has the chance to raise issues they would like to see addressed whether it is growing competition from hospital-owned practices, a need for hospitalists, a desire for more time with their families, or any other matter of importance to them.

IDEALLY, THESE DISCUSSIONS WILL LEAD TO CONSENSUS ON

A **mission statement** that reflects your practice's reason for being

A **vision statement** that describes where the practice wants to go

A **list of values** that define the behaviors and attitudes that drive your practice

Goals and objectives that explain how the practice will accomplish its mission and vision

Strategies that outline specific actions, rules and guideline used to reach the goals

An **implementation plan** that lists the who, what and when of the strategic plan

If, for example, your mission is to provide quality care to all patients, and your vision is to be the practice of choice for internal medicine within a three-county area, your values may be compassionate and effective care provided cheerfully and nonjudgmentally to all patients.

Then, your goals may be to increase the practice's visibility in its market area and to recruit more physicians and midlevel providers. Your strategies for reaching those goals may include developing a practice newsletter for local distribution, and working with recruiters to identify physicians and nurse practitioners who fit your practice patterns.

Include your entire staff in the process of developing goals and strategies. They will likely have some valuable input, and doing so will help build consensus and a sense of teamwork that will motivate everyone to achieve the practice's goals. Moreover, if your analysis reveals that one area of your practice is underperforming and should be scaled back or eliminated, the staff will likely be less upset if they understand how the underperforming area is impeding progress.

CHECKING YOUR ROADMAP

Once the plan is in writing, make sure it is being implemented. Assign responsibility for each task to specific employees, and set progress deadlines. Then regularly check to be sure everything is proceeding on schedule.

Michael J. Reilly, CPA/ABV, CVA, CDA, is a partner in Dannible & McKee, LLP. He is the partner-in-charge of the firm's Tax Services and Health Care Services divisions. He has an expertise in practice valuations, succession planning and the design of employee benefit and physician compensation plans. He is also a member of the national CPA Health Care Advisors Association (HCAA), which is a national organization comprised of CPA firms who specialize in the health care industry. You may contact him at (315) 472-9127 or via e-mail at mreilly@dmcpas.com.

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CLINICAL FEATURE

Not All Transitional Care is Created Equal

Amanda Brown

by Amanda Brown
Executive Vice President and Administrator of Kirkhaven

As Medicare pushes forward with the bundling of reimbursement funding, sub-acute or transitional care for senior adults, will play an increasingly important role in reducing costs and improving patient outcomes. Studies by the Center for Medicare and Medicaid Services indicate discharge planning for sub-acute care is critical to reducing 30-day rehospitalization rates[1] and the House and Senate health system reform bills call for incorporating post-acute care into bundling initiatives.[2]

Readmissions are responsible for up to half of all hospital admissions, and while readmission rates are not directly related to age, older individuals make a major contribution. Readmissions are costly, both in dollars and health. In June 2008, the Medicare Payment Advisory Commission reported the annual cost of Medicare readmissions alone was $15 billion.[3] Repeated admissions are responsible for up to 60% of hospital expenditures, and particularly among elderly patients, readmissions are associated with increased morbidity and mortality. Factors identified in previous studies that might lead to repeated admissions include premature discharge, poor patient compliance, age of the patient, chronic disability, patient living alone, inadequate medical management, inadequate rehabilitation and poor discharge planning.[4]

Transitional care has a constantly revolving patient case-mix, which requires a broader experience base of its staff.

