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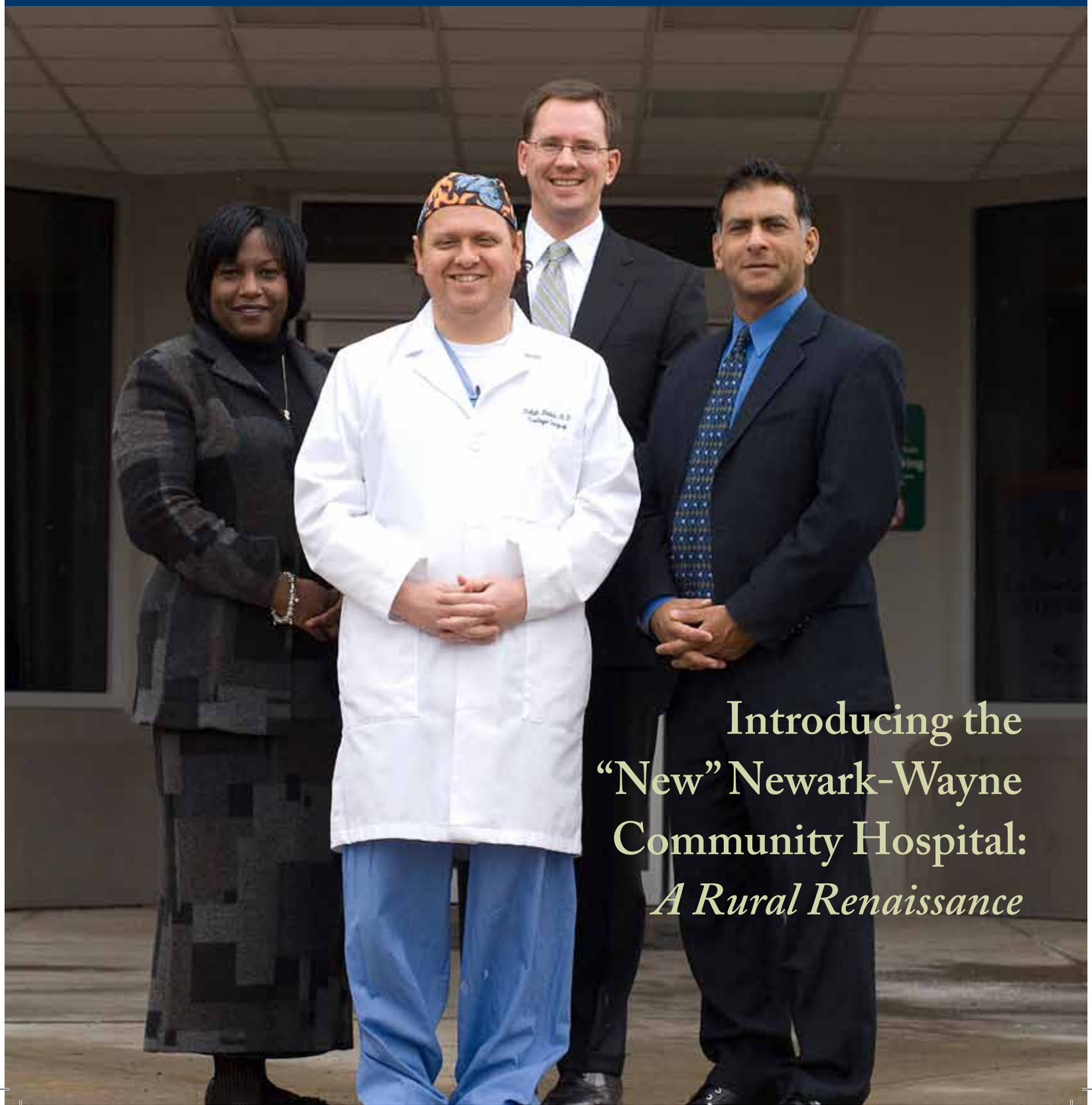

Introducing the "New" Newark-Wayne Community Hospital: *A Rural Renaissance*

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Dr. Madeb reviews the laser protocols with his lead Urologic operating Room assistant, Javier Betancourt.

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Jack be nimble, Jack be quick…

As with any organization, being nimble, agile and quick (aka responsive) in a changing landscape takes steadfast commitment and an entrepreneurial willingness to adjust – *explore new and enhanced ways to deliver* – all while striking and maintaining optimal balance between quality, efficiency and value for the clients served…you might call them patients.

In this issue, we visit the **"New" Newark Wayne Community Hospital**. With a fresh and focused leadership team, backed with a strong and integrated partnership with RGH and a $20 million modernization project underway, Newark Wayne Community Hospital is poised to become the healthcare gem of the Finger Lakes.

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*. We're now accepting editorial submissions and suggestions for 2012. To discuss a submission or learn about guidelines, please email the publisher – Andrea Sperry @ WNYPhysician@gmail.com or communicate directly with us via the website: www.WNYPhysician.com.

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Best –

Andrea

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Intervol Receives a $5,000 Grant from The UPS Foundation Dollars will help improve storage and productivity.

InterVol, a Rochester community-based non-profit organization affiliated with Rochester General Health System, has received a $5,000 grant the The UPS Foundation, the charitable arm of the United Parcel Service.

InterVol's mission is to create community partnerships that generate opportunities to protect the environment by reducing the amount medical waste while benefiting patients around the world. Since 1992, InterVol has collected tons of medical equipment and supplies that would otherwise (by regulation) be destined for disposal. Hundred of InterVol volunteers sort the collected supplies, the bulk of which are shipped to third-world countries in desperate need of these materials. However, some supplies stay here at home and benefit local organizations such as the Humane Society and the Seneca Park Zoo.

"We are very appreciative for this generous grant from The UPS Foundation," said Ralph Pennino MD, president/founder of InterVol and Chief of Surgery at Rochester General Hospital. "This grant will allow us to build new shelving in our warehouse, helping improve storage and productivity."

Get involved with Intervol – **www.Intervol.org**

Palliative Care Program Achieves Top National Certification

In the latest development in its decades-long leadership in the area of palliative care, the University of Rochester Medical Center's Palliative Care Program is one of the first nationwide to earn advanced certification from the Joint Commission, the nation's predominant standards-setting and accrediting body in health care.

The University's program is only the third in the nation – and the first at an academic medical center – to receive this level of recognition from the commission, which launched its advanced certification program in palliative care in September.

Palliative care provides symptom-relieving measures and added support during all stages of serious illness; the focus is on alleviating suffering and relieving symptoms of disease at the same time that patients receive all indicated medical treatments. Timothy Quill, MD, an international leader in palliative care and head of the Palliative Care Division of the Department of Medicine, directs the program and has worked to increase the availability of palliative care to all seriously ill patients, not just those who are facing the end of life. He estimates that about half of patients who receive palliative care recover and are not terminally ill.

Overcoming old stereotypes of what palliative care constitutes remains a priority for Quill, who is president-elect of the American Academy of Hospice and Palliative Medicine.

"Drawing upon palliative care does not mean the patient or family is giving up," said Quill, who notes that one study found that people with lung cancer lived longer if they received palliative care in addition to standard medical treatment.

"Medical treatments are always an important part of the puzzle. But many patients and families are left very frustrated by an increasingly complex health care system, where a single patient might have a dozen different medical teams involved with their care. As palliative care specialists, clear communication about which medical treatments make sense to the patient and family is our procedure of choice. Clear communication itself can provide a great deal of comfort."

URMC Smoking Cessation Expert Offers Tips for Smokers Trying to Quit

Success Comes After Making a Plan, Receiving Support from Loved Ones

With the start of a New Year, millions of smokers across New York State and more throughout the U.S. will attempt to quit smoking. Quitting smoking is a popular resolution, and an appropriate one given World Health Organization estimates that smoking contributes to five million deaths each year. For smokers who are considering quitting as part of a new year's resolution, pre-planning is an important step for a successful outcome.

Scott McIntosh, PhD

McIntosh offers 12 simple tips for quitting

1. Make a plan for quitting. Talk to your doctor about strategies such as quitting "cold turkey" versus nicotine replacement or other medication therapies.
2. If you can give up cigarettes for 24 hours, you double your chance for success.
3. Tell your friends, family and co-workers that you plan to quit and rally them to help you stick with it.
4. Consider using approved medications – nicotine gum, patch, lozenges, spray, inhaler, Chantix or Zyban – to help you quit.
5. Use resources available from the New York State Smokers' Quitline: 1-866-NY-QUITS (1-866-697-8487) and www.nysmokefree.com, the New York Smokers' Quitsite.
6. Use local resources (covered by Medicaid and many insurance plans) at the Healthy Living Center, which provides individual counseling and a quitting plan with tobacco dependence counselors and medical staff: (585) 530-2050.
7. Remove all ashtrays, lighters, matches and cigarettes from the house. Just seeing them can make you want to smoke.
8. Start eating sugarless hard candy or chewing crunchy vegetables – like carrot sticks – to keep your mouth busy. Consider using cinnamon candy, because its "burning" sensation mimics the feeling of smoking and kills the craving.
9. Drink a lot of water. It helps keep you feeling "full," and prevents you from overeating and gaining weight. It also helps "cleanse" your body of the toxins from years of smoking.
10. Practice breathing deeply or take a walk when you're craving a cigarette. Smoking involves taking long deep breaths, but now it'll be fresh air rather than chemicals entering your lungs.
11. Remind yourself why you are quitting - and reward yourself every day you make it without smoking cigarettes.
12. Age doesn't matter - older smokers are less likely to try to quit, but when they do try, they are more likely to succeed.

The New York State Smokers' Quitline is also prepared to assist the more than two million smokers in New York State who say they want to quit. A new advertising campaign that will run throughout the month of January highlights the risks of smoking and directs smokers to the free services that can help them be successful in their resolution to quit tobacco, including the Quitline.

The Quitline offers smokers a free nicotine patch starter kit, coaching tips for quitting, self-help materials, and motivational messages. The Quitline can be reached at 1-866-NY-QUITS (1-866-697-8487) Monday through Thursday, 9:00 a.m. – 9:00 p.m., and Friday through Sunday, 9:00 a.m. – 5:00 p.m. Additional support is available through a 24/7 online smoke-free community at www.nysmokefree.org, and additional tips and resources can be found at www.facebook.com/NYQuits and https://twitter.com/nysmokefree.

"Quitting smoking is the best decision anyone can make to improve their overall health," said Scott McIntosh, PhD, director of the Greater Rochester Area Tobacco Cessation Center and associate director of the Smoking Research Program at the Department of Community and Preventive Medicine at URMC. But McIntosh stresses that having a plan in place is essential to being successful to one's smoking cessation efforts.

"Research shows that if a person makes a plan, builds a support system of family, friends and professionals, that they have a greater chance of successfully quitting smoking and beating nicotine addiction," said McIntosh, who also serves as an Associate Professor in the Department of Community & Preventive Medicine and URMC's James P. Wilmot Cancer Center.

