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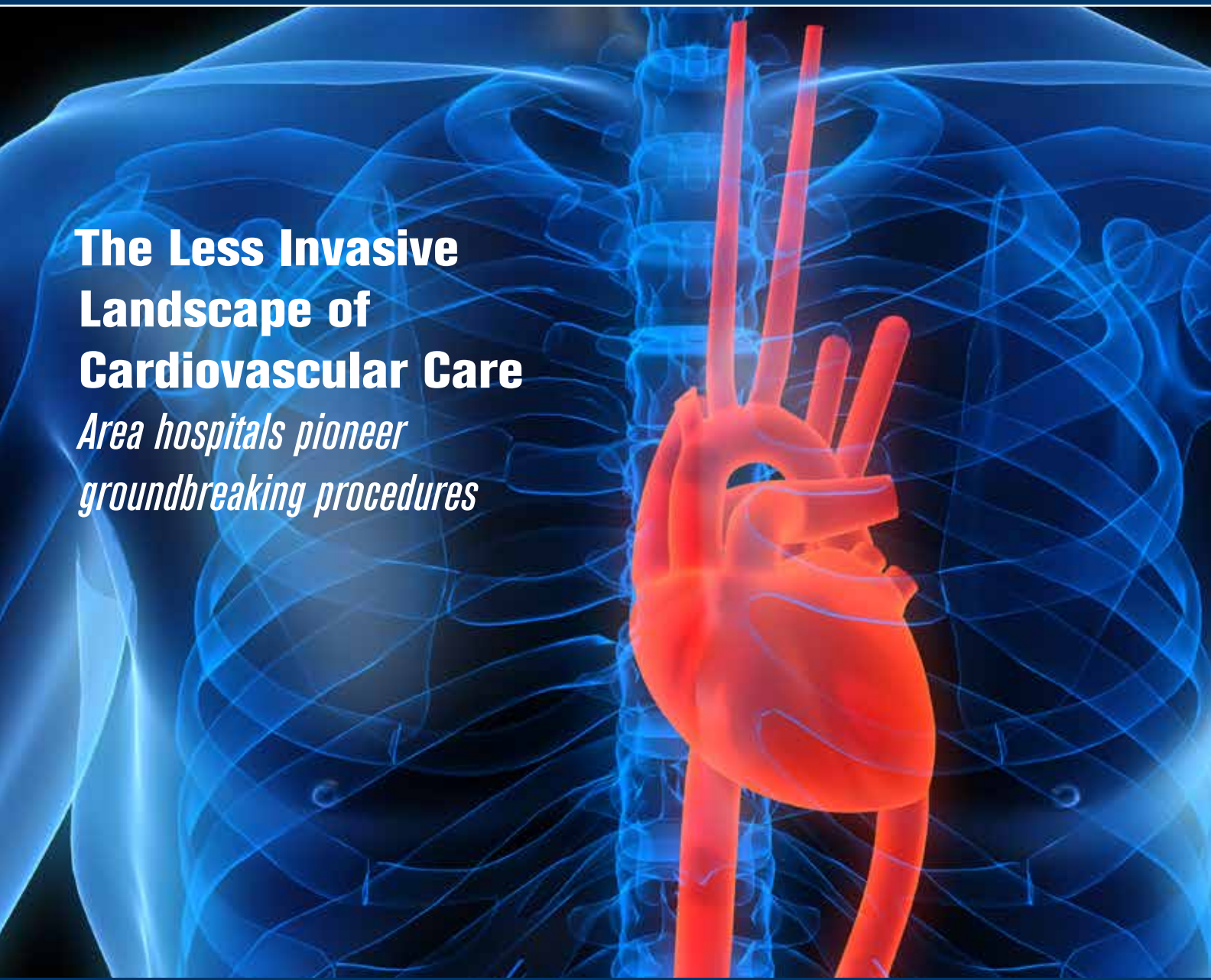

# The Less Invasive Landscape of Cardiovascular Care

*Area hospitals pioneer groundbreaking procedures*

**Innovative Breast Cancer Screening for Women with Dense Breast Tissue**
*A Q&A with Dr. William Bowen*

**Community HIEs: The Case for Better Information & Better Patient Care**

# From Our Hearts To Yours.
## Introducing the HeartMatters Cardiac Rehab Program.

St. Ann's Community is proud to introduce HeartMatters, a new evidence based program that was developed in collaboration with Cardiologists and Cardiothoracic surgeons including Rochester General Hospital Chief of Cardiology, Gerald Gacioch, M.D. and St. Ann's Chief Medical Officer, Diane Kane, M.D.