The burden of responsibility for preventable readmissions often falls on the post-acute care follow-up. Dr. Scott L. Schabel, Medical Director at Kirkhaven, calls hospital readmissions a "failure of the health care system." Readmissions seldom indicate inferior or inappropriate care by any single practitioner, but more often a lack of communication and appropriate transition between levels of care. For example, a Duke Clinical Research Institute study found fewer than 40 percent of heart failure patients saw a health care provider within seven days of discharge. On the other hand, those patients who did receive consistent follow-up were "15 percent less likely to be readmitted within 30 days of hospitalization than those who weren't."[5] Recent studies suggest that perhaps 90% of all rehospitalizations are the result of a breakdown in post-discharge care, specifically a lack of care coordination between hospitals and sub-acute care services.[6]

According to Sam Burge, OTR/L, President and founder of Freedom Therapy (a rehabilitation company that specializes in the development and management of SNF Transitional Care programs), long-term nursing and transitional care are "two completely different animals," and when skilled nursing facilities offer transitional care, they must be cognizant of those differences. Transitional care requires a distinctive mindset. Unlike long-term care where change is often perceived as negative, conditions are expected to change, and change quickly, in transitional care. This expectation of change requires distinctive skills. Discharge planning should begin before the patient arrives on site, and remain fluid at

all times. The accelerated pace of transitional care demands clear and effective communication between every discipline and level of care. Transitional care has a constantly revolving patient case-mix, which requires a broader experience base of its staff. And because the goal is to get the patient to a level of competent self-care as quickly as possible, integrating patient coaching and education throughout is critical.

Historically, average length-of-stay (number of days a patient resides in the facility prior to discharge) was considered a good quality indicator of a transitional care program's success. "Today", states Burge, "we know this is not necessarily true and the push to return patients home sooner often results in premature discharges, rehospitalizations, and less successful (or unsafe) home care." There is a delicate balance between sending a patient home too early and not soon enough; a successful transitional care program maintains this balance.

Post-hospital discharge care for senior adults is generally more challenging and complex than the care of their younger counterparts. Elders may have less home care support, often living alone or relying on equally aged spouses. By providing a graduated step-down in a more closely monitored environment, skilled nursing facilities with dedicated transitional care units are becoming increasingly critical to senior adult subacute care. However, there is no state or federally regulated definition of "transitional care"; any skilled nursing facility can hang out its shingle and accept short-term patients for transitional care. It is therefore incumbent upon physicians and their hospital discharge planners to be intimately familiar with the services, and the quality of those services, to which their patients are transferred for transitional care.

Amanda Brown is the Executive Vice President/Administrator of Kirkhaven, a transitional and skilled nursing facility in Rochester, New York. She has more than 20 years experience in operations and management of senior care centers in Philadelphia and Rochester. Passionate about senior care culture change, Amanda has developed an environment at Kirkhaven built on person center care. You may contact Amanda at a brown@seniorsfirst.com

[1] medstarhealth.org

[2] ama-assn.org/amednews/2010/01/04

[3] Pennsylvania Patient Safety Advisory

[4] International Journal for Quality in Health Care, Vol. 13, No.3

[5] AF Hernandez, MD, Journal of the American Medical Association

[6] amednews.com

Bankers Healthcare Group, Inc.

Prescribing a Plan for Healthier Practices

By Al E. Canal
Executive Vice President of Bankers Healthcare Group, Inc.

It is no secret that the recent spate of pressures and unpredictability in our political and financial systems have created a climate of uncertainty. Daily, the morning paper and the evening news are crowded with stories about healthcare reform, Medicare on the verge of bankruptcy and uninsured Americans. But for all of the focus on the healthcare system, there is little mention of the ways in which this storm has converged on healthcare professionals.

Office-based physicians find themselves squeezed between the political mandates, like EHR and the reduction in reimbursements, and the financial crisis, which has reduced revenue and tightened credit. Thankfully, there is something that you can do to regain control of your bottom-line in the midst of the tumult. A common and understandable error that many physicians make is the failure to see their practices as a business. In fact, every practice is a business. Dr. Steve Morris, MD, JD, FACP, and CEO of Galen Advisors, LLC (the nation's leading advisory group for physicians) states, "I believe physicians must run their practice as efficiently as any other business." And every business needs a business plan. The good news is that a business plan need not be overly complicated, but it can mean the difference between financial success and struggle.