Rochester General Health System

is pleased to announce the addition of several new physicians. Each is now accepting new patients and referrals.

Dr. Nicholas Karis, MD
has joined Genesee Valley Cardiothoracic and the Rochester Heart Institute at Rochester General Hospital as a cardiothoracic surgeon. A graduate of Finch University of Health Sciences, Dr. Karis completed a surgical residency at Mount Sinai Hospital Medical Center of Chicago and a cardiothoracic residency at the University of Mississippi School of Medicine, with surgical, thoracic surgery, and cardiothoracic surgery fellowships at The Buncke Clinic, Northwestern University Hospital, and Case Medical Center. Dr. Karis is Board Certified in Cardiothoracic Surgery. Dr. Karis enjoys spending time with his family, and playing basketball and racquetball. To learn more about Dr. Karis or to make a referral, please contact the Rochester Heart Institute at 585-922-5661.

Dr. Rohit Kumar Sahai, MD
has joined the Department of Surgery at Rochester General Hospital, where he focuses on surgical oncology while also treating patients with general surgical issues. A graduate of the University of Michigan Medical School, Dr. Sahai completed his residency at the University of Pittsburgh Medical Center, followed by a Surgical Oncology fellowship at Roswell Park Cancer Institute in Buffalo. Dr. Sahai is Board Certified in General Surgery. Dr. Sahai is a new father, and he and his wife are excited to be raising their baby girl near her grandparents in Rochester. To learn more about Dr. Sahai or to make a referral, please call 585-922-8350.

Dr. Karl Michalko, MD
has joined Hand Surgery Associates on the Linden Oaks Medical Campus in Penfield, where he focuses on treatment of the upper extremity including the shoulder. A graduate of the University of Rochester School of Medicine and Dentistry, Dr. Michalko completed his residency in Orthopaedic Surgery at University of Rochester Medical Center and in Plastic and Reconstructive Surgery at the University of Wisconsin in Madison, followed by a Hand Fellowship at Brown University's Rhode Island Hospital. Dr. Michalko is Board Certified in Orthopaedic Surgery and Plastic Surgery. A Rochester native and graduate of Brighton High School, Dr. Michalko lives in Pittsford with his wife and daughter. To learn more about Dr. Michalko or to make a referral, please call 585-641-0141.

Dr. Allison Ramsey, MD
has joined the Rochester General Medical Group Center for Allergy, Immunology, and Rheumatology on Alexander Street in Rochester. Dr. Ramsey, a graduate of the University of Rochester School of Medicine and Dentistry, completed her residency and a fellowship in Allergy and Immunology at University of Rochester Medical Center. She is Board Certified in Internal Medicine, with a professional focus on the treatment of drug and food allergies. Dr. Ramsey's outside interests include running, horseback riding, and spending time with her husband, their two children, and their yellow Labrador retriever. To learn more about Dr. Ramsey or to make a referral, please call 585-922-8350.

ROCHESTER GENERAL HOSPITAL

Introducing the "New" Newark-Wayne Community Hospital *A Rural Renaissance*

By Julie Van Benthuysen

Newark-Wayne Community Hospital, a 55-year mainstay to thousands of area patients, has been experiencing a powerful resurgence in recent years. Founded in 1957 to serve a growing rural population, the hospital has been witness to some of the most dramatic changes in healthcare over the past six decades – from groundbreaking new treatments and technologies to the way healthcare costs are reimbursed.

Chief of Surgery, Dr. Madeb in the OR with a few of the supporting surgical team. *"Collaboration between nurses and doctors is the only way our outcomes and satisfaction rates are so high" says hospital President, Mark Klyczek.*

Over the past 20 years, changes in health care combined with state and federal cuts, retiring and relocating specialists and surgeons, outdated facilities and technology threatened the viability of Wayne County's only hospital. Patients were beginning to travel to Rochester or other cities to receive specialty care.

Thanks largely to a renewed commitment by Rochester General Health System, its second largest affiliate, Newark-Wayne's plight has turned into a Cinderella Story of sorts. While the relationship between the two hospitals spans more than two decades, the start of a fresh administration in 2007 has guided Newark-Wayne toward a position of growth and modernization that mirrors many of the initiatives being taken throughout RGH's vast network.

At that time, Dr. Ralph Madeb, who had just completed his residency at the University of Rochester Medical Center, joined Newark-Wayne to help grow its Urology department and other specialty areas by incorporating a telemedicine approach between the rural hospital and RGH.

"Some of my colleagues laughed at me when they learned I was joining a rural hospital that had seen much decline," says Dr. Madeb, Chief of Surgery and Medical Director of Telehealth Services at Newark Hospital. "But I saw a unique opportunity to draw upon the sophistication of RGH in order to create a robust hospital in Rochester's outlying communities where so much need existed."

The condition of Newark-Wayne was not uncommon to rural hospitals, which continue to face great pressures as government payments decline due to their small size, modest assets, financial reserves, and a typically higher percentage of older Medicare patients.

Today, Newark-Wayne is in full partnership with RGH. In just half a decade, nearly 50 physicians have been recruited. Virtually every health care service within the hospital has experienced notable growth. Surgical cases have increased by 51%, up to 3,500 a year. In Urology alone, surgeons and staff have gone from an average of four operations a day to 15. Acute discharges have increased by 25%, and ER visits by 18%. Net patient revenue has increased by 30%, and total debt has decreased by 22%.

Recruiting Top-Notch Providers

"It's a compliment to RGHS hospital administration that we've been able to grow so quickly," says Dr. Madeb. Since he joined Newark-Wayne, several key positions have been assumed by an eager staff of senior professionals who've made marked improvements. "Recruitment is an important premise for becoming a magnet hospital."

As part of the new Emergency Department/Major Modernization Project, this rendering highlights the new Endoscopy Suite that will open this summer.

Dr. Arun Nagpaul, formerly at Clifton Springs Hospital, considered joining the hospital a decade ago, but it wasn't until he saw the aggressive turnaround that he joined in 2007 as Medical Director. "The hospital's relationship with RGH and its ability to integrate such sophisticated services appealed to me," he says.

The recent investments in nurse education have been a key factor in enhancing the quality of care provided at Newark-Wayne. Chief Nursing Officer Deborah Stamps, who has worked within

RGHS for the past 20 years, transferred to Newark-Wayne in 2009. "What a gem we have here. We are a full-service hospital with so much to offer our residents and team," she says. "It's an honor and a privilege to offer care to the more than 93,000 people here who depend on us."

"What a gem we have here."

Mark Klyczek joined the hospital in June 2010 as Administrator at the DeMay Living Center, and became hospital President in Sept 2011. He immediately recognized the high caliber of its nursing staff. "There's a reason why doctors choose Newark-Wayne when they see the level of our nursing care," he says. His vision has mirrored that of his colleagues – to recruit young, competent physicians, surgeons and support staff. "Mark makes sure the input of all hospital staff is taken into consideration as we continue to recruit and expand," adds Dr. Nagpaul.

Major Expansion Underway

RGHS has made a $100 million investment in implementation of an Electronic Medical Record (EMR). Unprecedented renovations now underway are helping to transform the hospital into THE health care provider of choice in the Finger Lakes. "No other rural hospital in the region has our competitive advantage," says Klyczek.

To accommodate the increased need and the modernization of Outpatient Services, Newark-Wayne has broken ground for the next phase of its first major modernization project in almost 20 years later this summer. The $13 million project will include the construction of a new Emergency Department to be completed March 2013.

"These are the biggest upgrades we've had since the ER was built in the 1970s," says Klyczek. "When it's complete, we'll continue to increase volume and add even more services after having experienced record volume last year."

Its Operating Room has received a half million-dollar upgrade with new equipment to support a robotics surgical platform. "The renovation and the addition of top-notch urologists like Ralph Madeb and John Valvo have changed the entire atmosphere in the OR," he says. "Our general surgeons Dr. Ken Toner and Dr. Al-Mahayri ensure that we provide around-the-clock patient coverage."

A new Endoscopy Suite will be completed this July, as well as the creation of a Patient Access Center to house Central Registration, Pre-Admission Testing, the Lab Draw/Specimen Collection Department and a patient reception area. The EKG/EEG Department has already moved to new space as part of the overall project. Other major changes include a newly renovated, state-of-the-art Intensive Care Unit staffed by a specialized care team, and a Birthing & Women's Care Center with a full surgical suite.

"We've made this commitment in money and resources not because Wayne County is necessarily growing, but because more local patients are now choosing to stay here for their care," adds Dr. Nagpaul. "While our area Primary Care physicians have always referred patients to us, they now recognize the greater depth of our offerings. It's ultimately the patients who are making the choice."

Responding to the patients need for access to care closer to home, strengthening Cardiac care and expanding its medically-supervised Cardiac Rehabilitation Program are a top priority.

Growth Across Disciplines

The 120-bed acute care hospital now includes 150 medical and dental professionals and 730 additional health care staff to support its growing patient base. The DeMay Living Center, directly attached to the hospital, averages 64,300 patient days a year, with 180 additional beds. "Collaboration between nurses and doctors is the only way our outcomes and satisfaction rates are so high," says Klyczek.

Throughout its recent growth, Newark-Wayne has also fostered a strong partnership with specialists within Rochester General Medical Group. "With the expansion of so many specialties, more RGH-

based surgeons are coming out to Wayne County to deliver their services," adds Dr. Nagpaul.

Services range from Bariatrics, Breast Surgery and Endocrinology to Plastics and Hand Surgery, Psychiatric Care and Urology. The hospital offers full-service Laboratory Medicine, Radiology, Rehabilitation Services and Musculoskeletal care. Its Allergy, Rheumatology, and Immunology specialty, complete with an Infusion Center, has not been available until very recently.

Several specialties have become key growth areas, particularly Nephrology, Pulmonary Medicine and Infectious Disease care. Strengthening Cardiac care and expanding its medically-supervised Cardiac Rehabilitation Program has also been high on the priority list.

Hospital administration also recognized the need for stronger Orthopaedic services, led by Dr. Daniel Alexander, and invested in specialty products for its new Orthopaedic equipment for joint replacement. Outpatient Orthopaedic services have enabled the hospital to bring in several new Physical and Occupational Therapists. The exponential volume of Orthopaedic cases performed by Dr. Alexander has made Newark-Wayne a center for Orthopaedic cases in the entire Finger Lakes area.

Obstetrics and Gynecology is experiencing explosive growth at Newark-Wayne, and is on its way to becoming a Baby-Friendly designation hospital. Sponsored by the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF), the Baby-Friendly Hospital Initiative (BFHI) is a global program to encourage and recognize hospitals and birthing centers that offer optimal care for infant feeding. The BFHI assists hospitals in giving mothers the information, confidence, and skills needed to successfully initiate and continue breastfeeding their babies or feed formula safely, and gives special recognition to hospitals that have done so.

