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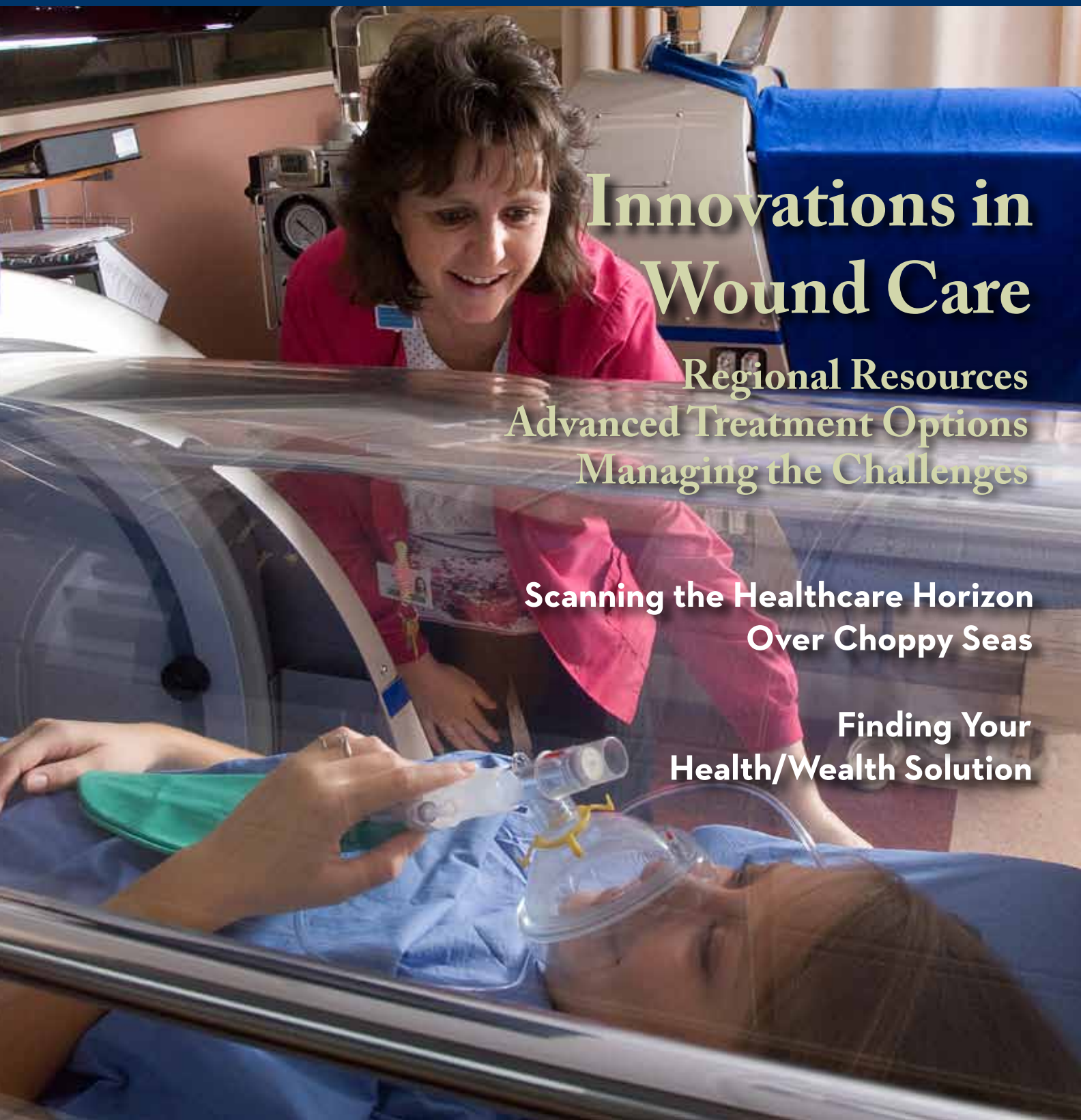
Western New York PHYSICIAN

THE LOCAL VOICE OF PRACTICE MANAGEMENT AND THE BUSINESS OF MEDICINE



Innovations in Wound Care

Regional Resources
Advanced Treatment Options
Managing the Challenges

Scanning the Healthcare Horizon Over Choppy Seas

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A team of specially trained clinicians provide comprehensive care to patients with chronic non-healing wounds at Unity's Wound Care Center. Seen here, Sharon Gavenda, R.N.

Welcome to the Sept–Oct Issue

As we wrap up another year of Western New York Physician, I wanted to share a few exciting developments and changes to the magazine. *We look forward to new opportunities this direction allows us to take and are inspired as we put our plan together for 2012.*

THE SCHEDULE

With this issue, the magazine shifts onto a bi-monthly publishing schedule. Space and time have consistently been the limiting factors for us to cover the topics more deeply and to invite perspective in from more physicians and experts. Going forward, a combined bi-monthly will grow the content of the magazine – expanding the conversation between physicians and regional experts.

WESTERN NEW YORK PHYSICIAN ONLINE

We're in the process of launching our companion website expected to go live in November. The site will make it easier for readers to reach us, share ideas, pose a question to our experts and inquire about and submit editorial. We'll be sure to announce the launch and look forward to your visit. Your feedback will be invaluable as the site evolves. You will find us at: **www.WesternNYPhysician.com**

This month's cover story takes a closer look at wound care. Non-healing wounds pose significant quality of life issues for patients. This series of articles takes a closer look at new therapies to treat chronic wounds, expanding regional resources and the unique challenges in caring for these patients in the nursing home setting.

Our famed Medical/Legal expert, James Szalados, MD, MBA, Esq took a break from the *What's Your Liability* column this month to respond to a few questions. As the current President of the Monroe County Medical Society, we wanted to get his view on the state of medicine in Monroe County. Read *Scanning the Healthcare Horizon Over Choppy Seas* to read what he has to say.

LOOKING AHEAD

Over the next few months, we will be getting out to meet with many practices and centers to learn more about your upcoming plans - expansion projects, innovations in your specialty area – as we begin to plot out our stories for 2012. We gladly welcome your story nominations – please send them to wnyphysician@Rochester.rr.com.

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

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

All the best,

Andrea

Western New York
PHYSICIAN

THE LOCAL VOICE OF PRACTICE MANAGEMENT AND THE BUSINESS OF MEDICINE

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Regional Providers Make Major Commitment to Growing Wound Care Needs

By Julie Van Benthuysen

An estimated 20,000 patients in our region with conditions ranging from diabetes and obesity to heart and vascular diseases suffer from chronic, non-healing wounds that often severely affect their quality of life. Not surprising, an aging population and numerous lifestyle factors are putting even far more at risk. Fortunately, several leading health care providers are aggressively responding to the wound care needs associated with these conditions.

This past June, Unity Health System opened a comprehensive Wound Care Center at its Ridgeway Campus to treat wounds from chronic diseases that have not healed in at least four weeks' time. Wound care involves procedures performed by different specialists depending on the wound's location and severity. The Unity Center coordinates its wound care approach through a case manager and team of physicians in a "continuum of care" that best suits the individual patient.

The Center has been in the planning stages for nearly four years and is a partnership between Unity and National Healing Corp., which accounts for 30 percent of the nation's outsourced and managed wound healing centers. Unity's financial commitment to lease and furnish the space for the project was approximately $215,000.

Just this month, United Memorial Medical Center (UMMC) in Batavia opened the Center for Wound Care and Hyperbaric Medicine, a million dollar project including state-of-the-art hyperbaric equipment and 3,400 square feet of space on the first floor of an expanded surgical center which opened earlier this year.

"UMMC is committed to expanding access for wound-care services in the Genesee, Wyoming and Orleans county areas, where demographics indicate a significant number of patients will benefit," says Medical Director Dr. Rabie Stephan. The hospital is partnering with Diversified Clinical Services Inc., a national leader in outpatient wound-care management services for more than 325 hospitals and 2,600 wound-care physicians nationwide. DCS Centers traditionally achieve excellent clinical outcomes, including high limb salvage rates, an 88% healing rate within 31 median days-to-heal, and extremely high patient satisfaction.

Rabie Stephan, MD

Toufic A. Rizk, MD

Care All In One Place

Because our regional population includes a rising number of diabetics, foot ulcers are steadily becoming a serious repercussion, says Unity Wound Care Center's Dr. Toufic A. Rizk. "We've found that many of our patients have been bounced around from doctor to doctor, having to start from scratch each time – resulting in lost resources, tremendous frustration and continued quality of life issues," he says.