The first two steps in creating a business plan are reflective: thinking about your business as it stands today. First, you need to write a concise mission statement that identifies your guiding principles. Next, outline the overall structure and organization of your business.

In other words:

- **How does your business work?**
- **Who does what? What services do you provide?**
- **What are the key policies and procedures that guide your daily activities?**
- **How do you market your business?**
- **How much money do you earn and spend?**

While it may be time-consuming, the act of writing down a thorough overview of your business will accomplish two pivotal goals: **making you aware of your practice as a business** and **laying a critical foundation for the next several steps.**

The next two steps require you to project your future desires for your business: set goals, and then create strategies and timelines to meet those goals. While your goals may range from the esoteric to the mundane, some of them must be focused on the financial well-being of your business. Keep in mind that it is this financial well-being that equips you to meet all of your other valuable objectives. Dr. Morris suggests, "By having a profitable and 'healthy' practice, physicians are able to offer pro bono care, maintain modern equipment and infrastructure, and accept the lower paying Medicare and Medicaid population. Conversely, a practice that is losing money will soon close or be forced to deny care to the groups that pay poorly."

For example, let's say that you would like to streamline your delivery of healthcare services to increase patient volume and receive some of the thousands of dollars in financial incentives provided in the American Recovery and Reinvestment Act of 2009 for physicians by installing and utilizing Electronic Health Records. First, you need to determine exactly what you want to achieve and when. Perhaps you want to purchase EHR software this year and begin a pilot implementation with two doctors in your practice with the goal of having these two doctors "up and running" by the end of the year. Then you need to craft a strategy to meet that goal. Let's say you intend to accomplish this by temporarily investing in an IT specialist to install and provide training on the software and hardware required and a clerical worker to assist with the time-consuming task of scanning records into the new system. With this strategic and detailed plan in place, you become a creative, problem-solving business owner capable of navigating the fjord of political mandates and economic recession.

"a practice that is losing money will soon close or be forced to deny care to the groups that pay poorly."

The last step, and arguably the most important one, in your business plan is the financial planning phase. You cannot hire the staff and purchase the supplies to meet your goals without money. For obvious reasons, it is crucial to manage your investments wisely. However, as with all businesses, there are times when you may have a need for alternative funding. Keith Drayer, Vice President of Henry Schein Financial Services points out, "Today's office-based healthcare practitioners who are doing projects need access to working capital, funds for contractors, plumbers, electricians, website development, marketing, etc..." Traditional or broad-based lenders may not have the expertise or willingness to provide the targeted needs of a healthcare provider. Fortunately, there are now financial institutions that work exclusively to provide financial products and working capital solutions that cater to healthcare providers. Think about it like this: a patient in need of a knee replacement is not going to go to his family doctor; he will go to an orthopedic surgeon. The same holds true with the financial solutions partner you choose to help you grow and develop your business into a healthy practice.

As an office-based physician, you are not only a provider of health care to your patients, you are a business owner, employer and CEO. You have the enviable position of being able to govern yourself and your business. It is not inevitable that the whims of our political system or the stock market determine your success or failure. A well thought out business plan will place you firmly at the helm of your financial future.

Bankers Healthcare Group is nationally recognized and has been trusted by over 50,000 healthcare providers for their working capital needs. In 2005 BHG was ranked the 5th fastest growing company by Inc. Magazine and honorably mentioned in 2007, 2008 and 2009. For more information please contact Al E. Canal at 315-408-3064 or email acanal@bhg-inc.com.

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Artist rendition of Golisano Restorative Neurology & RehabilitationCenter

WHAT'S NEW IN Area Healthcare

B. THOMAS GOLISANO GIVES $10 MILLION TO UNITY HOSPITAL

Major advances in neurological care for adults and children will become available at Unity Hospital with the establishment of the **Golisano Restorative Neurology & Rehabilitation Center** made possible by Golisano's $10 million gift. Unity will expand and build upon its unique capabilities in traumatic brain injury rehabilitation, stroke rehabilitation, neurological, pre-surgical and post-surgical services. The Center will serve adults and children in need of both inpatient and outpatient care for conditions that range from brain and spinal cord injuries to joint replacements to diseases such as multiple sclerosis and cerebral palsy.