Newark-Wayne has also engaged in the MORE^{OB} (Managing Obstetric Risk Efficiently) program. MORE^{OB} is a collaborative program designed to build and sustain a culture of safety by developing the knowledge, skills, attitudes, behaviors and practices that make safety the top priority. "This program will enhance our patient safety culture and improve clinical outcomes," says Stamps. In the past year alone, perinatologist Dr. Mann and two OB/GYN physicians have joined the hospital staff, a testament to its commitment to women's needs.

Keeping Patients in Town

Because of the increased number of hospital beds, Newark-Wayne is able to accept more patients, transferring them to RGH if the expertise is only available there. "We're a much busier surgical hospital these days," says Dr. Madeb, "particularly because we're able to employ a telemedicine approach. I joke that we've almost forgotten how to transfer a patient OUT of Newark-Wayne."

Telemed gives Newark-Wayne the ability to bring in other specialists from within its system, either inpatient or outpatient, so that patients don't have to leave the comfort of their own community. "While they might have their surgery at RGH, patients are able to handle all of their follow-up consults by just coming here and using our Telemed equipment," he says. Approximately 150 patients each month use this approach, with a large increase in Tele-ICU rounds.

The recent half-million-dollar upgrade to the OR prepares NWH to support lasers systems and the new robotic surgical platform. Above Dr. Madeb reviews the laser protocols with his lead Urologic operating Room assistant, Javier Betancourt. NWH is one of the only hospitals on the Finger Lakes that have its own dedicated Green Light Laser system which is used to treat men with enlarge prostate glands.

Telemedicine expedites testing, diagnoses and treatment, he adds, providing potentially life-saving access to medical specialties and leading-edge therapies without added travel and cost. Since Dr. Madeb brought it to Newark-Wayne, the hospital now has more than 30 physicians and five mid-level providers who participate, including daily use in the ER.

The recent addition of Allergy, Rheumatology and Immunology specialty care, complete with an Infusion Center, responds directly to the patients need for convenient access to services.

A Patient-First Story

Scores of patients have already reaped the benefits of Telemedicine – from those just requiring a one-stop follow-up after a sports injury to others whose multiple conditions require the care of specialists across many disciplines. For one such patient, the Telemed approach has truly kept him alive and hopeful during several years of ongoing challenges and setbacks.

Richard Ellinwood, a 44-year old Wayne County resident, developed H1N1 in 2009, which destroyed his immune system to the point where his lungs collapsed and his gall bladder and kidneys failed. Before he was brought to RGH from another rural hospital, he had been read his last rites three times. Once stabilized, he was transferred to Newark-Wayne in July 2010 to be closer to home.

Since that time, because of numerous medical conditions and surgeries, Richard has been moved between the hospital's ICU and the DeMay Living Center several times, and Telemed has allowed a multi-disciplinary approach to care.

Ellinwood was recovering from a large decubitus ulcer. Utilizing "Fred", Newark-Wayne'se Telemed robot, doctors have been able to monitor Richard's ulcer and continue effective treatment. "Fred's my buddy," he says. "He can focus and see everything that's going on in me. It's just amazing." His wound is now reduced to centimeters in size.

"Across the board, the care here has been great," says Ellinwood. "I've had the same nurses since Day 1 and they take good care of me."

Despite the grueling treatment regimen, and the development of a rare, particularly aggressive form of cancer that has spread to his legs and lymph nodes, Richard's spirits remain high and continue to be an inspiration to his team of care providers. "I'm lucky to have the access I do," he says. From plastic surgery, infectious disease, and wound care, to radiology, PT and OT, Richard has quite a staff at his disposal. "I have Telemed Frequent Flyer Miles and I fly first class here," he jokes.

Due to the constant PICC lines in his hands early on, his mobility was severely affected. "I worked with Infectious Disease and Hand specialist Dr's. Chessin and Pennino, who helped me get my right hand working well again. Now I can feed myself, dial a phone and use a computer," he says. "When I first got to Newark-Wayne, I couldn't even lift a glass."

Richard compliments the staff for going the extra mile for him. "They're like family here," he says. "They share their family photos with me. I'm part of their lives and they're part of mine."

Dr. Madeb, who has seen hundreds of patients using the Telemed vehicle, stated the possibilities are endless for expanded use across all specialtie . "A decade ago, patients would have just been transferred to RGH for specialty care," he says. "Now with the same level of acuity, we can keep them at home, by bringing the appropriate doctors here."

Becoming THE Hospital of the Finger Lakes

As Newark-Wayne moves forward early in this new decade, its administration is poised to create THE Hospital of the Finger Lakes.

"This is just the beginning," says Klyczek. "It took a lot of upward investment on our part, and a total top-down commitment. Having expertise from RGH to draw upon has had an enormous ripple effect. We've essentially become a mini-version of the RGH model, following all the same medical protocols."

By the same token, he says, Newark-Wayne has become a much greater benefit to its larger affiliate. "Even though we're smaller, RGH has been able to borrow some 'best practices' from us as well," says Dr. Nagpaul. "We have so many good things to share."

The hospital team members tout its advantages as a smaller hospital – less red tape and a more personal touch. "Its old-fashioned medicine with a modern feel, and more people outside of the Newark area are taking interest," adds Dr. Madeb. "We want patients to know that the Newark of yesterday is not the Newark of today, nor is it the Newark of tomorrow."

Process Makes Perfect

Embracing Standardization, Collaboration and a Passion for Quality, the Rochester Heart Institute has Become a National Leader in Cardiac Care

Number one in New York State for major cardiac surgery and overall cardiac care. Among the top three hospitals nationwide in those same categories. High marks from consumer publications. And hospital mortality indices that are regularly better than the average state and national rates.

These are just a few of the recent objective third-party reports that recognize the Rochester Heart Institute (RHI) at Rochester General Health System (RGHS) as a cardiac program of exceptional quality – a true regional and national leader. But to Dr. Ronald Kirshner, RHI's Chief of Cardiac Services and Cardiothoracic Surgery, those "raves" that compare his program to others around the country offer, at best, an incomplete measurement of his program's success.

The RHI standard, according to Dr. Kirshner, is simple. "Nothing less than perfection," he says. "People say we should be proud of our record, and I am – we have a great team, and they do great work. But when people get excited about being above average, I get confused. I mean, what's so great about just being above average?

"Anything less than perfection means there's still room for improvement," Dr. Kirshner adds. "So we aim for perfection every day."

Evolution of a Process

For the Rochester Heart Institute, the route to perfection requires precision; and the key to precision is a process that has taken shape over two decades, and that continues to evolve today. That process is the heart of RHI's success, uniting hundreds of dedicated team members – surgeons, cardiologists, physician assistants, nurses, technicians and other care providers – toward the pursuit of excellence in every aspect of patient care.

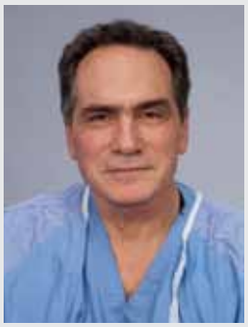
Ironically, the program that today sets a standard for cardiac care has origins outside of healthcare altogether. In the early 1990s, Dr. Kirshner and a team from the hospital met with representatives from General Motors and the Institute for Healthcare Improvement as the carmaker was looking for an ideal medical program to test a production model that prioritized quality-based standardization.

"Traditionally, working in healthcare means doing things a certain way," Dr. Kirshner says. "We wanted to create a system that worked the way we wanted it to work – not the way it had worked all along."

That meant redefining team relationships, and taking a hard look at any unnecessary or illogical steps in the customary cardiac-care model. "Everyone on the team understands that we all work together, and that there are no roles that aren't absolutely important," he says. "The same thing goes for the process itself: If there's something that doesn't make sense or that should be changed, we fix it or we get rid of it. There's no tolerance for things that slow us down, or that stand in the way of patient care."

Along the way, the team was prompted to consider the distinction between safety and quality. "Of course safety is important. But a system that makes safety the top priority can still accommodate small mistakes that don't result in patient harm,"

Dr. Kirshner says. "But if you develop a true quality-based program like we have – one that demands perfection from the process itself – then even the smallest error stands out as something to eliminate. And that's important, because who knows what a small error today could do tomorrow? The quality-based process is the best way to arrive at not only patient safety, but the absolute highest quality care possible."



"The quality-based process is the best way to arrive at not only patient safety, but the absolute highest quality care possible."

~ Dr. Ronald Kirshner, MD

Super-Standardization

The operational core of the RHI quality-based process is standardization – creating repeatable models that facilitate efficiency at every stage of patient care.

For example, because reduced surgical times also reduce the risk of complications and infections, standardizing the cardiac surgical service – in the makeup of the ORs, the procedures, and the teams themselves – has created a streamlined environment that minimizes delays and, in turn, maximizes positive patient outcomes.

That's why there are fewer tables of instruments in RHI's three operating rooms than you'll find in typical ORs – and why there's much less talking among the surgical team. "When you only need one table of instruments, setting up more than that just takes unnecessary time, and gets in the way," Dr. Kirshner says.

Those instruments and other necessary equipment are also set up the same way in every OR. "Once we thought about it, we knew it just didn't make sense to have different arrangements for different doctors," says anesthesiologist Dr. Robert Cafarell. "Having everything consistent definitely minimizes the potential for errors."

Caroline Kenyon, RPA, a Physician Assistant who regularly assists in the OR, attests to the benefits of that consistency. "It's like a ballet in the OR – everything's so well organized and thought out, and it happens the same way every time."

Pre- and post-op nursing procedures are equally well orchestrated – everything from the advance designations of specific pre-op beds for incoming surgical patients, to the myriad standardized infection prevention measures that have helped RHI reduce MRSA incidents and achieve a zero chest-wound infection rate for the last two years.

The nursing teams understand and embrace the process so well, that they can accommodate changes that track to individual patient needs before returning to the set process without missing a step. "Everyone goes above and beyond to make people feel cared about – not just cared for – before and after surgery," says Virginia Riggall, RN, a Clinical Nurse Specialist in the CTICU.

As these standardized protocols have proven their value in the cardiac service, other service lines within RGHS have begun adapting and integrating them with their own processes, as well.

A Collaborative Culture

A comprehensive process like this wouldn't work without exceptional communication – and total collaboration – among RHI team members. "Anybody who goes near a patient – from the surgeon to the nurse to even the housekeeper – holds in their hands the ability to affect that patient's outcome," says Linda Greene, MPS, RN, CIC, Director of Infection Prevention at RGHS. "That makes it really important for everyone to understand how vital they are to the process – and how vital it is for everyone to work together."

Structured communication takes two forms in the cardiac service. First are the daily huddles in the CTICU and Progressive Care Unit, brief meetings for sharing updates about the specific patients on the floors, and for teaching opportunities from nurse and physician leaders. Then there are the Friday morning meetings, where more long-range topics are discussed – and decisive solutions are encouraged.

"Too much administration in any environment can be its own worst enemy," Dr. Cafarell says. "Dr. Kirshner understands that, and he's set up a system that pushes us all to make the changes that we feel need to be made – and to do it immediately. At the Friday meetings we'll discuss an issue, and then we'll make a change. If we need to adjust it later, we will. The philosophy is, the longer we wait, the longer a problem goes unresolved."