HeartMatters provides the region's best program for patients with cardiac conditions such as heart failure, myocardial infarction and post cardiac surgery (i.e., CABG, valve replacement).

We recognize the uniqueness of each individual and will work with you to develop a plan of care that will improve your quality of life and reduce the likelihood of readmission back to the hospital. You and your family will receive the knowledge necessary to better manage your condition after returning home.

HeartMatters Cardiac Medical Director, Gerald Gacioch, M.D. and St. Ann's Chief Medical Officer, Diane Kane, M.D.

For more information or to learn how to preplan a rehab stay, **please call 585-697-6311 or visit stannscommunity.com.**

The HeartMatters cardiac rehab program is available at: St. Ann's Community, Irondequoit and St. Ann's Care Center, Cherry Ridge Campus in Webster.

ST. ANN'S COMMUNITY
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*Caring for The Most Important People on Earth*

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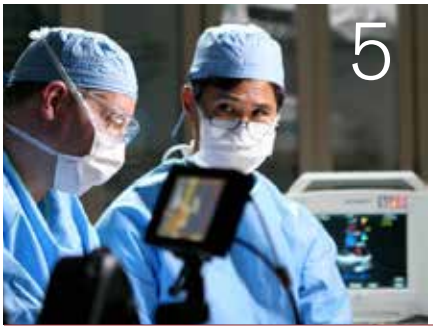


Instrumentation design and quality of imaging are not only allowing treatment options to a growing number of patients deemed high risk but also making procedures less invasive. With smaller incisions, minimized scarring and faster recoveries patients in western NY benefit as area hospitals keep pace bringing the most advanced therapies to the region.

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## Visit us Online

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**Welcome to Volume 2 of Western New York Physician where you will find informative stories and articles about and for physicians in western NY.**

Heart Disease is responsible for a shocking 1 in 4 American deaths according to a recent report by the CDC. This comes at great cost with an estimated price tag of more than $320 billion per year. Looking ahead, the American Heart Association projects this number to triple by 2030 mostly due to an aging population. Even worse, is the existing and growing shortage of cardiologists. Prevention and medical innovation offers the best hope to contain this growth as more patients are aging and living longer. Our cover story speaks with two local interventional heart and vascular experts, Drs Frederick Ling and Jeffrey Rhodes as they describe some of the latest technology available in minimally invasive treatment.

Meet cardiologist, Dr. Daniel Williford in the Provider Profile. In a field with too few cardiologists and a growing number of patients to care for, Dr. Williford breaks a mold – delivering "good old-fashioned" patient focused care.

***Looking ahead at some of the stories under development:***

- Viewpoints on Medical Marijuana
- Infection Control – Keeping Patients Safe
- Physician Burnout: Inspiring Mentors to Stay in the Game
- Expert Discussion - Financial Strategies to Chart Your Course

### Participate in the Conversation

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

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

Please drop us an email to share your feedback and suggestions to improve your reading experience.

In good health –

Andrea

Andrea

**CORRECTION FROM VOL 1**

The last issue misstated Dr. Dustin Fanciullo's employment status. To correct, Dr. Fanciullo is employed by Rochester Regional Health System (RRHS) and works at an RRHS practice – Vascular Surgery Associates. His office can be reached at (585) 922-5550.