The Golisano Center will be located at Unity Hospital in newly-renovated space currently under construction as part of Unity Hospital's four-year Modernization & Expansion Project. A key component of the Center is Unity's **Acute Rehabilitation & Brain Injury Unit**, which will be relocated from the Unity St. Mary's Campus by early 2014. The Center will also facilitate clinical research in restorative techniques, and ensure that patients have access to state-of-the-art diagnostics, rehabilitation treatments, and adaptive devices.

"We are extremely grateful for this generous gift," said Warren Hern, president and CEO of Unity Health System. "Over the past 20 years, our program has expanded beyond a brain injury unit into an outstanding, nationally recognized program that is like no other in New York State. In fact, very few organizations in the country have our unique range of resources."

Unity has the largest base of neuro-rehabilitation professionals in the Rochester area, headed by Mary L. Dombovy, M.D., M.H.S.A., chair of Unity Hospital's Department of Rehabilitation and Neurology. Her team also includes eight board-certified physician specialists in spinal cord injury care, vascular care, headache, pain, and electro-diagnostics; three neuropsychologists; more than 20 nursing professionals, and 95 therapists.

"As neurologic rehabilitation evolves into 'restorative neurology,' we're promoting recovery and restoring function," said Dr. Dombovy. "Advances in today's tools and technology are helping us to actually repair the brain as opposed to simply helping patients adjust to living with their conditions."

As the only licensed inpatient acute brain injury rehabilitation program in Upstate New York, Unity serves patients from Rochester and surrounding areas, including the Southern Tier and Pennsylvania. Unity's Physical Medicine & Rehabilitation program is:

- *The only program accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) in Western New York, a designation held since 1994.*
- *The only pediatric rehabilitation unit in Western New York.*
- *The Regional Resource Development Center for Individuals with a Traumatic Brain Injury, as designated by the New York State Department of Health.*
- *Specialized in stroke care. Unity Hospital is a Stroke Center, as designated by the New York State Department of Health.*
- *The only rehabilitation center in Rochester that participates in a national database.*

WILMOT CANCER CENTER EXPERT JOINS LYMPHOMA RESEARCH FOUNDATION GROUP


Steven H. Bernstein, MD

Steven H. Bernstein, MD, an oncologist with the **James P. Wilmot Cancer Center** and expert in lymphoma, was recently elected to the Executive Committee of the Lymphoma Research Foundation's **Mantle Cell Lymphoma Consortium**. Mantle cell lymphoma is a rare but aggressive form of non-Hodgkin lymphoma, affecting about 3,000 people each year in the United States. The foundation has launched a well-funded program to expand research for better understanding of the disease to improve care.

Bernstein is professor of Medicine and co-director of the **Lymphoma Program** at the **Wilmot Cancer Center** at the **University of Rochester Medical Center**. His laboratory and clinical research interests center on immunological approaches to the treatment of lymphoma as well as in the development of novel redox active anti-lymphoma therapeutics. Bernstein received two grants from the Lymphoma Research Foundation to examine the effects of rituximab on tumor-fighting T-cells and study the use of a synthesized plant derivative (triterpenoids) to force cellular changes that may destroy mantle cell lymphoma.

He also plays a key role in the Wilmot Cancer Center's major lymphoma research effort. The center holds an $11.5 million grant from the **National Cancer Institute** to identify and study new therapies for lymphomas. **Specialized Program of Research Excellence** grant positions the program as among the top four in the nation.

A graduate of the New York University Medical School, Bernstein completed internship at the University of Chicago, residency at New York University Medical Center/Bellevue Hospital, a clinical fellowship in Hematology and Medical Oncology at Beth Israel Hospital and a research fellowship at Dana-Farber Cancer Institute.