That mentality extends to all levels of the RHI staff. "I see bedside nurses come up with these incredible ideas, because they know they're going to be listened to," says Marcia Ragan, RN, a Nurse Manager in the CTICU. "Dr. Kirshner really understands how important it is for everyone to have a voice."

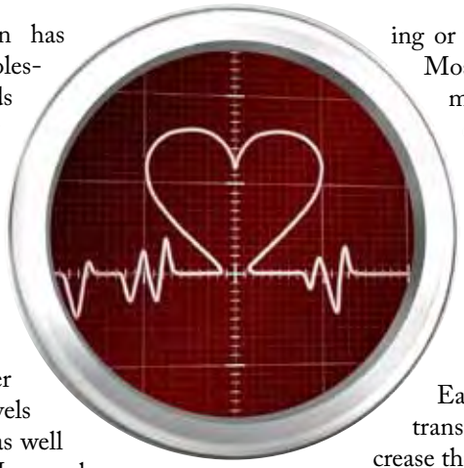
Meanwhile, the head of the Rochester Heart Institute is energized by his team's successes – and by the inevitable human error or mistake. "We always learn from our mistakes. In fact, our mistakes make us stronger," he says. "And every time I see how well we're doing, I think, 'So how come we're not perfect?'"

To learn more about the Rochester Heart Institute at Rochester General Health System, or to make a referral, contact ***585-922-5661*** *or visit www.rochestergeneral.org/heart.*

Reducing Your Risk of Cardiovascular Disease

John D. Bisognano, MD, PhD, *Director of Outpatient Cardiology and the Hypertension Program at the University of Rochester Medical Center*

CASE



A 57-year-old, reasonably active man has mild hypertension and elevated cholesterol. A former smoker, he is 40 pounds overweight. He exercises 3-4 times per month, sometimes vigorously, and suffers knee pain from a previous injury. He has a family history of diabetes, though he does not have diabetes. His father died from a stroke in his 60's and his mother is alive and in her mid-80s with minimal health problems. He has been prescribed medication to lower his blood pressure and his cholesterol levels and he reports taking natural remedies as well that he purchases from a local store. He says he wants to reduce the number of pills he takes daily.

DISCUSSION

This patient is on a common path toward cardiovascular disease. Standard care is to encourage him to lose weight through exercise and improved diet and intensify and adhere to the medications to lower his blood pressure and cholesterol levels.

However, this gentleman would benefit from adopting simple lifestyle changes to reduce his risk of serious heart disease. Doctors recommend:

Improve cholesterol levels.

The risk for heart disease increases as your total amount of cholesterol increases. Your total cholesterol goal should be less than 200 mg/dl; HDL, the good cholesterol, higher than 40 mg/dl in men and 50 mg/dl in women; and LDL should be less than 130 mg/dl in healthy adults and sometimes even lower in people at higher risk for cardiovascular disease.

Control blood pressure.

Hypertension plagues about 70 million people in the U.S., making it the most common cardiovascular disease risk factor. Nearly one in three adults has systolic blood pressure (the upper number) over 140, and/or diastolic blood pressure (the lower number) over 90, which is the definition of hypertension. The best way to control blood pressure is through diet, exercise, weight management, but many people will ultimately need anti-hypertensive medications. These medications are largely generic and most people can be treated to their blood pressure goal with minimal if any side-effects.

Get active.

Many of us lead sedentary lives and exercise is not a routine part of our lives. That's dangerous because many studies show that people who don't exercise face heart disease more often, and a greater risk of death. Even leisure-time activities like gardening or walking can lower your risk of heart disease. Most people should exercise 30 minutes a day, at moderate intensity, on most days. More vigorous activities can offer greater benefits. Exercise should be aerobic, involving the large muscle groups. Aerobic activities include brisk walking, cycling, swimming, jumping rope, and jogging. If walking is your exercise of choice, use the pedometer goal of 10,000 steps a day.

Eat right.

Eat a heart-healthy diet low in salt, saturated fat, trans fat, cholesterol, and refined sugars. Try to increase the number of fruits, vegetables, nuts and grains you eat every day. If you feel you should follow a specific diet plan, consider the DASH diet or the Weight Watchers program as well as the Ornish, Zone, and South Beach diets. Look on the web or browse the bookstore for a diet approach that you can tolerate for the long haul, and not just for a passing few weeks. It won't be easy to stick with a diet, and if you "fall off the wagon," don't worry, keep going. You have never spoiled your opportunity to start improving your diet and increasing your exercise.

Achieve and maintain a healthy weight.

Excess weight puts significant strain on your heart and worsens several other heart disease risk factors such as diabetes, high blood pressure, and high cholesterol and triglycerides. Research is showing that obesity itself increases heart disease risk. By eating right and exercising, you can lose weight and reduce your risk of heart disease.

Control diabetes.

If ignored, diabetes can lead to significant heart damage including heart attacks and death. Control diabetes through a healthy diet, exercise, maintaining a healthy weight, and taking medications as prescribed by your doctor.

Quit smoking.

Smokers have more than twice the risk for heart attack as nonsmokers. Smoking is also the most preventable risk factor. If you smoke, quit. Better yet, never start smoking at all. Nonsmokers who are exposed to constant smoke also have an increased risk. There are many resources available to help smokers quit and many people would benefit from short-term medication to enhance the chance of staying off the cigarettes.

Manage stress.

Poorly controlled stress and anger can lead to heart attacks and strokes, largely by causing us to slip into lifestyles that involve less exercise and poor eating habits. Practice relaxation techniques, learn how to manage your time, set realistic goals, and try some new techniques such as massage, Tai Chi, or yoga.

Combating Arrhythmias

URMC Launches Nationwide Trial to Test New Drug Therapy

Wojciech Zareba, MD, PhD
Director of Clinical Cardiology Research, University of Rochester Medical Center

Ventricular arrhythmias - irregular heart rhythms that originate in the lower chambers of the heart – are associated with an increased risk of death. Unfortunately, patients with heart disease who are at heightened risk for such arrhythmias have limited treatment options. Standard of care for such patients includes the use of an implantable cardioverter defibrillator or ICD, which is designed to prevent sudden, rhythm-related cardiac death. While ICDs protect patients if they have an arrhythmia, they do not treat the disease or decrease the risk of subsequent or new arrhythmias. A new, safe and effective anti-arrhythmic drug is in high demand.

With a $10.5 million grant from the National Institutes of Health, researchers at the University of Rochester Medical Center are leading a new nationwide clinical trial testing a drug called Ranexa® (ranolazine) – originally approved to treat chest pain – as a potential treatment for ventricular arrhythmias. Principal investigators Wojciech Zareba, MD, PhD, and Arthur J. Moss, MD, both world experts on the treatment of heart rhythm disorders, say this is the first major study testing a new concept – blocking late sodium currents that govern key components of the electrical activity in the heart – to combat these deadly arrhythmias.

This approach represents a new avenue of therapy after two decades of no significant developments in innovative drug treatment for ventricular arrhythmias. The study drug has been tested in animals and in pilot clinical studies and has shown anti-arrhythmic properties.

Dr. Zareba, Director of Clinical Cardiology Research and the Heart Research Follow-up Program at the University of Rochester Medical Center, says the study is very important because current anti-arrhythmic agents do not offer enough protection for high-risk patients or can't be used for long due to negative side effects, and some even cause additional heart rhythm disorders. He believes that ranolazine is a promising therapy and that this trial could provide a revolutionary approach to treat these difficult heart rhythm disorders.

In the double-blind, randomized clinical trial, high-risk patients who already have an ICD will receive either ranolazine or placebo. The aim of the study, known as RAID, for Ranolazine in High-Risk Implantable Cardioverter-Defibrillator Patients, is to determine if ranolazine decreases death or cardiac arrhythmias, and also if it decreases the risk of hospitalizations from cardiac causes, including arrhythmias, heart failure or heart attack. Study investigators plan to enroll approximately 1,440 patients at 80 centers across the United States. Researchers at the Medical Center have already started enrolling patients.

The trial, which is registered on clinicaltrials.gov (#NCT01215253), is funded by the National Heart, Lung and Blood Institute at the National Institutes of Health. Gilead Sciences, Inc., the biopharmaceutical company that markets ranolazine, will donate the study drug and placebo needed for the trial.

Rochester General's Diabetes Center Offers Collaborative Disease Management

Zachary Freedman, M.D., F.A.C.E.
Director, Diabetes Care and Resource Center
Rochester General Hospital Medical Group

In the past 20 years, the treatment options for Type 1 and 2 Diabetes have exploded – and physicians, in turn, have been vexed by questions about efficacy, safety and use of multiple treatment regimens. Seeking clarity, responsible physicians find many options but little relief: Various societies, institutions and countries have established treatment guidelines that face questions concerning conflicts of interest from those writing the guidelines, or on the quality of their evidence-based research. The complex algorithms can be confusing to practitioners: For example, although treatment to prevent microvascular complications of diabetes has been well-established, recent clinical trials of intensive glucose control in patients with Type 2 Diabetes have not supported prevention of macrovascular disease.

Today, effective Diabetes management often requires collaborative care from primary providers and specialized resources such as Rochester General Health System's multidisciplinary Diabetes Care and Resource Center (DCRC).

The treatment of Diabetes patients requires individual assessment that takes into account co-morbid conditions, patient insight, abilities and acceptance of goals and treatment plans. Further compounding this conundrum are insurance regulations limiting patient and physician choices. Simply stated, linear strategies – for example, Treatment A is followed by Treatment B, and then Treatment C – are often untenable. Appropriate treatments are usually progressive over time – not only with regard to the drugs used, but also with the changing needs of patients, as they adapt to their illness.

The Diabetes Care and Resource Center provides varied resources to help patients and providers for all aspects of Diabetes care. Referral to the DCRC can be for information only, for counseling, or for coordinated medical care. Patient referral can change over time as the disease process evolves. Physicians referring patients to the DCRC can take advantage of options including the following:

Co-Management –

Patients will meet with a Registered Nurse, Certified Diabetes Educator and Endocrinologist to develop a comprehensive treatment plan co-managing with primary care provider. This is especially helpful in patients to be treated with injectable GLP-1 analogues or mimetics, multiple insulin injections, or pumps and/or sensors.

Classes

These educational sessions can offer meaningful and constructive help for Diabetes patients. Specific classes at DCRC include "Living with Diabetes," "Nutrition and Diabetes," "Pre-Diabetes: Preventing Disease," and "Gestational Diabetes."

Counseling

Meeting one-on-one with a Registered Nurse and Certified Diabetes Educator, patients can receive individualized meal-planning assistance that can aid the day-to-day management of the disease.

Patients referred only to classes or counseling maintain care of their Diabetes with the primary care provider. Many patients later revisit the DCRC for co-management with the Endocrine/Diabetes team.