With Unity's recently opened Diabetes Center, providers within the Wound Care Center can better collaborate. Additionally, through its partnership with National Healing, all doctors undergo an intensive training to ensure uniformity of treatment. "Patients are being cared for the same way because we follow the same protocol," he says. Unity's Wound Center includes two vascular surgeons, two general surgeons and one podiatrist, with the hopes of adding a plastic surgeon in short order.

"Having everything available all in one place – from the instruments, skin products and wound dressings to the tools to measure blood flow –

ensures that our patients have a one-stop shopping experience," he says. Each patient has immediate access to care, and is given a full medical history review, with nutritional data and photos inputted, and everything graphed to follow progress from Day 1. "It gives our patients immediate peace of mind, especially those who might be embarrassed about their condition."

The Hyperbaric chamber is a tube about the circumference of a standard MRI machine with a clear acrylic shell around the patient's head and upper torso with capacity for a person up to seven feet tall and to support 550 pounds. The patient lies on a gurney, which is slid into the chamber. A hatch closes, and the oxygen is slowly released into the chamber until the proper pressure is reached, which goes directly to the wound. The average length of treatment is 30 to 40 sessions, lasting two hours each.

Latest Treatments Through Hyperbaric Oxygen Therapy (HBOT)

The Unity Wound Care Center includes two hyperbaric oxygen chambers, which deliver an oversaturation of oxygen under pressure to help tissues heal. Even though they claim marquee status in the Center, the chambers are used only for cases that have not responded to other treatment. National Healing owns the chambers, trains the physicians and develops the protocols for care.

While hyperbaric treatment can be used to treat burns or carbon monoxide poisoning, the Center focuses specifically on patients with bone infections, skin grafts or flap, radiation injuries or persistent diabetic foot ulcers. The indications used in order to proceed with hyperbaric oxygen include deep wounds that haven't responded to antibiotics and bone infections that have not responded to antibiotics beyond six weeks. These wounds often result from radiation therapy in the breast, jaw, prostate, colon and rectum areas. Wounds that are not healing lack oxygen because they indicate no arterial blood flow, he says. HBOT can also be a last resort for arterial ulcers and unreconstructed blood vessels.

This integrated approach to wound care is unique to Monroe County, and is available to patients from all area health systems. The model is similar to the Center for Wound Care and Hyperbaric Medicine at Clifton Springs Hospital in Ontario County, which opened in 2007.

"It's an adjunct to treatment," says Dr. Rizk. Already operating at 50% capacity, he treated his first HBOT patient within one day of opening. "We need to serve our most critical patients first," he says, "but I expect the number of patients will continue to increase each year, in large part due to an even younger diabetic population. Eventually, we'll need doctors and full-time technicians available 24/7."

UMMC's Dr. Stephan agrees, expecting more frequent and aggressive wound care management using the latest technology and techniques to increase healing and healing rates for the overall patient population. "The addition of hyperbaric chambers, which we have not had in the Batavia area before, brings us a new modality in treatment."

Ensuring Patient Compliance

Although diabetes can ravage the body in many ways, non-healing ulcers on the feet and lower legs are common outward manifestations of the disease. Diabetics also often suffer from nerve damage in their feet and legs, allowing small wounds or irritations to develop without awareness. Given the abnormalities of the microvasculature and other side effects of diabetes, these wounds take a long time to heal and require a specialized treatment approach for proper healing.

It's estimated that every 30 seconds a lower limb is amputated somewhere in the world because of a diabetic wound that was not aggressively treated. Many of these lower extremity amputations can be prevented through an interdisciplinary approach to treatment involving a variety of therapies and techniques, including debridement, dressing selection, special shoes, and patient education.

Clearly, the ultimate goal for both these Wound Care Centers is to reduce the need for amputations. "We want to partner with hospitals, Urgent Care Centers and primary care physicians to provide evidence-based medicine geared towards results," says Dr. Rizk. "Treating patients A to Z, we can ensure that most will heal within four weeks, and 90% within 16 weeks. Statistics indicate that 94% of patients with foot ulcers maintain an intact limb 55 months after HBOT therapy. In anticipation, the Center is set up to add a third hyperbaric chamber.

Providers at both Centers agree there must be a stronger emphasis on educating physicians, patients and the greater community that this modality exists and can benefit a wide spectrum of patient types. While these two Centers are brand new to the region, their other sisters sites across the country have experienced overwhelming patient response, with patient volume increasing faster than anticipated in almost every one. "I'm excited and eager to be able to offer hyperbarics to enhance patient care," says Dr. Stephan. "In the past, I've had many surgical patients who could have benefited from wound care or hyperbaric therapy. We need to let referring doctors and patients know that they now have the option."

While the majority of patients treated at the Centers do not require HBOT, those who do receive the treatment experience high healing rates faster, the doctors say. "Our program is completely devoted to this interdisciplinary approach to healing problem wounds, and to helping our patients reclaim their quality of life," says Dr. Stephan.

Both providers also agree that compliance continues to be the biggest challenging facing their patients -- first getting them in the door, and second, getting them to stay on a treatment regimen that might take up to four months. "The question at the beginning is whether the patient will do what I need them to do," says Dr. Rizk, "so we really stress the importance of staying on top of their condition."

St. Ann's Home

Addressing Challenging Wound Care Issues Within the Nursing Home/Rehab Setting

By Julie Van Benthuysen

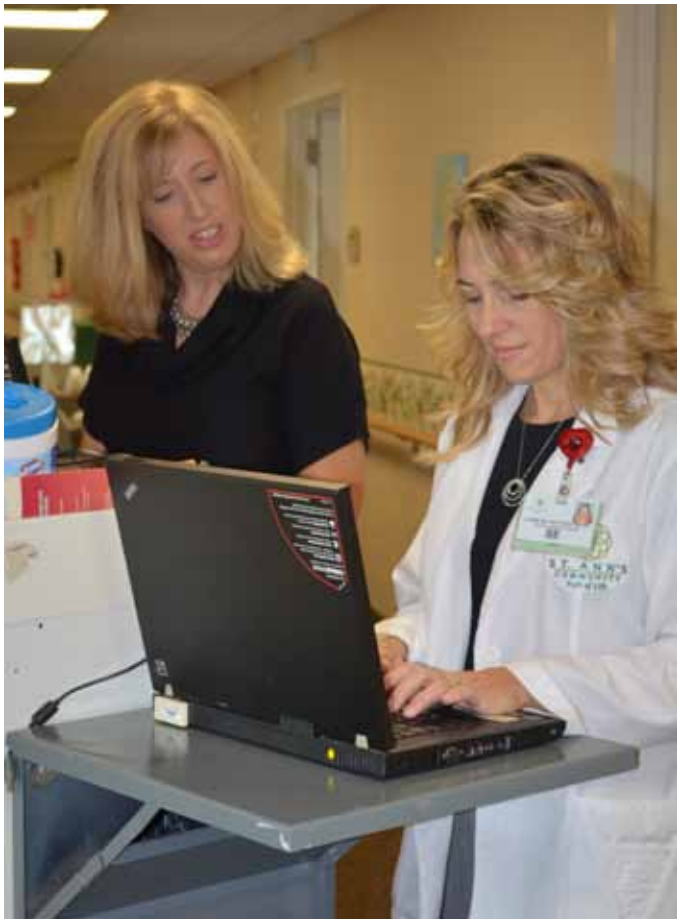
Providers at St. Ann's Home in Rochester have been providing exceptional wound care within the Western New York rehab and long-term care setting for decades. Unique to this setting is St. Ann's patient population – many with profound frailty issues and medical morbidity which makes wound healing far more challenging than in the typical outpatient provider setting.

"Oftentimes, wounds in our patient population arise because of multiple pathologies, making the healing process slower and the treatment plans much more complicated," says Kim Petrone, MD, CMD Associate Medical Director

Treating Variety of Ulcers

Nearly all long-term care facilities and rehabilitation centers see a mix of diabetic ulcers, venous ulcers, arterial ulcers, and pressure ulcers, National data indicates that about 8% of the population is diabetic with about 15% of these people developing a diabetic wound. About .08% of the population develops venous ulcers and .07% develops arterial ulcers.

Currently the percentage of rehab residents with pressure ulcers in New York State is 18%. The Minimum Data Set (MDS), which is used in nearly all long-term care facilities and rehabs, provides much more information about pressure ulcers as these ulcers are linked to quality markers. Prevalence and incidence rates of venous, arterial diabetic ulcers in the Long-Term Care setting are much harder to determine as a consequence, adds Certified Wound Specialist and RN Leanne Mathis. In addition, categorizing ulcers by their pathogenesis is not always easy and requires a skilled nursing and medical staff.