The Lymphoma Research Foundation is the nation's largest voluntary health organization devoted exclusively to funding lymphoma research and providing patients and healthcare professionals with critical information on the disease.

THE EXIGENCE GROUP OPENS ROCHESTER IMMEDIATE CARE

The Exigence Group, a national healthcare management organization that is owned and managed by physicians, opened its newest urgent care center, **Rochester Immediate Care** in Greece, NY. Residents now have a new, fast option for the treatment of non-life threatening illness and injuries. Located at 2745 West Ridge Road, Rochester Immediate Care features a warm and welcoming lobby and waiting area, 16 new exam and treatment rooms, and is equipped with X-ray, laboratory and other diagnostic capabilities. Board-certified physicians assisted by nurses, physician assistants and lab technicians, care for all patients.


Exigence ribbon cutting

Rochester Immediate Care is open from 10:00AM to 9:00PM Monday through Friday and 9:00AM to 7:00PM on weekends, 365 days a year. No appointments are required. In most cases, patients are treated and released in about an hour. The cost to both the patient and insurance provider is significantly lower than the cost of a visit to an emergency room. The phone number is 585.225.5252; web site is www.rochesterimmediatecare.com.

"The communities we serve have embraced the Immediate Care concept and we fully expect the Rochester area to embrace us as well," said Gregory Daniel, M.D., M.B.A., Chief Executive Officer of Exigence. *"By providing convenient, quality healthcare by board certified physicians and experienced staff, and a friendly and welcoming experience, Rochester Immediate Care will meet consumer demand for this kind of medical service."*

COMMUNITY CELEBRATES LOCAL SURVIVORS, WILMOT CANCER CENTER


Oral cancer survivor Lou Iovoli, right, accepts the Inspiration Award from Richard I. Fisher, MD, director of the Wilmot Cancer Center, during the 11th annual Discovery Ball.

Discovery Ball brings $730,000 for research, clinical programs

Hundreds of people celebrated the many clinical and research successes of the **James P. Wilmot Cancer Center** during its 11th annual **Discovery Ball** on May 1. The 730 people who attended the gala fundraiser raised (after expenses) $730,000 to support local cancer research and care.

A highlight was the presentation of the *Inspiration Award*, the center's highest honor, to **Lou Iovoli**. The Victor man is an oral cancer survivor who overcame his disease and went on to complete an IronMan triathlon last year.

As he accepted the award, Iovoli spoke of the difficult moments during his care and of the Ironman and how spectators cheered him on by ringing cowbells. He then challenged the Ball guests to ring cowbells at each table and pledge their support for the **Wilmot Cancer Center**. The room was filled with the clanging of bells and he ultimately raised nearly $150,000.

"Each year we are proud to share the incredible stories of our survivors and Lou Iovoli's courage, strength and determination inspired our patients and the doctors, nurses and staff throughout the Wilmot Cancer Center," said Richard I. Fisher, M.D., director of the Wilmot Cancer Center.

The Ball, chaired by Jim and Donna Hammer, was a success because of the volunteer effort and corporate sponsors that support the Wilmot Cancer Center.

The Wilmot Cancer Center is the Finger Lakes Region's leader for cancer care and research. The 400 doctors, nurses, scientists and staff provide care for more than 10,000 people each year and are dedicated to finding cures.

BRETT SHULMAN, MD APPOINTED TO HEAD NEW RGMG DERMATOLOGY CENTER

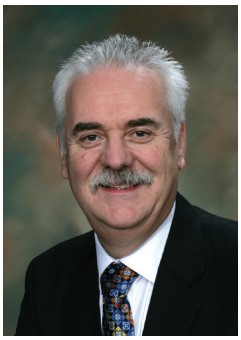

Brett Schilman, MD

Brett Shulman, MD, a Rochester area board-certified dermatologist and skin surgeon, has joined the **Rochester General Medical Group** to head the Group's new **Center for Dermatology** located at 20 Hagen Dr., Suite 220 in the Linden Oaks Medical Campus.