To learn more about the Rochester General Health System Diabetes Care and Resource Center, or to make a referral, contact **585-922-8400** *or visit www.rochestergeneral.org/DCRC.*

Wilmot Cancer Center Recognized as One of Top 70 in Nation

Becker's Hospital Review analyzes data from independent sources to identify top Oncology programs

The James P. Wilmot Cancer Center has been named as one of the Top 70 Oncology programs in the United States by *Becker's Hospital Review*, one of the nation's foremost publications on up-to-date business and legal news and analysis relating to hospitals and health systems. With its inclusion on the Top 70 list, the Wilmot Cancer Center joins the ranks of some of the country's most notable cancer centers, including Cleveland Clinic, Dana-Farber, Duke University, Johns Hopkins, the Mayo Clinic and the University of Texas' M.D. Anderson Cancer Center.

Becker's Hospital Review editorial team formed the Top 70 list based on clinical accolades, quality care and contributions to the field of oncology. Their analysis utilized data from reputable healthcare rating resources, including *U.S. News & World Report*, HealthGrades, Thomson Reuters, the National Cancer Institute, the American College of Surgeons and the American Nurses Credentialing Center.

The Wilmot Cancer Center and the others on the list were characterized as having demonstrated continual innovation in treatments and services, patient-centered care, and the achievement of clinical milestones and groundbreaking discoveries. The Becker's editors specifically cited that radiation oncology experts at the Wilmot Cancer Center were the first to successfully take a new brain cancer treatment — shaped-beam radiosurgery — and apply it to patients suffering from cancer that spread to the lungs and other organs. They also noted that University of Rochester Medical Center and Wilmot scientists also discovered a method to protect against HPV strains, which led to the first anti-cancer and HPV vaccine approved by the FDA in 2006.

"This is a wonderful affirmation of our ongoing mission to bring the very best in cancer care and research to the greater Rochester community and well beyond," said Richard I. Fisher, M.D., director of the Wilmot Cancer Center. "This type of recognition does not happen by chance. It is the result of drawing some of the nation's best and brightest clinicians and scientists to Rochester, as well as our firm commitment to multidisciplinary, specialized cancer care – the model used by the leading cancer programs in the world. I applaud the efforts of our entire team of physicians, scientists and staff and am confident that our continued focus on research and a highly collaborative strategic planning process will continue to bring ever-improving, leading-edge care to those battling cancer."

Managing Joint Disease in the Elderly

New Options for a Growing Population

By Julie Van Benthuysen

Nearly 50 million Americans have some form of arthritis or chronic joint symptoms. Of that amount, nearly 27 million adults have the most common form of arthritis – osteoarthritis – or degenerative joint disease. Most people over 65 are affected with osteoarthritis in at least one joint, making this condition a leading cause of disability in our country.

As our nation's aging population continues to live longer and more active lives, the growth in rheumatology conditions like osteoarthritis has skyrocketed, says Rashmi Khadilkar, M.D., a board-certified, fellowship-trained rheumatologist at Rochester General Medical Group. Dr. Khadilkar and her colleagues study, diagnose and treat disorders affecting the joints and the muscles and soft tissues around the joints and bones.

Given the rising need, Dr. Khadilkar was surprised to find a shortage of rheumatologists within the Western New York region when she joined the practice last August. She hopes to spread awareness to area Primary Care Physicians and patients about the signs and symptoms for more effective diagnosis and treatment of rheumatological conditions.

"There's a growing demand for rheumatology care, plain and simple," she says. "Not only is our geriatric population increasing, but patients are living longer with various medical conditions. There's quite a lot of illness for us to see and treat, and we're receiving more referrals than ever."

As medicine becomes more specialized, she says, PCPs are seeing the value of referring patients to rheumatologists who can manage their care with more options. "Doctors are seeing far more elderly patients these days, and you can't expect them to handle every condition, particularly a patient who might require an injection in a doctor's office not equipped to administer it." With more than 100 types of arthritis including some considered autoimmune disorders, rheumatologists can offer the expertise that PCPs often can't.

Knowing The Signs and Symptoms

In general, she says, PCPs are well-equipped to recognize rheumatologic conditions. "Our geriatric population has seen plenty of wear and tear as they age." In fact, by the age of 80, nearly 80% of patients have osteoarthritis. Typically, pain and any unexplained joint area swelling is the first sign of osteoarthritis. Many PCPs tend to send patients to an orthopedic surgeon before a rheumatologist if there is a strong suspicion of osteoarthritis. However, if the PCP isn't sure whether there is an inflammatory, auto-immune issue involved, it's important for

them to check the patient's lab results. "Rheumatologists can help decide which labs are key indicators if the PCP desires," she says. Any abnormal lab can reveal specific antibodies with positive rheumatoid factors. Other, less obvious signs to look for include back pain and lung, heart and eye symptoms. "If PCPs aren't sure, it's better to refer to us than not."

While other rheumatological conditions affect the geriatric population, they are nowhere to the level as osteoarthritis. Rheumatoid arthritis, the most crippling form of arthritis, affects approximately 1.3 million Americans, predominantly women, with the average onset between ages 30 and 60. Patients with this condition and other inflammatory, auto-immune diseases including Polymyalgia Rheumatica (PMR) and lupus and tend to have a combination of contributing factors – a genetic predisposition and environmental triggers like viruses and chemicals.

"There are disease modification medications now available that can help suppress the immune system and slow down the progression of RA."

Rashmi Khadilkar, MD

More Treatment Options Available

The number of effective treatment options has grown notably for patients with any of these rheumatological conditions. The most common still include general pain relievers, anti-inflammatories, and steroids.

PMR is a relatively common cause of widespread aching and stiffness in older adults, but it can be difficult to diagnose because it rarely causes swollen joints or other abnormalities. Symptoms tend to be worse in the morning, and the aching is located primarily around the shoulders and hips. "Many patients have been languishing for years, now knowing what was wrong with them, but with low-dose corticosteroids they can feel better the very next day."

For patients suffering from rheumatoid arthritis, treatment options have exploded in the last 20 years. "There are disease modification medications now available that can help suppress the immune system and slow down the progression of RA." Since PCPs don't typically prescribe these medications, rheumatologists need to be part of this treatment process from the beginning, she says.

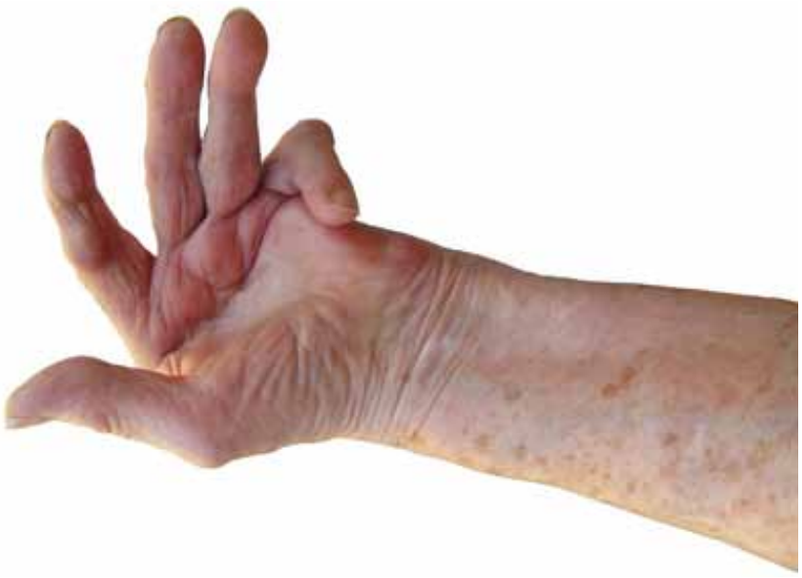
"The newer biological agents like monoclonal antibodies have revolutionized the specialty." Patients at her practice's Infusion Center can receive medication, on-site ultrasounds, joint aspirations, soft tissue injections, infusions and EMGs. "I'm excited to be a part of such a changing field," she says.

For patients with osteoporosis, another disease affecting the aging population, Rochester General Medical Group will be opening an Osteoporosis Center in the coming months, being spearheaded by Dr. Ana Maria Arango.

"While joint replacement surgery and arthritis-related reconstructive surgery are also options, we can help find a useful alternative treatment it patients want to avoid surgery." Many patients have benefited from water therapy, yoga, and weight training to specifically strengthen the muscles around their joints, she says.

An Ounce of Prevention

Typically, by the time patients have seen a rheumatologist, their condition has reached a serious stage. Nonetheless, measures can still be addressed at the PCP level to reach patients before their condition turns acute. "I've said to a lot of patients, 'I wish I had seen you earlier.'"



Eating a high-fiber, low-fat diet, avoiding smoking and exercising regularly are proven to contribute to overall health, and can go a long way in preventing or at least reducing the symptoms of osteoarthritis, she says. Maintaining a healthy weight is critical. Statistics indicate that 66% of adults with doctor-diagnosed arthritis are overweight or obese. "I tell patients it's never too late. For every pound of weight you gain, you put four pounds of pressure on your knee joint, and over time, that adds up."

Cash Balance & 401(k) Combination Plans Breaking the $50,000 Defined Contribution Barrier...

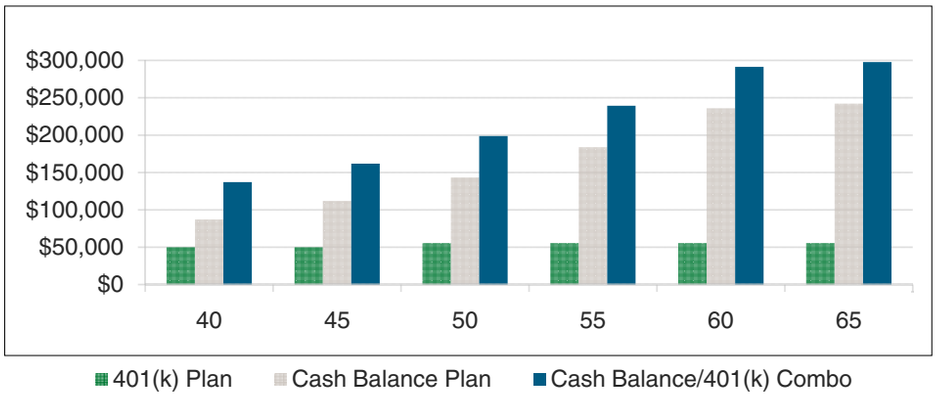
James Vito Esposito, QPA, QualifiedPlans Consultant Manning & Napier Advisors, LLC

Cash Balance Plans, and Cash Balance 401(k) Combination Plans have become one of the most popular qualified plan designs among small to mid-size employers today, especially for professional employers. The reasons are that the Pension Protection Act of 2006 (PPA):

- Provided validation of Cash Balance Plans as an allowable plan after much litigious turmoil, and
- Relaxed the dual plan deduction limit for employers sponsoring both a Defined Benefit (DB) and a Defined Contribution (DC) Plan.