Patients and residents benefit from the collaboration among specialists. Dr. Petrone rounds with Certified Nurse Wound Specialist, Leanne Mathis.

Because a larger portion of St. Ann's residents are functionally dependent as compared to community dwellers, ulcers arising from pressure are more prevalent and can be harder to heal. Additionally, residents with delirium or dementia may not understand why a treatment is being rendered, and consequently may not leave dressings in place or comply with positioning recommendations. For this reason, extensive discussions with families and care providers are necessary to balance best practice

guidelines for wound healing with the residents' quality of life and overall prognosis. What's more, wound care management in general is hampered by the lack of large, randomized control trials to help guide an evidence-based approach to wound care, says Ms. Mathis.

Adopting a Multidisciplinarian Approach

As the prevalence of wounds increases due to aging and increasing rates of diabetes, our nation's health care system at large will need to adapt to provide more holistic care, says Dr. Petrone. For example, treatment of a pressure ulcer in a diabetic with decreased mobility due to a stroke will need to not only address the specific characteristics of the ulcer and the local treatment but also the person's nutrition, positioning, and overall goals of care.

"A multidisciplinary approach invoking the skills of a nutritionist, medical provider, nurse, occupational therapist and physical therapist will be necessary." The health care system will also need to invest in a more systematic approach in studying various wound care treatments. "Currently, there is a dearth of well designed trials investigating wound care products and adjunctive treatments to help guide the clinician in choosing the best treatment," she says. "The future will likely see an ongoing development of biologic therapy."

Currently at St Ann's, its providers maintain a refined and effective means for monitoring and treating residents with wounds. For the last three years, providers have rounded on all residents in long-term care and rehab with any type of wound on a weekly basis. Rounds are attended by a medical provider (MD or NP who is a Certified Wound Specialist), Certified Wound Ostomy Continence Nurse (CWOCN), dietician, and floor nurse, as well as a physical or occupational therapist if appropriate.

Currently, there is a dearth of well designed trials investigating wound care products and adjunctive treatments to help guide the clinician in choosing the best treatment.

"This approach has helped us provide real time education to our nursing staff, residents, and families about the cause of ulcers, prevention of wounds, and their management," says Dr. Petrone, "It has also helped us to heal some ulcers more expeditiously." In addition, St. Ann's wound care database helps support the holistic approach to wound care by cuing providers to not only document a detailed exam but to also examine diabetic control, positioning, offloading devices, and nutrition. "This system augments the data tracked by the MDS and helps us continue to monitor the rates of multiple different types of ulcers."

St. Ann's Leads The Way

St. Ann's supports ongoing wound care education for both nursing and medical providers. Its commitment to refining its wound care formulary is evidenced by a number of different types of products and adjunctive treatments offered, including ultrasound, electrical stimulation, bedside ankle brachial indices, and compression therapy.

In addition to further honing the practices and policies already implemented, St. Ann's Home is exploring collaboration with acute care to develop an advanced wound center that would also serve an outpatient population and offer further adjunctive modalities for wound healing, says Ms. Mathis. "We're well positioned and deeply committed to continue providing excellent wound care to the resident population we serve."

Podiatrists Offer Latest Treatments For Diabetic Foot Ulcers

By Julie Van Benthuysen

Nationwide, more than 25 million people have diabetes, with millions undiagnosed or diagnosed only after presenting acutely for any of its clinical manifestations. Diabetic Foot Ulcers represent a typical overt sign, and their growing occurrence has become dire. Of patients with DFUs, 15% develop osteomyelitis (acute or chronic bone infection) and just as many require amputation. Approximately 84% of lower extremity amputations performed in diabetic patients are preceded by a foot ulcer.

DFUs can become chronic within hours and share common conditions – peripheral neuropathy (damaged sensory nerves) and some level of repetitive foot trauma. These two conditions perpetuate one another while other factors further exacerbate the condition, including bacterial organisms, poor vascular supply, poorly controlled diabetes and co-morbidities, poor nutrition, lifestyle, continued wound trauma, not "staying off" the wound and low cellular viability within the wound bed that delays normal tissue repair and regeneration. Underlying bone deformities, an abnormal gait and poor or improper footwear are also problematic.

Fortunately, regenerative medicine is among the latest innovations for treating DFU. Greater understanding about the natural tissue repair and regeneration process has led to products that provide what's needed to jumpstart wound healing. Dermagraft®, a skin substitute made of living cells, is an FDA-approved product that demonstrates comparative efficacy for treating DFU, and is already helping diabetic patients throughout the region.

Treatment options vary depending on the wound's severity and patient compliance, says Dr. Joseph Carbone, DPM, Rochester Foot Care Associates. These include localized wound care, antibiotics, a Podiatric vascular and neurologic consult and revascularization. If standard care doesn't produce more than 50% improvement of wound size over four weeks, then regenerative medicine is considered along with good wound care practices. Hyperbaric Oxygen Therapy (HBOT) is typically a last resort.

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

Area Patients Receiving Synthetic Treatments

Dr. Carbone's practice is providing successful synthetic wound treatments to its DFU patients. Dermagraft® is a cryopreserved human fibroblast-derived dermal substitute manufactured from human fibroblast cells derived from newborn foreskin tissue.

During manufacture, the human fibroblasts are seeded onto a bioabsorbable polyglactin mesh scaffold. The fibroblasts proliferate to fill the interstices of this scaffold and secrete human dermal collagen, matrix proteins, growth factors, and cytokines to create a three-dimensional human dermal substitute containing metabolically active, living cells.

This living cell therapy has already helped heal more than 50,000 DFU patients. The first step is identifying potential infection and addressing it with antibiotics and other topical or systemic treatments. Infections in diabetic patients are often more severe, involving several types of bacteria acting together, and are prone to develop quickly, spread rapidly, and lead to substantial tissue destruction.

Then Dermagraft® is delivered weekly to the wound. "It appears to be the best option for reorganizing the dermal layer to enable wound closure," says Dr. Carbone. After Dermagraft® is applied, patients must keep weight off the foot. "A supportive home and work environment makes a big difference."

Severe Dangers If Left Untreated

"The biggest challenge to diagnosis and treatment," he adds, "is apathy." Patients with peripheral neuropathy don't feel associated DFU pain, so there's no sense of urgency about seeking medical attention. A typical person might feel a pebble in the shoe, but a patient with this condition doesn't. Consequently, patients with DFUs usually don't see their doctor until they can't feel their feet. Some may have had an open wound for months, even years, due to sub-standard care, and have little hope.

"We have to transfer the lack of visual pain cues to create more awareness about the devastating consequences of open wounds and the need for expeditious wound closure," he says. "An open wound is a portal for infection, hospitalization and amputation."

Once diagnosed, compliance remains a challenge. Patients can resist the lengthy therapy involved, and the inconvenient, off-weight bearing requirement. To complicate matters, diabetic patients may have psychosis and exhibit behaviors inconsistent with adherence. The latest statistics are alarming: about 45% of DFU patients are deceased in five years – representing more fatalities than prostate and breast cancer combined.

Prevention Is Critical

Dr. Carbone emphasizes that prevention goes a long way toward avoiding foot ulcers altogether, including controlled sugar intake and general good nutrition. "DFU prevention can save patients' limbs and lives," he says. "Patients can check their foot daily for bruises, cuts and abrasions as part of a routine similar to brushing their teeth." Getting regular podiatric check-ups, wearing proper shoes or having surgery to correct foot deformities are key.

"We have to look beyond the veil and take on the challenge of healing our patients," he says. "As providers, we're their last line of defense against infection, amputation or worse."

Prescription Medications and Patient Safety

THE RISK

Patient injuries and malpractice claims can result from known risks and side effects, allergic reactions, drug interactions or errors in prescribing.

RECOMMENDATIONS

1. Since there are significant risks and side effects associated with prescribed drugs, physicians must discuss this information with their patients and document these discussions in the medical record.
2. The patient's allergic history must be reviewed before a new drug is prescribed. Known allergies must be documented and flagged in a prominent, easily viewable place in the medical record.
3. Medication updates, including dosage changes and refills, and the use of any over-the-counter drugs, must be clearly documented in the medical record. A medication flow sheet can be used to monitor and track current and past medication usage, as well as allergies.
4. Any specific instructions provided to patients regarding the medications must also be written in the record.
5. There must be written confirmation that the laboratory and/or diagnostic tests necessary to monitor certain drugs for their effectiveness or side effects are ordered, as recommended by professional guidelines, and the test results viewed and necessary adjustments made.
6. The rationale for the discontinuing a medication must be documented in the medical record.