Noted for his expertise in psoriasis, skin cancer surgery and the latest techniques in cosmetic dermatology, Dr. Shulman's practice provides a comprehensive scope of dermatology services from preventive medicine and complex surgeries to a wide range of cosmetic dermatology procedures for people of all ages. He has participated in more than 20 advanced Food and Drug Administration (FDA) sponsored clinical trials and has plans for others.

Dr. Shulman received his undergraduate degree from Northwestern University and his medical degree from the State University of New York at Buffalo. He completed his internship in the Primary Care Internal Medicine program, as well as his residency and chief residency in dermatology, at the University of Rochester's Strong Memorial Hospital. He is a fellow of the American Academy of Dermatology Surgery, the American Society for Dermatologic Surgery, and is a member of many local and national medical societies.

ROCHESTER GENERAL HEALTH SYSTEM APPOINTS NEW CHIEF OF OBSTETRICS AND GYNECOLOGY


Abraham Lichtmacher, MD

Rochester General Health System president and CEO **Mark Clement** has announced the appointment of **Abraham Lichtmacher, MD, FACOG**, as Chief of Obstetrics and Gynecology for Rochester General Health System, effective April 1. Dr. Lichtmacher succeeds Dr. Robert Tatelbaum, who is stepping down after 35 years of outstanding service to RGHS and the greater Rochester community.

Dr. Lichtmacher comes to RGHS from ABQ Health Partners, successor to Lovelace Medical Group, in Albuquerque, New Mexico. Since 2004, Dr. Lichtmacher has served as senior system leader for women's care, first as Department Chair for OB/Gyn at Lovelace, and subsequently as Chairman of Women's Health at ABQ. From 2007 to 2009, he also served in a concurrent role as Chairman of the Board of Governors for ABQ. Prior to his tenure in Albuquerque, Dr. Lichtmacher practiced in Hartford, Connecticut, and served as Lead and Partner Physician for Greater Hartford Women's Health Associates.

Dr. Lichtmacher received his Medical Doctorate from New York Medical College, and completed his residency in OB/Gyn at Brookdale Hospital and Medical Center, where he also served as Chief Resident for Obstetrics and Gynecology. He is Board Certified by the American Board of Obstetrics and Gynecology, and is a Fellow of the American College of Obstetricians and Gynecologists.

CARDIAC, SURGICAL ICUS EARN AWARDS FOR CRITICAL CARE EXCELLENCE

Two intensive care units at **Strong Memorial Hospital of the University of Rochester Medical Center** will be honored with a prestigious award that recognizes the nation's top ICUs. For the fourth consecutive year, Strong's cardiac-vascular intensive care unit (CVICU/7-1600) will accept the **Beacon Award for Critical Care Excellence**, and for the first time, the hospital's surgical intensive care unit (SICU/8-3600) also will be honored.

Sponsored by the **American Association of Critical-Care Nurses**, the Beacon Award for Critical Care Excellence is given to ICUs that consistently exhibit high quality standards, exceptional care of patients and families, and healthy work environments. The awards will be presented at the 2010 National Teaching Institute in Washington, D.C.

"Offering the very best care for our critically ill patients and their family members through the latest evidence-based practices is the primary goal of our team," said Anna Lambert, R.N., M.S., associate director for cardiovascular nursing. *"We are proud to be honored again."*

Each year, staff members provide specialized care on the 14-bed cardiac-vascular ICU for about 1,000 patients who are undergoing treatment for complex cardiovascular surgical and medical issues, such as advanced heart failure, which require a high level of sophisticated and coordinated care.

In addition, the CVICU houses the region's only **ICU-based Critical Care Transport Team**, which operates a customized ambulance to transport critically ill cardiac patients from throughout the region to URMC. These patients are often too sick to travel by standard ambulance service and require extensive staff training and specialized equipment in order to make the several-hour trip to URMC.