For owners and employees over age 40, Cash Balance and Cash Balance 401(k) Combination Plans offer some of the highest allowable tax-deductible contributions, as well as extreme flexibility in plan design. The chart below illustrates the maximum allowable contributions by age, assuming $250,000 in compensation and that the Cash Balance Plan requires coverage by the Pension Benefit Guaranty Corporation (PBGC).

Maximum 1st Year Contribution by Age



A Cash Balance Plan is a DB Plan that looks very much like a money purchase plan to participants. Cash Balance Plans may offer employers advantages over traditional DB Plans, including:

- Large deductible contributions that can exceed 100% of pay for older participants.
- Design flexibility to offer different benefits to different employee groups.
- Increased design flexibility when paired with a 401(k) Plan.
- Lump sum or lifetime annuity benefits for all participants.
- Ease of understanding and communication.

While Cash Balance Plans broadly appeal to businesses of all sizes and types, they are not ideal for every employer. Before making a decision to adopt one, business owners should consider the following questions:

- Do you want to greatly increase your tax-deductible retirement savings?
- Do you want to control the cost of benefits for employees?
- Are you and your key executives much older on average than your rank & file employees?
- Is your business's income and profitability consistently stable and high?
- Can you make a commitment to increased plan contributions for the foreseeable future?
- If you think a Cash Balance Plan, or a Cash Balance and 401(k) Plan combination might be right for your business, you first should understand what a Cash Balance Plan is...

*Analysis by Manning & Napier. Illustrates the maximum Cash Balance Plan allocation that can be distributed as a lump sum to a participant that is fully vested and terminated after one year of plan participation.

Cash Balance Plan Basics

First and foremost, Cash Balance Plans are Defined Benefit Plans. They are often called hybrid plans because they share characteristics of both DB and DC Plans. They're DB Plans because they are not individual account plans, and as such cannot be DC Plans. They are like DC Plans because allocations for participants are referred to as a percentage of pay.

A Cash Balance Plan works differently than a traditional final average pay DB Plan, by defining an allocation formula in the plan document, instead of a normal retirement benefit formula. A hypothetical account (aka: the "cash balance" account) is created for each participant, and is maintained on paper as a bookkeeping artifice. Also defined in the plan document is an interest crediting rate. Each year, the hypothetical account receives the allocations as defined in the plan document, as well as the guaranteed interest credits.

The hypothetical account is not related to actual plan assets and does NOT represent a participant's share of actual plan assets. It is merely a bookkeeping artifice that tracks participants' accrued benefits. Because Cash Balance Plans are Defined Benefit Plans, employer contributions are based on an actuarial valuation and may not equal the sum of participants' hypothetical account additions. It is important to remember that the investment risk in a Cash Balance Plan remains with the plan sponsor, not the participants.

The participant's vested share of the hypothetical account balance is what can generally be paid out upon retirement or separation from service. The projected accumulation of hypothetical account allocations and interest credits is the amount shown to the participant annually, on a benefit statement.

A Cash Balance Plan may be designed to assign different percentage of pay allocations to different employee groups. Using this new comparability approach, the plan can provide meaningful benefits to non-owners, while maximizing benefits for the owners—so long as complex non-discrimination testing is satisfied. In general, benefits for all must be demonstrably comparable. But comparable doesn't necessarily mean equal.

Key Elements

- We believe Cash Balance Plans are better appreciated by participants—Traditional final average pay DB Plans are often misunderstood and unappreciated.
- More easily communicated—Percentage of pay and guaranteed interest credits are easier to explain than accrued retirement benefit formulas.
- Guaranteed retirement benefits—A Cash Balance Plan is a DB Plan; and DB Plans provide a guaranteed monthly retirement benefit.
- Allocations to owners and/or partners can be made equal, despite differences in age—This cannot be accomplished with a uniform benefit formula in a traditional DB Plan.
- If combined with a 401(k) Profit Sharing Plan can provide even more flexibility in contributions— Cross-tested Profit Sharing allocations aggregated with Cash Balance Plan benefits can produce compelling results.

Plan Design

While a numerical analysis is beyond the scope of this article, it's important to understand what a Cash Balance Plan offers over a traditional Defined Benefit Plan. A Cash Balance Plan using a new comparability allocation formula generally allows the Sponsor to control the cost of staff benefits—particularly for older, shorter-service employees—as well as to match owner allocations to the actual ownership (or partnership) percentages. A traditional DB Plan with a uniform benefit formula cannot accomplish this. Also, such a Cash Balance Plan is more easily communicated to employees than a traditional DB Plan—let alone a traditional DB Plan using a new comparability benefit formula.

To control costs even more, while further increasing allocations to the owners over a stand-alone Cash Balance Plan, a combination arrangement, where a 401(k) Profit Sharing Plan is aggregated with a Cash Balance Plan can be implemented. Here, both plans are aggregated and tested together to demonstrate non- discrimination.

Taking Action

In order to adopt a Cash Balance Plan, the Employer should retain the services of a Third Party Administrator (TPA) to establish a formal Plan Document. You must adopt the Plan by the last day of your fiscal year (i.e., 12/31 if the fiscal year equals the calendar year). The TPA will typically have an actuary on staff to provide needed certifications, although this function may be contracted for separately. In addition to retaining a TPA, the Employer also needs to work with a Recordkeeper and Custodian to invest and custody the plan assets.

You may want to see some initial design projections to determine if a Cash Balance Plan is right for your business. Manning & Napier offers a Qualified Plan Consulting Service and can help you design a Cash Balance Plan, or a Cash Balance and 401(k) Combination that meets your goals and objectives. Please call **800-551-0224.**

What is My Liability?

RAC AUDITS

James E. Szalados, MD, MBA, Esq.

Issue

The Centers for Medicare & Medicaid Services (CMS) is building upon foundation laid by the False Claims Act and OIG's Medicare Fraud and Abuse program designed to guard the Medicare Trust Fund. Liability under the False Claims Act is well and now widely recognized as significant. The retention of an identified overpayment can result in civil monetary penalties of up to $11,000 plus treble damages of 3 times the amount of each claim. In addition, failure to report and return an overpayment may also result in an exclusion from participation in federal and state healthcare programs and even criminal liability. More recently, the Fraud Enforcement and Recovery Act of 2009 (FERA), extended False Claims Act liability to "any person who ... knowingly makes, uses or causes to be made or used a false record or statement to conceal, avoid or decrease any obligation to pay or transmit property to the government." However, the term "knowing" is now broadly defined to include both "deliberate ignorance" and "reckless disregard" thereby eliminating the threshold showing of an affirmative act of concealment. The "Healthcare Reform Act" or the Patient Protection and Affordable Care Act of 2010 (PPACA), through the RAC program, has now further explicitly increased the power and the reach of billing audits; thereby creating new expanded risks to both institution and providers for false claims liabilities.

In many ways, RAC audits are similar to other third-party payer audits and the defensive strategies are based in existing Corporate Compliance Programs

The Recovery Audit Contractor (RAC) Program Section is the newest legislatively mandated program with the mission of audit of physician billing designed to identify improper Medicare payments, and to fight fraud, waste and abuse in the Medicare program. From March 2005 through March 2008, the RAC program operated only as a demonstration program but in July 2008, CMS determined that RACs had succeeded in correcting more than $1.03 billion in improper Medicare payments: of these 96% ($992.7 million) were overpayments collected from providers and 4% ($37.8 million) represented underpayments that were repaid to providers. Based on the initial financial successes of the program, it was expanded to all states and made a permanent CMS recoupment program. The U.S. is divided into four RAC regions; New York State falls within Region A and the RAC entity charged with oversight for this jurisdiction is Diversified Collection Services (DCS). RACs function as independent contractors under the authority of CMS who employ trained coders and perform focused chart reviews to identify both overpayments and underpayments in return for a contingency fee of up to 12.5%.

In demonstration projects, the RACs did not target individual physicians, most likely since the largest dollar overpayments would normally be associated with Part A hospital billing rather than personal professional services billings. Also, physicians fall under Part B billing, and RACs receive less of a contingency percentage for recovery efforts from Part B claims. However, this focus on hospitals is unlikely to continue as the lowest hanging fruit is picked. In fact, many believe that RAC audits may actually pose a heightened threat to providers since, unlike many other prior third-party payer audits, RAC audits are based on processes and timelines which are unilaterally defined; represent extremely intensive audits requiring significant resources to meet a large volume of documentation requests in a short period of time; and have associated complex audit response and appeal processes.

In many ways, RAC audits are similar to other third-party

payer audits and the defensive strategies are based in existing Corporate Compliance Programs. In addition, most providers have gained experience with third-party audits of billings and payments, and have established procedures for handling the audits and the accounting for denials. Corporate Compliance is not, in itself complex, but involves tedious preparation, education, regular internal auditing, monitoring, investigating, reporting, disciplining, and legal and financial risk analysis. Recently, the American Medical Association has successfully persuaded CMS to make changes to the RAC program in favor of physicians, such as a shortened "look-back" period, to 3 years (from 4 years); requiring that all coders working for RACs be certified coders; and a medical record request limit of 10records per practitioner within a 45 day period.

Practitioners and practices that have not yet prepared for a possible audit should seriously begin preparing for and plan for the potential of a RAC audit since, all practices that submit claims to federal payer programs are likely to, at some point, be reviewed through a RAC audit. The threat from RACs is that they are local, focused, and incentivized. Affirmative steps for practices to consider include:

(1) **implementation of an active compliance program**; and,
(2) **implementation of an electronic medical record.**

The compliance program should conduct mock audits and assess coding and billing procedures to screen and identify systematic errors, rare but obvious coding errors, encounters of questionable medically necessity or where documentation in the medical record does not support the complexity of the claim, claims with a secondary diagnosis assigned as a complication or comorbidity, and multiple or excessive units billed. Practices should also create a process for responding to any RAC inquiry through a designated point person (such as a Compliance Officer), since, once a practice is notified of an audit, documents must be submitted within 45 days, or an error is declared and penalties may result. RAC response protocol should also include an "audit log" to track requests for documents, demand letters from CMS, appeal deadlines, and final determinations. RAC-based denials, identified with the unique denial code -M432- in order to facilitate any future appeal. Practices should plan to appeal aggressively and frequently, since Administrative Law Judges will make final appeals rulings and may be more sympathetic than the RAC. Records in electronic format are in a potentially more easy-to-retrieve, track, and submit format and therefore EMRs will minimize disruptions to practices during audits. Finally, involvement of experienced legal counsel is recommended in the case of any formal payer audit.

Overall, the intent of the False Claims Act, and its many derivatives, is not specifically to identify and prosecute institutions and individual practitioners for occasional errors in documentation and coding, but rather to recoup overpayments associated with intentional, pervasive, or systematic and deficiencies or errors. ***Chance always favors the prepared mind.***

Dr. Szalados is a licensed physician engaged in the practice of anesthesiology and critical care; a senior-level hospital administrator, and an attorney admitted to the practice of Law in New York and concentrates his practice in the areas of Health Law.