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**PUBLISHER**
Andrea Sperry

**CREATIVE DIRECTOR**
Lisa Mauro

**WRITER**
Jenn Bergin

**PHOTOGRAPHY**
Lynne Tseng
Department of Surgery
Rochester Regional Health System



**CONTRIBUTORS**
Jenn Bergin
William D. Bowen, MD
Gillian Soles, MD
James E. Szalados, MD, MBA, Esq.
Michael J. Schoppmann, Esq
Ted Kremer, MPH
Marty Martin, PsyD, MPH
URMC Press

**CONTACT US**
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WNYPhysician@gmail.com
Phone: 585.721.5238

# The Direct Anterior Approach
# A Current Option in Hip Replacement

Gillian Soles, MD

## *Orthpaedic Q&A with Dr. Gillian Soles*

**Dr. Gillian Soles is an Assistant Professor of Orthopaedics in URMC Orthopaedics and Rehabilitation. She specializes in direct anterior approach total hip replacement, the surgical treatment of orthopaedic trauma and fractures. She has specialty training in pelvic and acetabular fracture treatment and reconstruction.**

*Q. How does the direct anterior approach differ from the traditional lateral or posterior approach to hip replacement?*

**A.** All types of hip replacement surgery have the same purpose – to remove damaged bone and/or cartilage of the hip joint and replace them with prosthetic components. The key difference between the direct anterior approach and the posterior or anterior-lateral method is the site of the incision.

In the direct anterior approach, the patient is laying face-up on the operating table and I make the incision on the front of the hip. This enables me to go between muscles to access and remove the damaged hip joint.

In the anterior-lateral or posterior approach, the patient is laying on the side and the incision is made on the side of the leg or toward the buttock. Because the surgeon accesses the hip joint from the posterior aspect, the surgeon has to cut through muscles and tendons to dislocate the patient's hip and insert the artificial hip components. Muscles and tendons that have been cut and repaired form scar tissue and this can affect their function permanently.

*Q. What are the potential benefits using the direct anterior approach?*

**A.** Because we are not cutting through muscles or tendons to remove the hip joint, recovery seems to be easier and a bit quicker. Additionally, the risk of hip dislocation after anterior hip surgery is much lower. Posterior hip replacement requires limitations on a patient's movement post-surgery; patients can't flex their hip past 90 degrees, cross the leg that has the artificial hip, or sleep on their side. With the anterior approach, there are no restrictions. According to Medicare quality data, the rate of hip dislocation post-surgery for posterior approach cases is 3 to 4 percent; for the direct anterior approach, it is less than one tenth of one percent. That is a significant difference; some patients who have had posterior surgery can experience hip dislocation years following their surgery.

*Q. Can any patient who needs hip replacement surgery have the anterior approach?*

**A.** Yes – the direct anterior approach is suitable for anyone who is a candidate for hip replacement surgery.

*Q. When should a primary care physician refer a patient to see a joint specialist?*

**A.** Patients who present with signs of hip arthritis usually have X-rays to determine the progression of the disease. Those in the early stages of arthritis can benefit from anti-inflammatory medications, physical therapy, modification of their activity and weight loss, if that is an issue. But patients who have exhausted non-operative treatments and find that their pain is not controlled or that their condition is limiting their activities of daily life should see a joint specialist.

*Q. Can any patient who needs hip replacement surgery have the anterior approach?*

**A.** Yes – the direct anterior approach is suitable for anyone who is a candidate for hip replacement surgery.

*Q. How long should a patient wait before having hip replacement?*

**A.** I tell patients, if you wake up in the morning and the first thing you think about is how you are going to get through the day because of the pain you're in or because your hip is limiting your mobility, you are a candidate for hip replacement. Implants we use today are lasting a long time – there's an 85 to 90 percent chance that an artificial hip will last a patient 30 years. I think it's good for older patients to act to preserve their mobility. We don't want to have patients be in such severe pain from moving that they become sedentary and then gain weight, which can adversely affect their health and make it more difficult for them to recover from joint replacement surgery when they do have it.

*Q. How long does it take to recover from hip replacement surgery?*

**A**. In general, patients begin walking, with assistance, the day of their surgery. Patients are in the hospital one or two nights. They go home from the hospital and do not need to stay in a rehab facility. They will need to use a cane or walker, usually for about two weeks following their surgery. At six weeks, patients can return to their previous activity level. Patients who have the direct anterior surgery find rehab goes faster because they don't have to worry about any restrictions on their movement.