Standardization for the Diagnosis of Breast Cancer

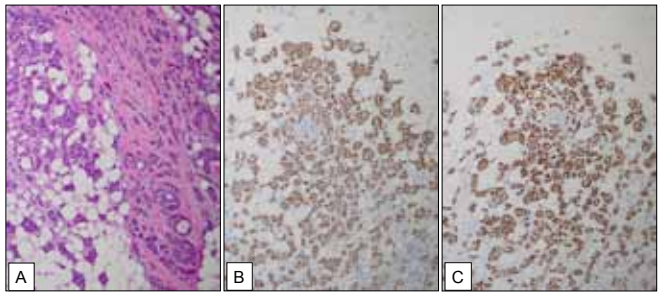
An Important Consideration for Clinical Management

David G. Hicks, MD

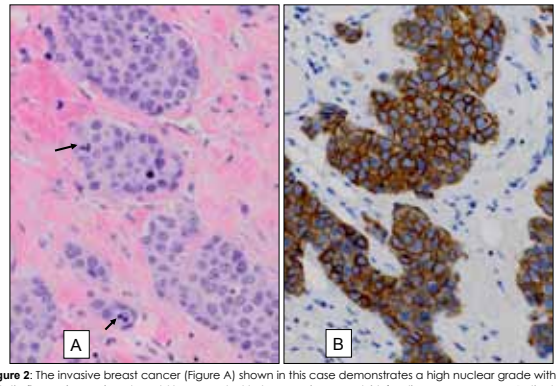
Adenocarcinoma of the breast is a leading cause of cancer morbidity and mortality among women worldwide. The diagnosis of breast cancer is distressing news for women of any age and raises a number of important questions that must be worked through by the patient and her physician. Questions related to the risk for recurrence and what additional treatments beyond surgery are necessary for the best possible outcome typically dominate these discussions.

Breast cancer is a disease with significant clinical and biologic diversity, necessitating an individualized approach to management and decisions about treatment. Of central importance to this decision-making process is the information about the patient's tumor that is provided by the pathologist. Useful prognostic information is obtained from an accurate assessment of the resected tumor, and includes size, histologic type, grade, lymph node staging and evidence of lymphatic invasion. This information has been validated in numerous studies and years of clinical experience as providing helpful information for determining the probability of disease recurrence and the need for systemic therapy. In addition, three predictive markers (estrogen receptor [ER], progesterone receptor [PR] and human epidermal growth factor receptor 2 [HER2]) are routinely utilized to help define therapy in breast cancer (Figure 1 and 2). These factors are used to help identify subsets of patients who are appropriate candidates for specific treatments that target molecular drivers of disease progression. The use of these predictive markers in adjuvant treatment decisions requires that the results be as accurate as possible, given their role in determining optimal and effective therapy.

The growing importance of molecular analysis of clinical samples and the use of biomarkers in clinical practice has led to a growing emphasis on optimal tissue quality for these assays. Specimen preparation, including tissue handling and fixation, are increasingly being recognized as important elements for the assessment of ER, PR and HER2 as well as other traditional prognostic factors in breast cancer. Proper tissue handling and fixation will help to ensure high quality histologic sections for morphologic assessment, as well as accurate and reliable analysis of important tumor target molecules in clinical samples that are increasingly being used to help define therapy. Recent reports have suggested that delays from the surgical removal of tissue to the receipt in the laboratory and the initiation of formalin fixation may have an adverse effect on the analysis of ER, PR and HER2 results. These studies have shown that the level of ER expression starts to fall after a 2-hour delay and similar changes are seen for PR after only one hour. Fluorescence in situ hybridization, a methodology



- **Figure 1**: The diagnosis of breast cancer is established after review of a high quality slide of the patient's tumor tissue which has been stained with Hematoxylin and Eosin. The tumor shown here (A) demonstrates a low nuclear grade and a low proliferative index and would be expected to have an indolent clinical course. Such tumor would be expected to demonstrate high levels of estrogen receptor expression and have a greater likelihood of benefit from adjuvant endocrine therapy. ER and PR expression for this tumor are shown in figure (B) and (C) respectively. Immunohistochemistry is the most common methodology for assessing ER and PR expression. This method uses monoclonal antibodies to demonstrate receptor protein expression in the nucleus of invasive tumor cells. Appropriate tissue handling and good tissue fixation are a prerequisite for accurate, reliable and reproducible analysis of these receptors.



- **Figure 2**: The invasive breast cancer (Figure A) shown in this case demonstrates a high nuclear grade with frequent mitotic figures (arrows) and would be expected to have an increased risk for disease recurrence. Patients with breast cancers showing these features would typically be offered chemotherapy as part of their adjuvant treatment. An immunohistochemical test for HER2, a membrane growth factor receptor that signals cellular proliferation, shows gross over-expression of this protein at the cell membrane of the invasive tumor cells (Figure B, Intense, circumferential membrane staining). HER2-positive breast cancers can be treated with anti-HER2 targeted therapies, which have shown remarkable clinical efficacy in prospective clinical trials for reducing the relative risk of disease recurrence. Again, appropriate tissue handling and good tissue fixation are a prerequisite for accurate, reliable and reproducible analysis of these receptors.

used for the analysis of HER2, begins to be compromised after a 1-hour delay to the start of tissue fixation. The potential clinical implications for these reports are significant.

New national testing guidelines for breast cancer recommend that resected breast tissue samples be placed in formalin within one hour from removal. Monitoring and documenting the times for each clinical sample will require a coordinated effort between surgery and the laboratory. To help address the problem of variable tissue handling at Strong Memorial Hospital, we have implemented a rapid tissue acquisition program in which technical personnel from pathology are stationed in the operating room suites during regular hours and are equipped with cell phones. These personnel are notified when a specimen has been removed from a patient and they are responsible for the rapid transport of the tissue to the laboratory. The collection time from the operating room, the laboratory receipt time and the fixation start time are all recorded for each specimen and documented in the pathology report. Following implementation of this program, we have seen significant improvements in the median time to fixation and the total number of specimens placed into formalin within 1 hour from removal.

Advancements in molecular biology will continue to lead to a better understanding of human disease and novel treatment approaches with new therapeutic agents. This emerging individualized approach to treatment will be heavily dependent on the quality of clinical samples available for molecular analysis while looking for new biomarkers. Going forward, greater emphasis must be placed on developing standardized methods for tissue procurement and documentation about how these variables affect the quality of tissue for accurate molecular analysis. The results from these efforts will improve the quality of clinical tissue samples and will help provide the best possible information for patient care decisions.

ACKNOWLEDGMENT

The author would like to thank Ms. Mary Jackson for her help in manuscript preparation.

Dr. Hicks is the Director of Surgical Pathology at the URMC. His current research interests focus on the molecular genetic profiling of clinical samples from patients with cancer. Much of his recent work has involved a search for new molecular genetic markers to help better understand the prognosis and guide therapeutic management of breast cancer. He received his MD with honor and distinction from the University of Rochester School of Medicine and Dentistry, completed his residency at the Hospital of the University of Pennsylvania in the Department of Pathology and Laboratory Medicine and is certified in Anatomic Pathology by the American Board of Pathology.

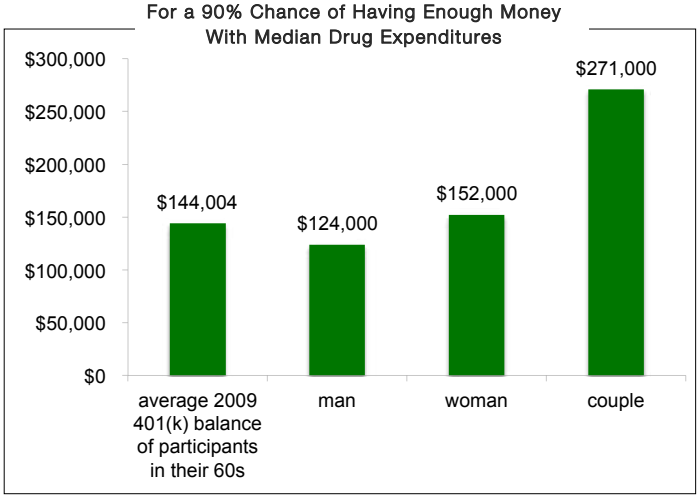
Finding Your Health/ Wealth Solution

Considerations for Benefits Plan Design and Open Enrollment

Angela Obuhanych

At this time of year, many employers with a calendar year plan for their employee benefits are entering their open enrollment season. This is not only the time of year for employees to make their benefit choices for the coming year, but it's also the time for you to make decisions about what plans to offer, how much to budget for your health plan expenses, and what share of the expenses you will ask your employees to pay. Health plan costs rank among the highest concerns of U.S. employers, and with good reason, since health care cost increases have outpaced inflation for years. Employer health costs more than doubled from 2000-2010, and they are estimated to double again in the next 5 years.