INNOVATIVE APPROACH TO CANCER CARE FOR THE GERIATRIC PATIENT

The Wilmot Cancer Center Geriatric Oncology Clinic

Older people make up the largest segment of the cancer population, and we have yet to define the optimal treatments for many of them."

Lodovico Balducci, MD
Director, Senior Adult Oncology Program
Moffit Cancer Center

WHILE MUCH OF THE FOCUS OF CANCER PREVENTION CENTERS on – rightly so – avoiding smoking, limiting exposure to the sun, and genetic and environmental influences, the simple fact remains that the single most important risk factor for cancer is age. As life expectancy in the US continues to rise, cancer in older adults is becoming increasingly common. Recent data compiled by the American Cancer Society shows that 77 percent of all cancers are diagnosed in individuals over the age of 50. Other data reveals that 70 percent of all cancer-related deaths occur in people 65 and older.

Yet, the practice of Geriatric Oncology is, ironically, in its relatively infant stages, and physicians and researchers at the James P. Wilmot Cancer Center have been pioneers and leaders in the quest to advance the treatment of older adults diagnosed with cancer.

"As people age, they naturally develop a variety of co-existing conditions that can make their cancer treatment more complex," said Supriya Mohile, MD, MS who directs the Wilmot Cancer Center Geriatric Oncology Clinic, one of the few of its kind in the country. "For older patients, we need better data on how to both manage and cure cancer. We are seeing very healthy patients well into their 80s who are still working, traveling, playing golf, swimming, and then they get cancer. Unfortunately, many of these patients are not treated for their cancers solely due to their age. We are trying to educate the thought-leaders in oncology of the need for hard data to address the unique situations of older people with cancer."

Mohile is widely recognized as among the top specialists in the field and was invited to present at the annual American Society of Clinical Oncology (ASCO) meeting, held last summer in Chicago. She was selected by ASCO to be the leader for organizing all the geriatric oncology sessions at next year's meeting. She and other geriatric oncologists are sharing a stark message. While more than 20% of Americans will be older than age 65 by 2030, managing their health needs and cancer treatments may be challenging as there are not yet standards of care for such patients within geriatric and oncology communities. While there are some overlaps in the care models for oncology and geriatrics, the more collaborative approach that Mohile and other geriatric oncologists bring melds the fields and ultimately evaluates when the benefits of therapy outweigh the risks given the underlying health status of the patient.

Patients like James Barbato, an 80-year-old survivor of stomach cancer, were the primary inspiration for Mohile's drive to develop a multidisciplinary geriatric oncology clinic. The SOCARE (Specialized Oncology Care and Research for the Elderly) clinic, which she founded and runs at both the Wilmot Cancer Center and Highland Hospital, is one of just three such programs on the entire east coast. The overarching goals of the clinic are to help with decision-making for cancer treatment including chemotherapy and surgery in an older person as well as maintaining function and quality of life during treatment. The clinic offers a comprehensive assessment and multidisciplinary approach to the care of the older person with cancer. Participants in the clinic include a nurse (Deb Bacon), clinic coordinator (Terri Lloyd), Physical Therapist (Emily McGrain), Occupational Therapist

(Nancy Dukelow), and Social Work (Michelle Kettinger). The SOCARE clinic partners with a similar clinic directed by Dr. William Dale, Chief of Geriatrics and Palliative Medicine, at the University of Chicago.

"Mr. Barbato was one of the first patients I treated when I came to Rochester, and individuals like him are the reason for the clinic," Mohile explained. "He had a very serious form of stomach cancer but was fit and healthy. It was simply not appropriate to withhold aggressive treatment for him based solely on his age. On the other hand, if he had other significant health problems such as co-morbidities or disabilities, he would have a high likelihood of having significant side effects from standard treatment for his cancer."

Instead, because of her overall assessment based on both geriatrics and oncology, Mohile decided to treat him with an aggressive form of therapy that may not have been otherwise considered for a person of his age. Barbato is currently without evidence of disease and is forever grateful for her progressive approach.

"I think she's great…I told her she is my hero," Barbato says of Mohile. "I feel like they saved my life. Stomach cancer is not a minor illness. I was 76 years old when I was diagnosed and Dr. Mohile approached it like my age didn't matter. The treatment was aggressive. I did not like it at the time, but it worked."

Four years later, Barbato is the picture of health. At age 80, he still plays two rounds of golf a week with friends during the summer, and stays as active as he can.

Board certified in both Geriatrics – the area of medicine that focuses on chronic disease, assessment of life expectancy, and disability in older adults – and Oncology, which addresses cancer prevention, diagnosis and treatment, Mohile is one of just a handful of geriatric oncologists in the US.

In addition to managing a clinical practice that focuses on managing and treating cancer in older patients, she is also engaged in geriatric oncology research and is a member of the Cancer and Aging Research Group, a cadre of 15 researchers whose mission is to link new and senior geriatric oncology researchers in an effort to design and implement clinical trials to improve the care of older adults with cancer, and to promote the development of academic geriatric oncologists.

"There are only a few of us (geriatric oncologists) in the country and there is limited opportunity for mentoring, so we mentor each other or engage senior mentors who may not be at our respective institutions," Mohile said.

Mohile is now mentoring others. For example, Jennifer Andreozzi Ouillet, a 4th year medical student, spent a year doing a "Year-Out" Research Program sponsored by the University of Rochester Clinical and Translational Science Institute. Her research using the data from the SOCARE clinic was presented at the American Geriatrics Society last year and she was awarded a Hoffman Award for this work.

Mohile follows a trail first blazed at URMC by Dr. John M. Bennett, whose groundbreaking work in the field of Geriatric oncology was recognized in 2011 when the American Society of Clinical Oncologists (ASCO) awarded him the B.J. Kennedy Award and Lecture for Scientific Excellence in Geriatric Oncology for his leadership and contributions to the field.

Bennett, professor emeritus of oncology in medicine, laboratory medicine and pathology at the Wilmot Cancer Center, was an early advocate for the integration of geriatrics into the study and practice of oncology. A hematologist by training, he became the clinical director of the University of Rochester's cancer center in 1974, a position he held for two decades. In this role, he learned more about how a person's age affected their experience with cancer and cancer care and how it was apparent that the attitudes and perceptions of clinicians were different with respect to older patients as compared to younger patients.

Cancer and the Older Adult: *Quick Facts*

According to the US.Census Bureau, the number of people in the U.S. aged 65 and older will grow from approximately 40 million in 2010 to 50 million in 2020, an increase of 25% over a period of 10 years.

The percentage of individuals aged 65 and older who survive to age 90 has increased by 400% since 1940.

The median age of cancer patients in the U.S. is 70. People 65 and older incur more than 50% of all cancers, and more than 60% of all cancer deaths.

Between 1968 and 2007, cancer mortality decreased by 23% in patients under the age of 55, but increased 17% in those 55 and older.

In the late 1990s, Bennett, led the development of a new program that would allow young oncology fellows to train and be certified in both geriatrics and medical oncology. Fellows in the proposed program would complete rotations in geriatric clinics and hospice programs, and also would have dedicated research time to develop programs of cancer care for the unique needs of elderly patients. Bennett was also influential in securing geriatric oncology education grants from ASCO and the Hartford Foundation. He and colleague William Hall, M.D., the Paul Fine professor of medicine in the division of Geriatrics and Aging at URMC, obtained critical funding to train fellows at several institutions across the country, including URMC. Mohile was the first geriatric oncology Fellow trained under the auspices of the ASCO-Hartford grant at the University of Chicago.

Having benefitted from the groundbreaking work of Bennett and Hall, Mohile now carries the torch passed on by her mentors.

"Thanks to visionaries like Dr. Bennett and Dr. Hall, we now have a much better understanding of the intricacies of caring for older patients with cancer, and how to share that understanding with their entire care team," Mohile said. "I benefitted directly from John Bennett's work because I was at the University of Chicago and they were one of the first programs to receive a geriatric oncology education grant. One of the main reasons I came to Rochester was the work and leadership of John Bennett and Bill Hall."

Mohile's geriatric oncology program is one of just 10 spread throughout the U.S. It includes consultative clinics which she piloted two years ago at URMC affiliate Highland Hospital, and comprehensive assessments at the Wilmot Cancer Center, where the majority of treatment is also offered.

"We offer a complete geriatric assessment, which is what we are trained to do," Mohile said. "It's a very comprehensive assessment that helps us to look past the chronological age of an individual and identify an approximate physiological age by looking

"It is critically important that oncologists learn to assess elderly people correctly."

Supriya Mohile, MD, MS
Director of the Wilmot Cancer Center Geriatric Oncology Clinic

at other variables such as frailty, cognitive function, nutritional and psychological status, social support and co-morbid medical conditions. Approximately 80 percent of the patients we see have co-morbidities that can influence the approach to their cancer treatment."

Through the complete geriatric assessment (CGA), the patient is classified into one of three "stages" of aging: fit, vulnerable and frail. The CGA helps anticipate toxicities from treatment, and identify predictable needs for and sources of extra support for treatment.

One of the challenges that Mohile faces, and what Bennett identified decades ago, is the lack of data for the population subgroup (ages 70+) that she serves. Mohile attributes the data gap to a number of factors, including the fact that most clinical trials are designed to enroll young or middle-aged adults and do not address the typical problems of aging or use the comprehensive geriatric assessment that Mohile uses in her evaluations.

Mohile and some of her colleagues in the U.S. are working to remedy that. She is one of just three physicians who received a five-year U13 grant from the National Institute on Aging and National Cancer Institute to conduct conferences with health-care leaders. Her colleagues are Arti Hurria, MD, at City of Hope in Duarte, Calif., and William Dale, MD, PhD, at University of Chicago.

"To advance the care we provide to older adults with cancer we need to really accelerate our research," Mohile said. "That includes enrolling elderly patients in available clinical trials and designing prospective trials specifically for the elderly population. We also need to promote further collaboration between researchers in fields such as geriatric medicine, the biology of aging, translational research and palliative care."

Mohile and Hurria have collaborated to compile data and share it with colleagues. For example, in a session at ASCO chaired by Mohile, the investigators discussed the results of a new study, led by Hurria, on the prediction of chemotherapy toxicity in older patients.

"We face nuances every day in the clinic that need to be addressed with research – such as the seemingly fit individual whose unseen medical problems might put him at risk for life-threatening toxicities, versus the apparently frail person who could actually tolerate aggressive treatment," Mohile said. "It is critically important that oncologists learn to assess elderly people correctly. We are proud that our studies and our educational seminars begin to fill this gap in knowledge."

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WHAT'S NEW IN Area Healthcare

URMC Otolaryngology Department Welcomes Three to Its Faculty

Dr. Benoit is an assistant professor specializing in all aspects of pediatric otolaryngology and one of only two pediatric otolaryngologists in the Rochester area. She came to the **URMC** from the **Children's Hospital Boston**, where she trained in pediatric disorders of the ear, nose and throat.