# The Less Invasive Landscape of Cardiovascular Care

## *Area hospitals pioneer groundbreaking procedures*

by Jenn Bergin

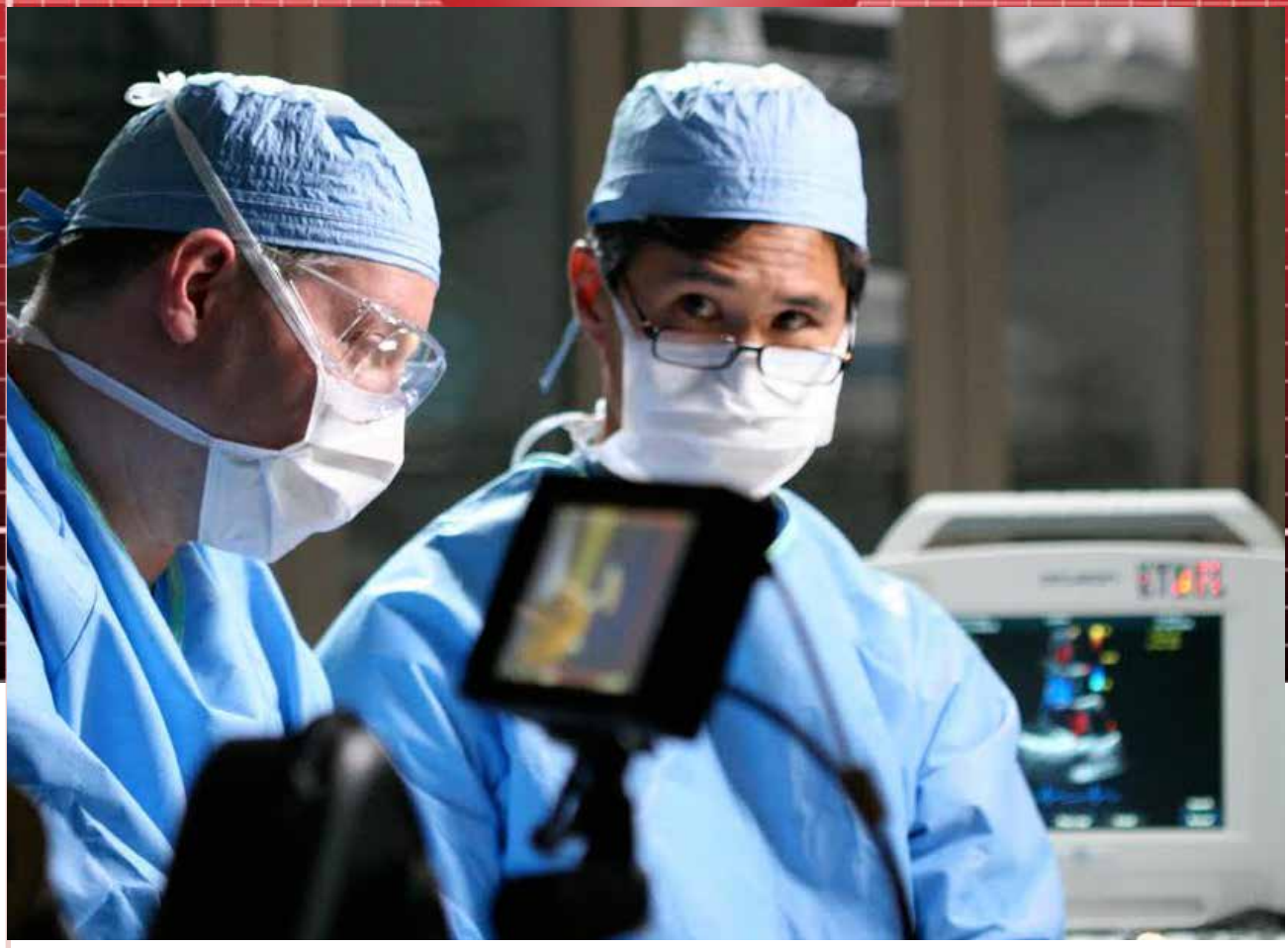


Photo courtesy of URMC

As a retired nurse, Jane Watkin, 92, understood how to manage her heart disease. Still, three years ago she began to develop symptoms of severe aortic stenosis. Despite having always led an active life, she had to give up singing in the church choir – she could no longer walk from her apartment to the music room in her senior living facility, let alone sing.