For employees, not only are they facing increasing cost sharing on their employer health plans today, but they also face the very real possibility of having insufficient retirement funds to cover their health expenses in retirement. In fact, a couple with median drug expenses would need $271,000 in savings to have a 90% chance of adequately funding their health care costs in retirement, while the average 401(k) balance for participants in their 60s in 2009 was only $144,004.



Employers have been faced each year with the choice of absorbing these alarming increases or passing them on to their employees in the form of higher cost sharing or reduced benefits. Many are now turning to other options in an to attempt to reduce the trend of cost increases while still offering competitive employee benefits and giving employees an opportunity to accumulate funds to help pay for their health care in retirement. Below are a few plan design options for you to consider.

Plan Design

Consumerism

Consumerism is a movement by employers away from the traditional model of a health plan paying most – or all – of a member's expenses and toward the model of increasing personal responsibility for the use of health care services. Consumerism attempts to change behavior because behavior accounts for a significant portion of health care costs. As much as 87.5% of health care costs can be attributed to an individual's lifestyle.[1] High deductible health plans, often coupled with health savings accounts (HSA) or health reimbursement arrangements (HRA), are designed to give employees more responsibility for managing health care dollars and making wise consumer choices in how they spend them. Both HRAs and HSAs can be used as savings accounts to fund health care expenses in retirement, since unused balances carry over from year to year. A health savings account also gives employees the opportunity to save on a tax-advantaged basis for their current and future health expenses, since both employers and employees can contribute.

Wellness and Disease Management

Wellness programs are designed to reduce costs by improving member health. They typically include incentives for participation, and more recently, incentives for improved health measurements. A typical wellness program would include a health risk assessment completed by employees, biometric screenings (e.g., body mass index, cholesterol, blood pressure, blood glucose and nicotine) and participation in health coaching for those with certain health risks. Disease management programs for employees with chronic conditions, such as diabetes, hypertension, or asthma, are offered to increase employees' compliance with recommended treatment. Employers can build incentives around these programs to motivate employees to take an active role in improving their health and reducing their risks of future health complications.

These plan design strategies stress the importance of proper

preventive care and following treatment plans to improve employee health and reduce the incidence of chronic, and potentially life-threatening, illnesses. For employees, these options offer a win/win proposition – better health today and a better chance for a healthy and financially secure retirement in the future.

Enrollment

This is also the time of year to plan for what method your employees will use to make enrollment changes. Web-based enrollment tools streamline the enrollment process and allow employees' on-line elections to be electronically transmitted to your insurance companies or administrators. The use of web-based enrollment tools can also enhance your communication efforts with options such as:

- Easy one-click links to important information (e.g., vendor websites, documents, plan summaries and employer policies)
- Educational presentations to explain benefit options
- Decision-support tools to help employees estimate expenses and select the most appropriate plans for their needs

A recent study by Colonial Life estimates that the average employee spends less than an hour making benefits decisions each year. An effective communication plan that puts the appropriate information and decision-making tools at their fingertips is critical to ensure your employees are making the best choices for themselves and their families.

We understand there are many moving parts to consider when reviewing your available options and selecting the appropriate solutions for your unique employee population. For more information on how you can help your employees improve their health and wealth, contact Angela Obuhanych, Health Plan Consultant with Manning & Napier Advisors, LLC at 800-551-0224.

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[1] The Seattle Times "Health-insurance premiums outpacing wages, inflation" September 16, 2009

[2] 2010 Kaiser Family Foundation/Health Research & Educational Trust Employer Health Benefits Survey

[3] Aon Hewitt 2011 Health Care Survey

[4] Employee Benefit Research Institute Issue Brief No. 351, December 2010

[5] Investment Company Institute Research Perspective, November 2010

[6] Indiana University-Purdue University, Fort Wayne (IPFW) Study, 2007

Elizabeth Wende Breast Care, LLC Offers New Tomosynthesis 3-D Mammography

Women who undergo routine mammography at Elizabeth Wende Breast Care, LLC have the latest screening and diagnostic technology available to them. EWBC is one of the few breast imaging centers in the nation, and one of the first in our region, to offer 3D breast tomosynthesis, the newest technology in breast imaging.

Stamatia Destounis, MD

Breast tomosynthesis, which was approved by the FDA in February 2011, is designed to deliver superior screening and diagnostic performance. "When 3D breast tomosynthesis is used in conjunction with a screening mammogram, it acts as an additional screening tool to assist our radiologists in interpreting the mammogram," says Dr. Stamatia Destounis, EWBC. During the tomosynthesis exam, our technologist positions the patient and compresses her breasts in the same way she routinely would, and while acquiring the standard digital mammogram images, 3D tomosynthesis images are also being captured. Therefore, no additional time is added to a patient's visit. As multiple low dose images of the breast are being taken at different angles, they are displayed in stacks of thin slices, creating a three-dimensional mammogram for our radiologists to review. "This allows us to view the breast tissue millimeters at a time and makes tissue more visible, which helps reduce the need for additional mammogram views," explains Dr. Destounis.

> *"This allows us to view the breast tissue millimeters at a time and makes tissue more visible, which helps reduce the need for additional mammogram views"*

Apple's iPad has taken medicine by storm. Research firm **Knowledge Networks** reported in March 2011 that 27% of physicians in the United States had a tablet-style computer, or about 5 times the general public's adoption rate. That study didn't break down tablet usage by platform or model, but healthcare industry analyst **Chilmark Research** estimated that 22% of all physicians in the United States were using iPads at the end of 2010

Vitamin D Supplementation

An estimated 1 billion people worldwide, across all ethnicities and age groups, have a vitamin D deficiency. This is mostly attributable to people getting less sun exposure because of climate, lifestyle, and concerns about skin cancer. The 1997 Dietary Reference Intake (DRI) values for vitamin D, initially established to prevent rickets and osteomalacia, are considered too low by many experts. DRI values are 200 IU for infants, children, adults up to age 50 years, and pregnant and lactating women; 400 IU for adults aged 50 to 70 years; and 600 IU for adults older than 70 years. Current studies suggest that we may need more vitamin D than presently recommended to prevent chronic disease. Emerging research supports the possible role of vitamin D in protecting against cancer, heart disease, fractures and falls, autoimmune diseases, influenza, type 2 diabetes, and depression. Many health care providers have increased their recommendations for vitamin D supplementation to at least 1,000 IU. As a result, more patients are asking their pharmacists about supplementing with vitamin D.

URMC Plays Lead Role in Identifying Effective Bladder Cancer Screening Tools

Researchers at URMC are seeking men over the age of 60, with a strong smoking history, to participate in an investigation aimed at improving bladder cancer screening techniques.

Edward Messing, MD, chair of Urology and a leader of the genitourinary oncology team at the James P. Wilmot Cancer Center, is lead investigator for the NIH-funded study, which also includes University of Texas M.D. Anderson Cancer Center, Baylor College of Medicine, and Laval University in Quebec.