On 8-3600, the 12-bed surgical ICU cares for more than 500 patients annually who require high-level treatment following vascular, thoracic, transplant and ENT surgery.

"Our unit practices an intensivist model of specialized critical care and has around-the-clock coverage with nurse practitioners and residents," said nurse manager Joan Romano, R.N., B.S. *"The team also prides itself on providing family-centered care with open visiting hours to allow full access."*

Kathy Parrinello, chief operating officer for Strong Memorial Hospital, said the recognition by the American Association of Critical-Care Nurses is a testament to the commitment demonstrated by the teams of 7-1600 and 8-3600.

"We witness their dedication here on a daily basis and it is only fitting that they are acknowledged nationally as two of best ICUs in the United States."

Stat Law

UPDATE 2010

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

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President Signs Healthcare Reform Bill – State Attorneys General & Doctors Sue to Stop It: Eighteen State Attorneys General and two medical societies have filed lawsuits against the federal government, challenging the constitutionality of the new federal healthcare reform act. The constitutional challenge is based, in large part, upon Congress' decision to fine those who fail to purchase health insurance. This is the first time in U.S. history that the federal government has mandated that its citizens purchase anything. Whether the federal government can do so is the question. The state lawsuits also attack the legislation for creating enormous additional financial burdens on the states to fund Medicaid. It is expected that Medicaid rolls will swell under the new law and that the states will bear much of the associated cost. Physician groups, including a number of state medical societies, specialty societies and even former Presidents of the AMA have voiced strenuous objection to the new Act, despite its endorsement by the AMA. To date, however, only two societies– NJ Physicians and an Arizona based physician organization – have taken action to challenge the bill. KACS represents NJ Physicians in the litigation.

Decreasing Medicare Rates May Lead to Shortage of Medicare Physicians: The recurring reduction in Medicare payment rates has resulted in frustration among physicians who treat patients covered by the plan. Increasingly, practitioners who can afford to absorb the lost revenue are "boycotting" Medicare, effectively shunning the antiquated Medicare rate methodology whereby reimbursement rates are adjusted annually according to the health of the national economy. As the plan is poised to accept an additional seven million "baby boomers" to its beneficiary roll over the next 5 years, the risk that there will be a shortage of physicians accepting Medicare patients is high. Physicians have options when reducing their Medicare load: keep existing Medicare patients but close their practice to new Medicare patients; stop serving Medicare patients altogether; choose non-participation status; or opt out of Medicare and contract privately with Medicare patients. Specific rules and timeframes apply, including state laws governing the termination of the physician-patient relationships. Go to www.drlaw.com for more information on opting out of Medicare.

Office of the Medicaid Inspector General Responds to Provider Complaints: Inspector General James G. Sheehan testified before a Joint Legislative Budget hearing in Albany, on February 9, 2010, responding to multiple complaints of abuse of power and authority during provider audits conducted by the New York Office of the Medicaid Inspector General (OMIG). As previously reported in *Statlaw* (February 2010), these complaints were first brought by the Healthcare Association of New York State (HANYS) and the Home Care Association of New York State (HCA).

In his testimony, Sheehan sought to assure legislators of OMIG's continuing commitment to allay concerns raised by provider groups, telling them that OMIG "takes these matters to heart." Sheehan also announced the adoption of a "one-percent" rule, under which an OMIG audit can be canceled upon a showing of "low levels" of non-compliance.

However, Sheehan did not back down on OMIG's aggressive enforcement stance. Rather, he told the Committee that OMIG is working with agency partners as well as providers to ascertain emerging trends and to take action to recover monies from, and to punish, those who submit improper claims.

While Sheehan promises a renewed commitment to "core values," providers who have already fallen victim to OMIG's abusive audit practices may view Sheehan's vague assurances as little consolation. KACS will continue to monitor OMIG's efforts.

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