Because of her age and the condition of her health, open heart surgery was not an option. Doctors began to discuss less invasive approaches to her care, which are allowing patients like Jane, who are inoperable or assessed at high-risk for surgery, anew lease on life.

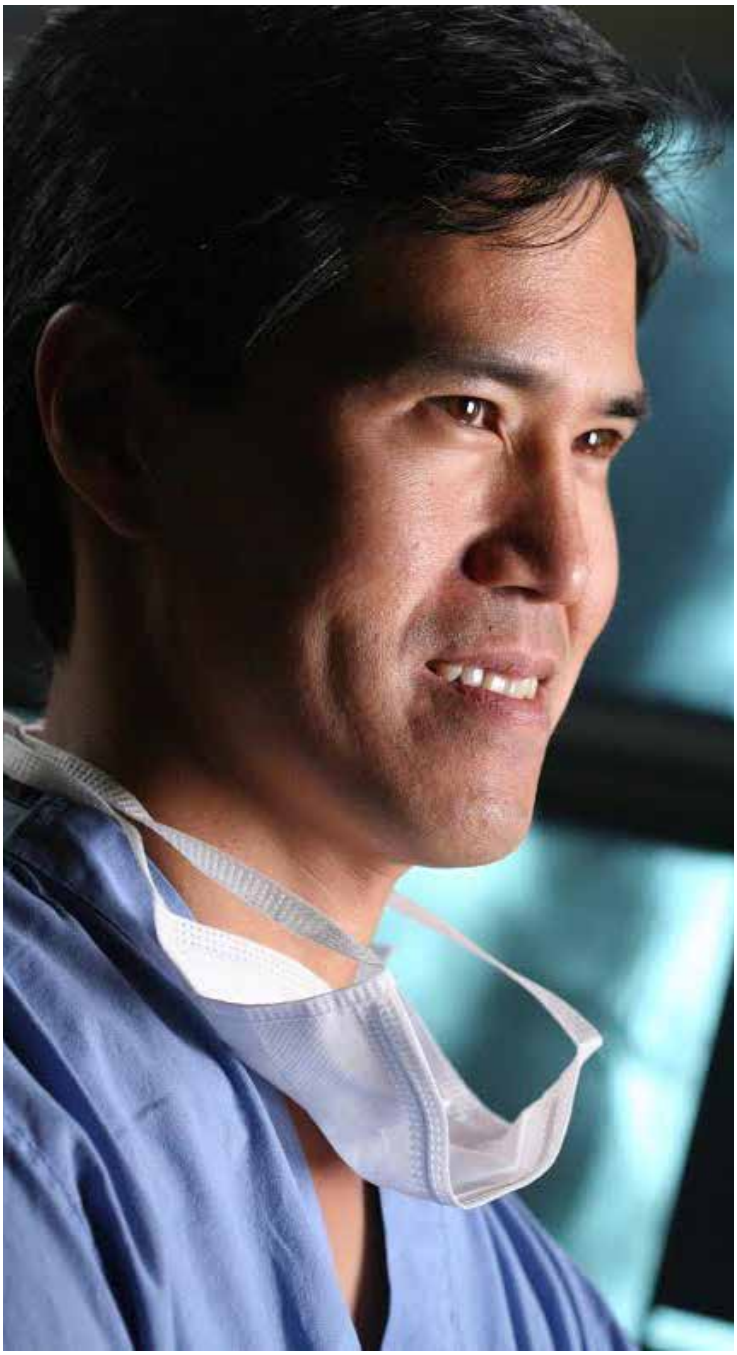


Photo courtesy of URMC

## TAVR and Aortic Stenosis

Jane Watkin's medical team recommended transcatheter aortic valve replacement (TAVR – also known as TAVI, or transcatheter aortic valve implantation), a revolutionary new treatment for advanced aortic stenosis. Early studies of this less invasive heart valve replacement procedure show that it restores the quality of life andextends survival for inoperable patients with advanced disease.

"It's a game changer," says Dr. Fred Ling, interventional cardiologist at URMC and director of the Cardiac Catheterization Laboratory. "It is the beginning of transformational change in the care for some people with valvular heart disease."