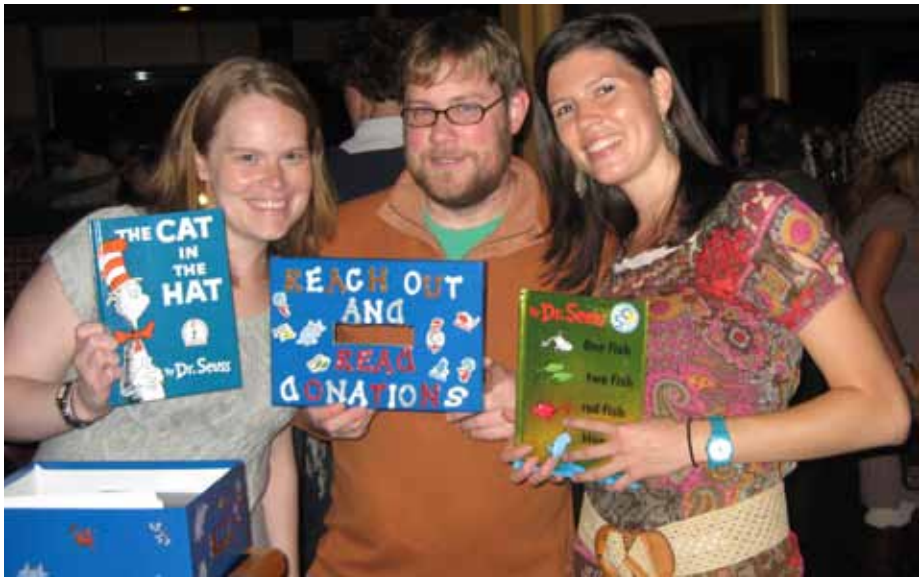
The study focuses on detection of hematuria, a first sign that a tumor may be growing in the bladder, through the use of the Ames Hemastix, a simple, at-home screening tool. There is currently no approved screening method for bladder cancer, one of the most common forms of cancer, particularly among the elderly.

This study aims to confirm promising findings of a preliminary trial in which this test resulted in significantly earlier detection of aggressive bladder cancer, leading to reduced mortality in screening participants compared with unscreened patients.

Study participants will test their urine with the Ames Hemastix daily for two 10-day testing periods – spaced within approximately nine months. A mail-back questionnaire, completed at the beginning of the study, will provide information about participants and their results will be reported after each testing period. Individuals with even a solitary positive test will undergo a thorough urologic evaluation to determine the cause of hematuria; follow-up will continue for two years after completion of the study.

Messing is an expert in the diagnosis and treatment of cancers of the bladder, prostate, kidney and other genitourinary organs. He leads extensive research in the basic biology of bladder and prostate cancers.

Reading is Fundamental



2nd year residents seen from left to right are Drs. Karen James, Reed Evers and Tania Marie Caballero.

Reach Out and Read is a simple, yet highly effective concept. During well child checks from six months to five years of age, pediatricians give anticipatory guidance to parents about the importance of reading aloud and the developmental milestones of early literacy, and the child receives a brand new, developmentally appropriate book to take home.

For more information, contact Susan Huppé at **RORUpstate@frontiernet.net**, or visit the website – **www.reachoutandread.org.**

Residents from URMC joined together with staff and friends to raise money for the Reach Out and Read program. The team raised nearly $900 at the event held at Tap & Mallet on September 15th. Reach Out and Read is a pediatric early-literacy program designed to encourage literacy development in young children, with an emphasis on families living in poverty. There are more than 4,688 programs nationwide that are preparing America's youngest children to succeed in school, with 103 programs in Upstate New York.

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COOKING FOR A CURE

(l to r) Ralph Madeb, MD; New York State Senator James Alesi; and John Valvo, MD, Director of Robotics for Rochester General Health System, enjoy the festivities

Cooking for a Cure, to benefit prostate cancer care at Rochester General Health System, was held on September 23 at Max at High Falls. Four of the area's top local chefs created prostate-healthy meals for guests to enjoy with wine and live music. Nearly $30,000 was raised to support the prostate cancer program at Rochester General. To learn more or make a gift, visit www.giveRGH.org

THE HEALTHCARE HORIZON

Scanning the Healthcare Horizon over Choppy Seas

James E. Szalados, MD, MBA, Esq.

Serving my peers in the Rochester medical community as President of the Monroe County Medical Society over my 2011 – 2012 term is both an honor and privilege. I am blessed with the opportunity to live a life filled with challenge and to have found my calling in a profession which I both truly love and have excelled in. My most fundamental inspiration comes from my parents, who immigrated to Canada from Hungary after the failed 1956 Revolution. My father was a "freedom fighter" during the Hungarian Revolution, a revolutionary, who wanted to make his country a better place and to help restore to Hungary the personal freedoms and opportunities for prosperity which existed before the Soviet invasion. My parents, my mother and father, brought their vision and fortitude to Canada, where they built a highly successful life and provided for and inspired both my sister and I (my sister is an ICU nurse working in Ottawa, Canada). From my parents, I learned that persistence and dedication can change the world. I have always had a need to learn and to know. I am also quite driven and competitive. I grew up a voracious reader and have seldom encountered a book, or person for that matter, that I did not learn something from. I have many mentors during my life, and I have been fortunate enough to both recognize and appreciate the gifts of insight they gave me. Now, I love what I do and because I see myself as privileged to do what I do, I love the challenges and opportunities that come my way because I see them as a chance to contribute – give back – and another potential opportunity to succeed both individually and as a member of the team.

In my role as President of the MCMS, I am afforded the luxury of insight into the world of organized medicine and its leadership. Medicine has come a long way, from a cottage industry to a significant sector of the US economy; as such it is subject to many external forces such as legislation and regulation, compensation-related and competitive pressures, and a greater need than ever to be a part of the force shaping the changes. The high degree of regulation in healthcare affects every aspect of healthcare delivery from the medications we prescribe and the technologies we employ, through the way we treat patients, interact with payers, and defend the practice of medicine as a professional service delivered by physicians. I suspected some time ago, that in order to get involved in advocacy for our profession, I would need not only to be a capable and credible clinician, but also to have education and training in both administration and law to understand the issues and contribute meaningfully to discourse and debate. Nancy Adams, the CEO of the MCMS, recognized my energy and interest and has now become my mentor, introducing me to and helping me navigate the interactions we regularly have with our constituents, our Board and Committees, as well as meetings with our legislators, insurers, and hospital executives. We also interact closely with the Medical Society of the State of New York. Each day brings a new problem, and each day affords a new opportunity to get involved and work towards a solution.

American medicine is experiencing a time of unprecedented change – both in the magnitude and the rapidity of change – as well as great uncertainty about the form that future healthcare delivery will take - the State of New York is no exception. In NY, as elsewhere, we are seeing a substantial number of physicians considering early retirement, selling or merging

their private practices, or relocating. Once again, the key drivers influencing private practitioners are rising practice overhead due to regulatory pressures and non-patient-care related activities, decreased reimbursement, and high malpractice premiums. Physicians are working harder, while striving to work more efficiently, in order to meet their practice overhead. New physician graduates continue to graduate with a huge financial medical education debt which requires increasingly longer periods of time for them to repay at a time when they are starting out in their practices and also potentially starting their families. In this arena, the MCMS has helped implement a 'loan forgiveness program' which helps incentivize recruitment of primary care physicians who are setting up practices in Monroe County. Still, Monroe County and NYS continue to see a gradual loss of physicians, both primary care providers and specialists, to other more economically attractive regions in the US. Local physicians face competitive pressures from Urgent Care clinics and non-physician providers lobbying for increased scope of practice and prescribing privileges. The availability of well-trained physicians is essential to the infrastructure of our state. MCMS and MSSNY continue to work with state legislators regarding critical issues and to help shape policies that will attract the best and brightest physicians to NYS.

❖ ❖ ❖ ❖ ❖ ❖ ❖ ❖ ❖

Nonetheless, we in Monroe County remain fortunate – we have a very strong University presence – a University which is nationally recognized in the quality of its education and research, excellent community hospitals which lead the state in quality and patient satisfaction scores, a high-quality physician workforce, and an active and visionary Medical Society. For example, the Rochester RHIO is a recognized model for effective and secure medical information exchange, helping ensure that medical information about patients is available at every point of care. Rochester is well ahead of the rest of the state and the nation in information technology adoption meeting 'meaningful use' requirements. Rochester is also leading the way in NYS in the development of telemedicine programs bringing subspecialist support to patients receiving care at critical access hospitals. Monroe Country has lower malpractice premium rates than most of the State. Rochester, as a community, has also both traditionally and recently, fared well against economic challenges that have ravaged other parts of the country. Rochester is also a great place to live, with excellent public and private schools, vibrant cultural offerings, and a geographic location between Lake Ontario and the Fingerlakes Wine Country which potentially enhances our attractiveness to new physicians.