Margo Benoit, MD

Originally from western New York, Benoit earned her medical degree from the **University of Buffalo**, completed an internship in general surgery at Boston's **Brigham and Women's Hospital** and a residency in **Harvard Medical School's** combined otolaryngology program.

Dr. Karelsky is an assistant professor of Otolaryngology providing a wide range of ear, nose and throat services to adults and children.


Sveta Karelsky, MD

Karelsky holds a medical degree from **Vanderbilt University** and completed her otolaryngology residency at URMC, where she received the resident research award and completed projects relating to quality of patient care between specialties.

She is a member of the **American Academy of Otolaryngology** and is currently board-eligible in otolaryngology.

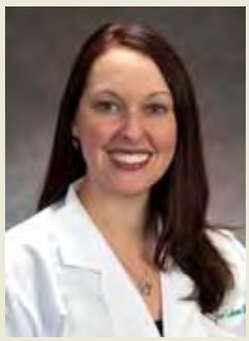

Li-Xing Man, MD

Dr. Man is an assistant professor of Otolaryngology and the only fellowship-trained rhinologist in the Rochester area. Specializing in sinus and nasal disease, Man's areas of expertise include the medical and surgical management of refractory chronic sinusitis, sinonasal tumors, image-guided surgery, revision sinus surgery, endoscopic lacrimal and orbital surgery, CSF leak repair and minimally-invasive anterior skull base surgery.

Man earned his medical degree from the **University of Pennsylvania.** He completed residency training in Otolaryngology at the **University of Pittsburgh** and pursued fellowship training in rhinology at the **Texas Sinus Institute, University of Texas Medical School at Houston**.

Geneva General Hospital Medical Staff Welcomes Dr. Kristin S. Baltazar-Ford

Kristin S. Baltazar-Ford, MD recently joined the medical staff of **Geneva General Hospital**. Dr. Baltazar-Ford attended medical school at the **State University of New York Upstate Medical University** in Syracuse, NY, and completed her residency at the **State University of New York at Buffalo** in Buffalo, NY. She is seeing patients at **Geneva General Surgical Associates** in Geneva, NY.


Kristin S. Baltazar-Ford, MD

Edward Schwarz, PhD, to head The Center for Musculoskeletal Research

Edward M. Schwarz, PhD, the **Burton Professor of Orthopaedics and Rehabilitation**, has been appointed to the additional role of director of **URMC's Center for Musculoskeletal Research (CMSR)**.

Schwarz replaces **Regis J. O'Keefe, MD, PhD**, chair of the **Department of Orthopaedics**, who remains chair but was recently named **Associate Dean for Clinical Affairs** at URMC.

The CMSR has many projects and grants on the horizon in 2012, Schwarz said. He also is writing a strategic plan for the CMSR, which will guide and identify opportunities as the health care industry moves toward a new era of comparative effectiveness research. That will entail a greater emphasis on research that measures and compares tests, drugs, and surgeries used in orthopaedics to determine the best ways to treat patients and prevent infections.

In addition to leading the CMSR, Schwarz operates a laboratory that focuses on finding solutions to bone loss due to conditions such as rheumatoid arthritis, infections, tumors that spread to bone, and bone destruction near the implants used in reconstructive surgery. He also leads a project to develop a vaccine to prevent life-threatening methicillin-resistant staphylococcus infections following bone and joint surgery.

Schwarz earned doctorate and master's degrees in immunology at **Albert Einstein College of Medicine of Yeshiva University**.

URMC Heart Failure Program Earns Prestigious Certification

The Program in **Heart Failure and Transplantation** at the **University of Rochester Medical Center** has received prestigious advanced certification in heart failure from the **Joint Commission**, the nation's leading body for setting health care standards and accreditation.

URMC joins 37 other institutions in the country that have met the standards to earn the certification and is one of only two programs in New York recognized for excellence in care.

"This is an impressive achievement for the dedicated team of doctors, nurses and staff who maintain the highest levels of care for our patients," said **Charles Lowenstein, MD**, chief of the **Division of Cardiology** and director of the **Aab Cardiovascular Research Institute**.

RGH Saves Big Dollars on Waste Disposal

Collaborative Effort Saves More than $185,000 in 3 Years

The move toward sustainability, defined as the long-term maintenance of responsibility, is paying off at **RGH**.

Rochester General, in collaboration with the **New York State Pollution Prevention Institute** at the **Rochester Institute of Technology** has completed a waste reduction study at RGH.

The study (2009-2011) found that in the course of waste disposal at RGH, Municipal Solid Waste (MSW) was routinely mixed in with Regulated Medical Waste (RMW). Because of its potentially infectious nature, RMW requires special handling and treatment making it ***10 times more expensive to process than common solid waste.***

The study also determined that by increasing awareness among employees of the cost and environmental benefits of better separating waste components appropriately, there would be a positive impact on both fronts. And, in fact, the three year study determined that Rochester General Hospital has saved over $185,000 in waste disposal costs.

Thuc Doan Huynh, MD Joins Rochester General Health System's Medical and Dental Staff

Thuc Doan Huynh, MD specializes in Family Medicine and is practicing at the **Gananda Family Practice**, 1200 Fairway Seven, Macedon, NY.

Thuc Doan Huynh, MD attended **Medical University of the Americas**, Charleston, Nevis, West Indies and completed her residency at **Rapid City Regional Hospital**, Rapid City, South Dakota.

Jae Hyun Shin, MD Joins Rochester General Hospital's Medical and Dental Staff.

Jae Hyun Shin, MD specializes in Internal Medicine and has joined the hospital's **Outpatient Medical Department**. Jae Hyun Shin, MD attended **Seoul National University College of Medicine**, Seoul South Korea and completed his residency at **Rochester General Hospital**.

Maria Kilari, MD Joins Rochester General Hospital's Medical and Dental Staff

Maria Kilari, MD specializes in Internal Medicine and is practicing at the **Northridge Medical Group** in Rochester, NY.

Dr. Kilari, MD attended **Ziauddin Medical University**, Karachi, Pakistan, completed her residency at **New York Methodist Hospital**, Brooklyn, NY and is Board Certified in Internal Medicine.

Dawn Riedy MD Appointed Chief of Pathology & Laboratory Medicine at Rochester General Health System

"Since 2009 Dr. Riedy has served with distinction as the Director of Pathology," said **Richard Gangemi MD**, Senior Vice President of Medical and Academic Affairs and Chief Medical Officer/**Rochester General Health System**. *"Anyone who has worked with her can attest to the combination of skill, dedication and enthusiasm that makes her a natural choice for this new role."*

Dr. Riedy attended medical school and completed her residency at the **University of Rochester School of Medicine and Dentistry**, and completed a fellowship in surgical pathology and cytopathology at the **University of Virginia.**

Prior to serving as Director of the **Department of Pathology at Rochester General**, she headed the **Department of Cytology at RGH**. She has also practiced at the former Genesee Hospital and served for two years as the **Director of Pathology at Penn State University Hershey Medical Center**.

Dr. Riedy currently serves as an elected member of the Medical and Dental Staff at **Rochester General Hospital** and on the Executive Committee of the **RGH Breast Center**. She has a strong interest in patient advocacy and is a champion of the interdisciplinary approach to patient care at **Rochester General Health System**.

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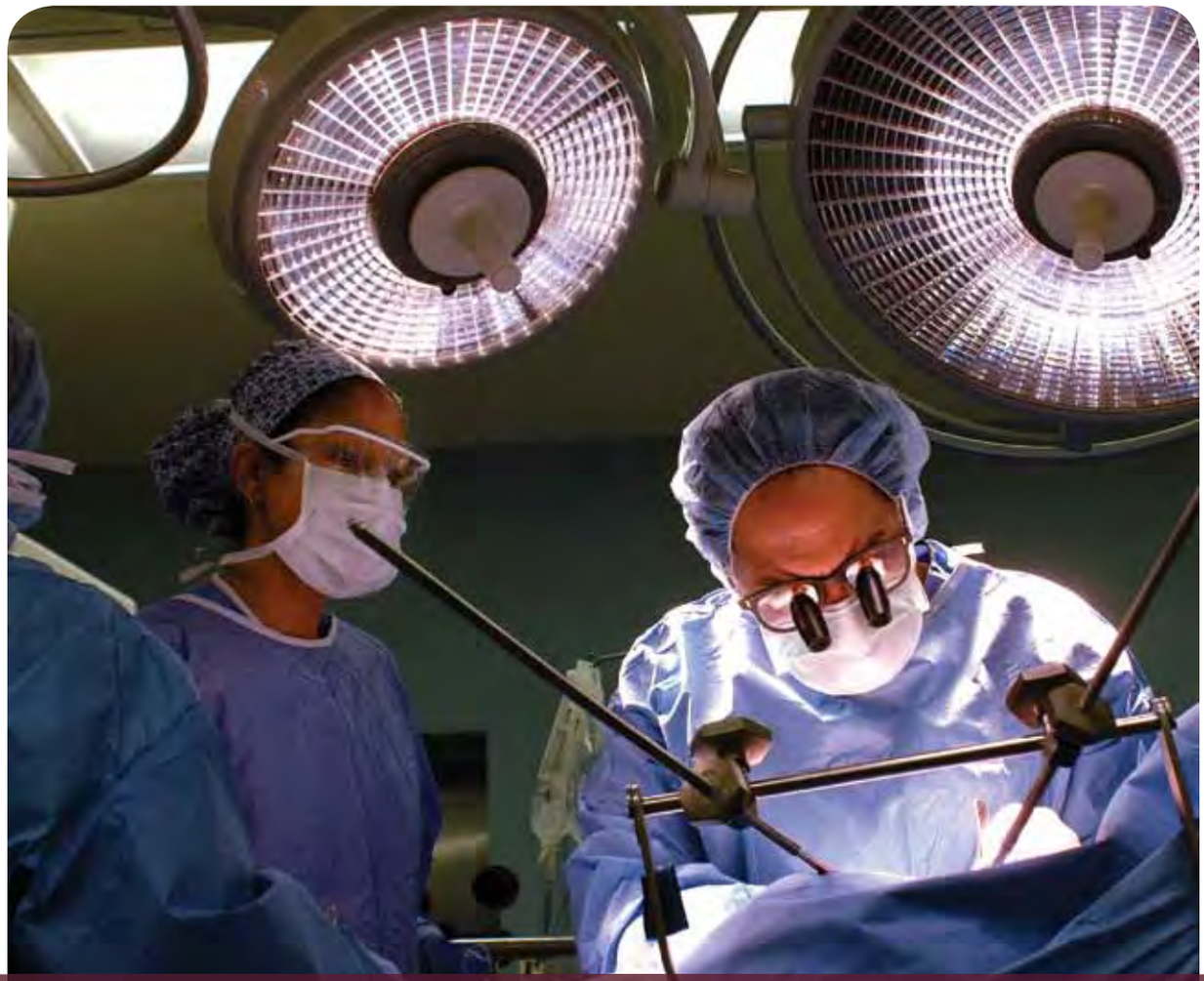

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