URMC is first in the region, and one of about 80 originally selected sites in the country, to offer this delicate procedure – which was introduced in France in 2002 and approved by the FDA in 2011. A team of specialists from URMC's Heart and Vascular Center – which includes interventional cardiologists, cardiac and vascular surgeons, anesthesiologists, radiologists and support staff – perform the procedure.

"The process is truly the result of partnership," Dr. Ling says. "It has made hospitals and physicians into a team. Cardiac surgeons and cardiologists collaborate with the TAVR heart and valve team – everyone that has the expertise contributes."

TAVR works by replacing the diseased heart valve with either the Edwards Sapien Transcatheter Heart Valve (THV) or the Medtronic Corevalve Heart Valve. During the procedure, a temporary pacemaker is implanted to control heart rhythm, unlike open heart surgery which requires stopping of the heart. An incision is made at the groin to access the femoral artery. Interventional cardiologists and cardiovascular surgeons work together to thread a catheter, slightly larger than the width of a pencil, through to the heart.

The collapsible valve is then crimped down and fed through the catheter. According to URMC, just before implantation the heart is sped up to 180 beats per minute, causing it to quiver. At that point, the valve is expanded using a balloon, pushing aside the leaflets of the diseased valve. The valve's metal stent walls embed into the original valve, locking it into place. The balloon is then deflated and removed, along with the catheter and pacemaker.

The impact is immediate, and early studies show that the procedure restores quality of life and extends survival. Patients are hospitalized for one or two weeks and are typically walking within 24 hours. Results of the PARTNER (Placement of Aortic Transcatheter Valve) trial indicate some complications can include stroke and vascular problems such as aortic dissection or perforation, and a full surgical team is on hand to address any complications.

***"It is the beginning of transformational change in the care for some people with valvular heart disease."***

A few hours after Jane Watkin's TAVR procedure, when it was time to move from the ICU to the floor – she walked on her own. "I could feel the difference right away," she says. "As soon as I started moving around, I could see how much easier it was to do ordinary things."

That is the objective, Dr. Ling says. "I see many 90-year-old patients, who if it weren't for valve disease would be otherwise quite healthy," he says. "This procedure brings us closer to our goal, which is not only to help patients live longer, but to also improve their quality of life."

As TAVI continues to gain acceptance, experts are exploring additional patient populations who may benefit from the procedure, such as those who have already undergone surgery but whose bioprosthetic valves have failed. In addition, URMC was selected to participate in the Medtronic SURTAVI Trial to study treatment of aortic stenosis through TAVI for patients with intermediate surgical risk. So far, the data is encouraging, Dr. Ling says. If the clinical trial proves the hypothesis that TAVI will be as good as traditional surgery for lower-risk patients, it's expected to be approved by the FDA.

"With newer technology and trials, it does not take much to imagine that TAVR/TAVI will be the dominant way aortic valve disease will be treated in the future," Dr. Ling says. "Active research is ongoing to do the same for other valves, such as the mitral valve."

As for those who have already had the TAVR procedure, the results speak for themselves. "My outlook on life changed," Jane Watkin says. "I can do the things I love again, that I couldn't do before." She can be found a few days a week in the fitness center of her senior living facility – and has returned to singing in the soprano section of her church choir.

Photo courtesy of RRHS

## The Lutonix Catheter and PAD

The Lutonix DCB Catheter is the first drug coated balloon catheter in the United States, and Rochester General initiated use of the technology to treat peripheral artery disease (PAD), upon its approval by the FDA in late 2014.

Dr. Jeffrey Rhodes, head of the Vein Care Center of Rochester and vascular surgeon at Vascular Surgery Associates, a Rochester Regional Health System practice, says the results are as good as if a stent, and often a bypass, is done.

PAD is common in people with heart disease and causes debilitating leg cramping, with symptoms that can occur daily, even when walking short distances. If left untreated, it causes a narrowing of the arteries and reduction in blood flow that can result in the loss of limbs and shortened life expectancies. In fact, PAD is the leading cause of amputation in people over the age of 50 and accounts for up to 90 percent of amputations overall, according to Rochester Regional Health System.