Overall, I see Monroe County as the shining star of medical care in the Upstate New York region. We have many challenges and every new regulation penned in Washington and Albany is a potential game-changer requiring that we respond effectively, as individual physicians, as a profession, and as a Medical Society. At the least we must remain educated about the issues, look for opportunities to get or stay involved with our Medical Society, and remain dedicated and resilient. My hope is to both learn from my experiences and to contribute to the MCMS as President and going forward, to help the Monroe County medical community rise above the challenges and to find every opportunity to succeed, individually and collective, on the behalf of our patients. Medicine, after all, is the most noble of professions, and we as physicians, enjoy both the privilege to take care of our patients and the duty to carry our profession forward into the future. ❖

James E. Szalados
is a graduate of McGill, (B.Sc. 1981); A.U.C., (M.D, 1986); Pfeiffer University, (MBA, MHA, 1998); and the State University of New York at Buffalo (J.D. 2005). Dr. Szalados completed two years of post-graduate training in Surgery at the Downstate/Brooklyn-Caledonian Hospitals, a residency in Anesthesiology and subsequently a fellowship in Critical Care Medicine at the University of Rochester. Dr. Szalados also completed a Clinical Research Fellowship in Anesthesiology addressing the pharmacology of neuromuscular blockade at McGill University in Montreal. Dr Szalados holds dual Board Certification in both Anesthesiology and in Critical Care Medicine. Dr. Szalados has been elected to Fellowship in the American College of Critical Care Medicine, the American College of Chest Physicians, and the American College of Legal Medicine. He is the co-author of four critical care textbooks, has authored numerous papers and book chapters, and regularly lectures at local, national and international symposia on medical, administrative, public policy, and legal issues. Dr. Szalados is President of the Monroe County Medical Society for the 2011 – 2012 term.

Dr. Szalados has served in many administrative roles including Critical Care Fellowship Director and Division Head of Critical Care at UNC-Chapel Hill; Executive Vice-Chair of Anesthesiology, Director of Operating Rooms, and Co-Director of Adult Critical Care at the University of Rochester; Medical Director of Respiratory Care at Unity Hospital. Presently, is Medical Director of Surgical Critical Care and Critical Care Telemedicine at Rochester General Hospital, Professor of Anesthesiology at the University of Rochester, practices Anesthesiology, Critical Care, and Medicine at Unity Health System, and is Vice President of Medical Affairs at Lakeside Health System. Dr. Szalados is a member of the American Medical Association, the Medical Society of the State of New York, the American Society of Anesthesiologists, the American College of Chest Physicians, and the Society of Critical Care Medicine; he is also a member of the American Bar Association (Health Law Section), New York State Bar Association (Health Law Section), the Monroe County Bar Association, and the American College of Legal Medicine. Dr. Szalados is admitted to the practice of Law in the State of New York and concentrates his law practice on medical and health law issues and has additional interest in public policy.

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WHAT'S NEW IN Area Healthcare

University Medical Imaging, P.C. welcomes Steven D. Weiss, MD

Dr. Weiss has fellowship training in MRI from the **University of Rochester School of Medicine and Dentistry**. He completed his residency at the **University of Massachusett**s and earned his MD from the **University of Florida College of Medicine**.

In addition to being-board certified in radiology, he is licensed by the Drug Enforcement Administration and has a certification in Advanced Cardiac Life Support from the American Heart Association. His research efforts include inquiries into sickle cell anemia, bone marrow transplantation, and MRI signal intensities in lesions of the liver. Dr. Weiss has been published in the Journal of Radiology Case Reports and the American Journal of Roentgenology.

Geneva General Hospital and Soldiers & Sailors Memorial Hospital Medical Staffs Welcomes Dr. Aran W. Laing

Aran W. Laing, MD

Aran W. Laing, MD recently joined the medical staffs of **Geneva General Hospital** and **Soldiers & Sailors Memorial Hospital**. Dr. Laing is board certified in Internal Medicine, attended medical school at the **University of Auckland** and completed his internship at **Northern Clinical Training Network** both located in Auckland, New Zealand. Dr. Laing completed his residency and fellowship in gastroenterology and hepatology at Strong **Memorial Hospital** at **University of Rochester** and is now seeing patients at **Finger Lakes Gastroenterology.**

Thompson Provides Lower-Radiation CT Scans

F.F. Thompson Hospital's Diagnostic Imaging Department now provides low-radiation dose CT scanning to its patients, making Thompson the first hospital in the Finger Lakes region to do so.

By upgrading to new CT software using the **Philips iDose** iterative reconstruction technique, the department reduces the risk for patients while maintaining optimal image quality.

"At a time when the public is increasingly concerned about radiation, we are pleased to provide this state-of-the-art software to the community," says **Ben Wandtke, MD**, Chief of Diagnostic Imaging for Thompson. "It provides our patients with peace of mind, while providing us with the information our clinicians need in order to offer accurate diagnoses and appropriate treatment."

A breakthrough in CT imaging that just recently came on the market, Philips CT iDose lowers radiation dose up to 80 percent while providing equivalent diagnostic imaging quality with the same look as full-dose images. The iDose iterative reconstruction technique uses advanced reconstruction algorithms to overcome the inherent challenges of low-dose scanning.

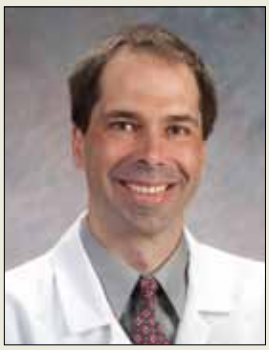
Accredited by the **American College of Radiology**, Thompson's Diagnostic Imaging Department performs over 12,000 CT scans each year. Its services also include interventional radiology, digital mammography, MRI, nuclear medicine, X-ray and ultrasound.

New Medical Staff Joins Finger Lakes Health's Emergency Department

Virgil W. Smaltz, MD, MPA, FACEP

Virgil W. Smaltz, MD, MPA, FACEP specializes in Emergency Medicine and has been appointed as **Director of Emergency Services** at **Finger Lakes Health**. He attended medical school at **Marshall University School of Medicine** in Huntington, WV and completed his post-graduate studies in emergency medicine and public administration at **West Virginia University** in Morgantown, WV. Dr. Smaltz completed his residency at **West Virginia University Hospitals** in Morgantown, WV. and is board certified by the **American Board of Emergency Medicine** and the **National Board of Medical Examiners.**

Douglas Sinclair, MD, MPH specializes in Emergency Medicine. Dr. Sinclair completed his undergraduate studies at **Cornell University** in Ithaca, NY and received a master's degree in Public Health from **Emory University** in Atlanta, GA. He received his medical degree from the **Medical College of Georgia** in Augusta, GA and completed his residency at **Albany Medical Center** in Albany, NY. Dr. Sinclair is assigned in the Emergency Departments at both **Geneva General Hospital** and **Soldiers & Sailors Memorial.**


Douglas Sinclair, MD, MPH

Stamatia Destounis, MD Named Fellow of the American College of Radiology

Dr. Destounis was formally recognized as a Fellow of the **American College of Radiology**, one of the highest honors bestowed upon members for exceptional achievement in the radiology profession. ACR Fellows are members who have distinguished themselves with a long-standing history of service and dedication to the College, organized radiology, teaching and/or research. This honor is given to those who have demonstrated distinctive accomplishments beyond the high standards of achievement expected of all College members.


Stamatia Destounis, MD

RGH Announces New Clinical Appointments in Division of Surgery

Ralph Pennino MD/Chief of Surgery, Rochester General Health System has announced the following appointments:

Robert Tripp, MD has been appointed **Associate Chief of Surgery** at **Rochester General Health System**. Dr. Tripp received his medical degree from **Loyola University in Chicago**, and completed his residency in General Surgery at **Thomas Jefferson University Hospital** in Philadelphia, PA. Dr. Tripp has a private practice with **Genesee Surgical Associates.**


Robert Tripp, MD

Timothy O'Connor, MD has been appointed **Division Chief of Plastic Surgery at Rochester General Hospital**. Dr. O'Connor received his medical degree from **Trinity College** in Dublin, Ireland, and completed his residency in Plastic Surgery at the **University of Rochester School of Medicine**. Dr. O'Connor has a private practice with the **Plastic Surgery Group of Rochester.**


Timothy O'Connor, MD

Louis Eichel, MD has been appointed **Division Chief of Urology at Rochester General Hospital**. Dr. Eichel received his medical degree from the **University of Rochester School of Medicine,** where he also completed his residency in Urology. He also completed a minimally invasive surgery fellowship at the **University of California**, Irvine. Dr. Eichel has a private practice with the **Center for Urology**.


Louis Eichel, MD

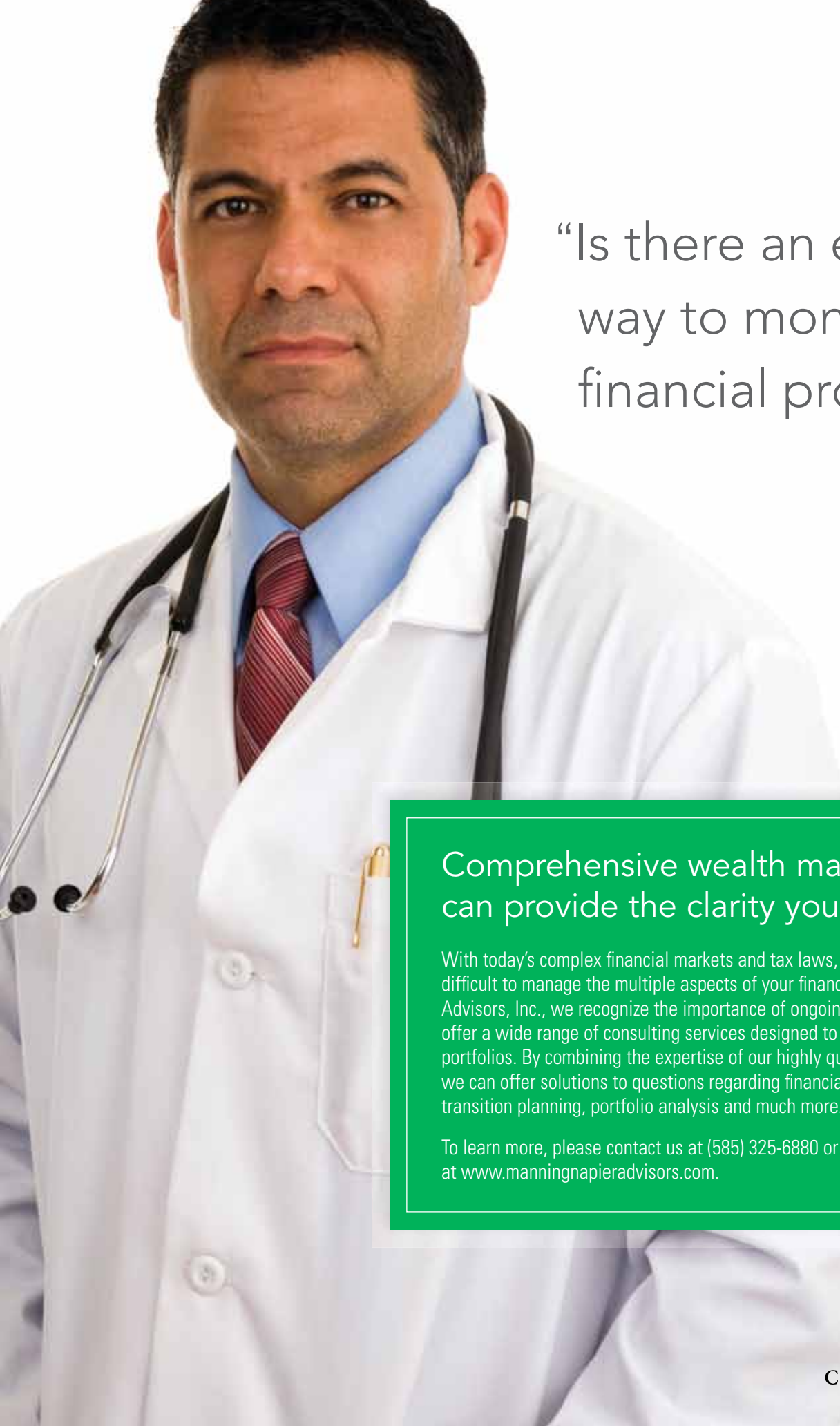
Jennifer Ellis, MD, Joins URMC Division of Vascular Surgery

The **URMC Department of Surgery** welcomes **Jennifer Ellis, MD**, to its **Division of Vascular Surgery**. She is board certified in general surgery and board eligible in vascular surgery and performs surgery at **Highland** and **Strong Memorial** hospitals. She has earned **Registered Physician in Vascular Interpretation** accreditation from the **Society for Vascular Ultrasound.**


Jennifer Ellis, MD

Dr. Ellis performs all aspects of vascular surgery with an emphasis on endovascular procedures, including placement of stents to treat blockages and aneurysms and to provide access for dialysis treatment. She also treats chronic venous diseases and varicose veins.

Dr. Ellis graduated with honors from the **University of Michigan Medical School** in Ann Arbor. She completed her residency at **Henry Ford Hospital** in Detroit, where she was Chief Resident of General Surgery. She completed her fellowship in vascular surgery at the **Cleveland Clinic Foundation.**



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They rehabilitated my hip.
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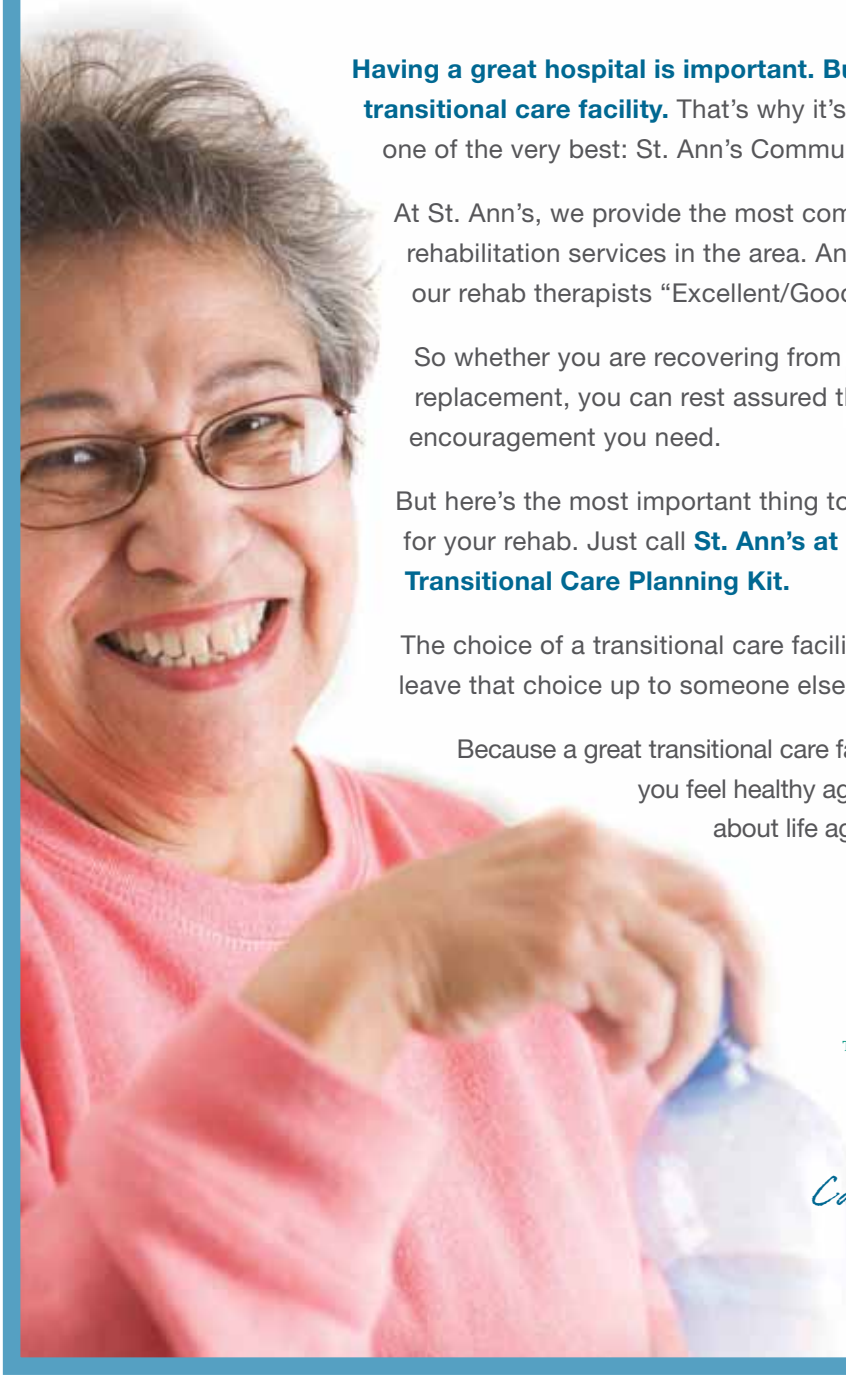

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