*"there's definitely been shown a benefit to keeping interventions open"*

"Minimally invasive endovascular procedures such as angioplasty balloons and stents, medications and vascular bypass surgery are some of the accepted ways to treat PAD," Dr. Rhodes says. "What makes the Lutonix Catheter unique is the drug coating, which is designed to prevent scarring once the arteries are opened by the balloon catheter."

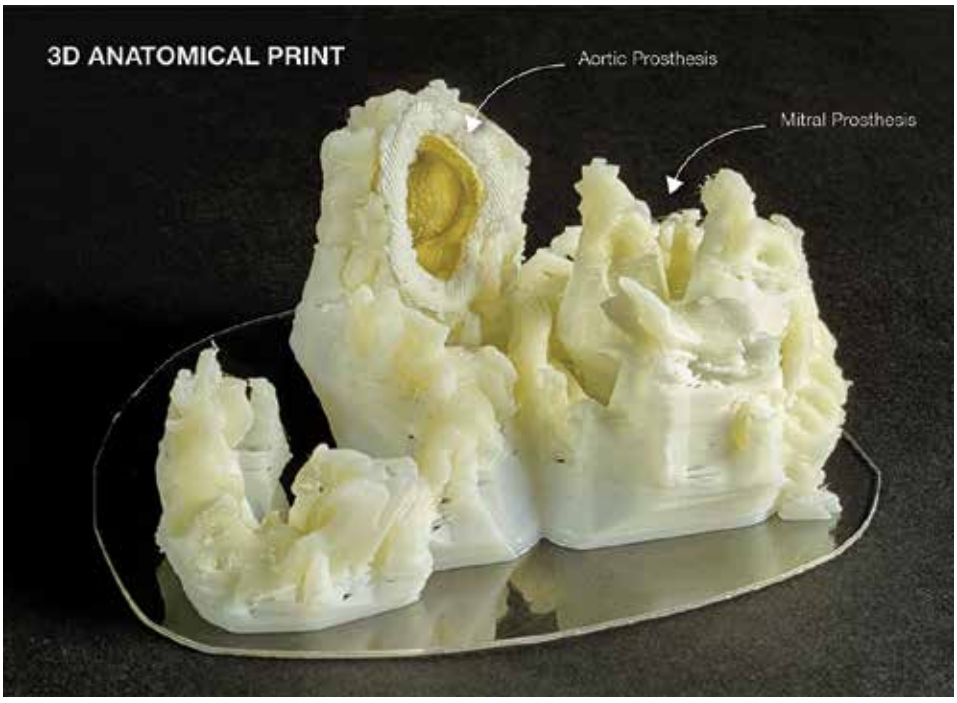


Photo courtesy of URMC

For years, drug coated stents for the heart have been successful. While a stent for the leg has recently been developed, because the arteries in the leg twist and bend unlike those in the heart, traditional stents aren't often ideal, Dr. Rhodes explains. The Lutonix Catheter is cutting-edge technology designed specifically for the femoral arteries in the leg.

A balloon catheter carries a low-dose chemotherapeutic agent (paclitaxel), which inhibits scar tissue from forming. It delivers the drug to the arteries of the peripheral and 30 days later, the agent is still present and at work in the wall of the artery. Since scar tissue causes recurrent narrowing of the arteries, the capacity to slow the growth of cells that cause this scarring is groundbreaking.

*"there is nothing like 3D visualization by an actual model you can manipulate in your hands."*

The Lutonix Catheter is an option for 15 to 20 percent of patients suffering from PAD, which lessens the number of surgical procedures overall and reduces recovery time to one week. Early clinical studies indicate that 75 to 80 percent of arteries remain open two to three years later. Still, not every patient, or artery, is suited for it.

"Often surgery is a necessity, but this gives us an option," Dr. Rhodes says. "If we can do something less invasive, and keep the patient walking with good blood flow in the legs, that gives the benefit of a few extra years until a bypass may be needed, or even avoided altogether."

Minimally-invasive alternatives to treatment of PAD such as the Lutonix balloon, in conjunction with recent developments in atherectomy devices – an alternative to angioplasty, which cuts plaque from the wall of the artery without opening it – means potentially fewer invasive surgical procedures and more tools at hand for the ultimate goal of limb salvage and advancing vascular care.

## A Focus on the Future

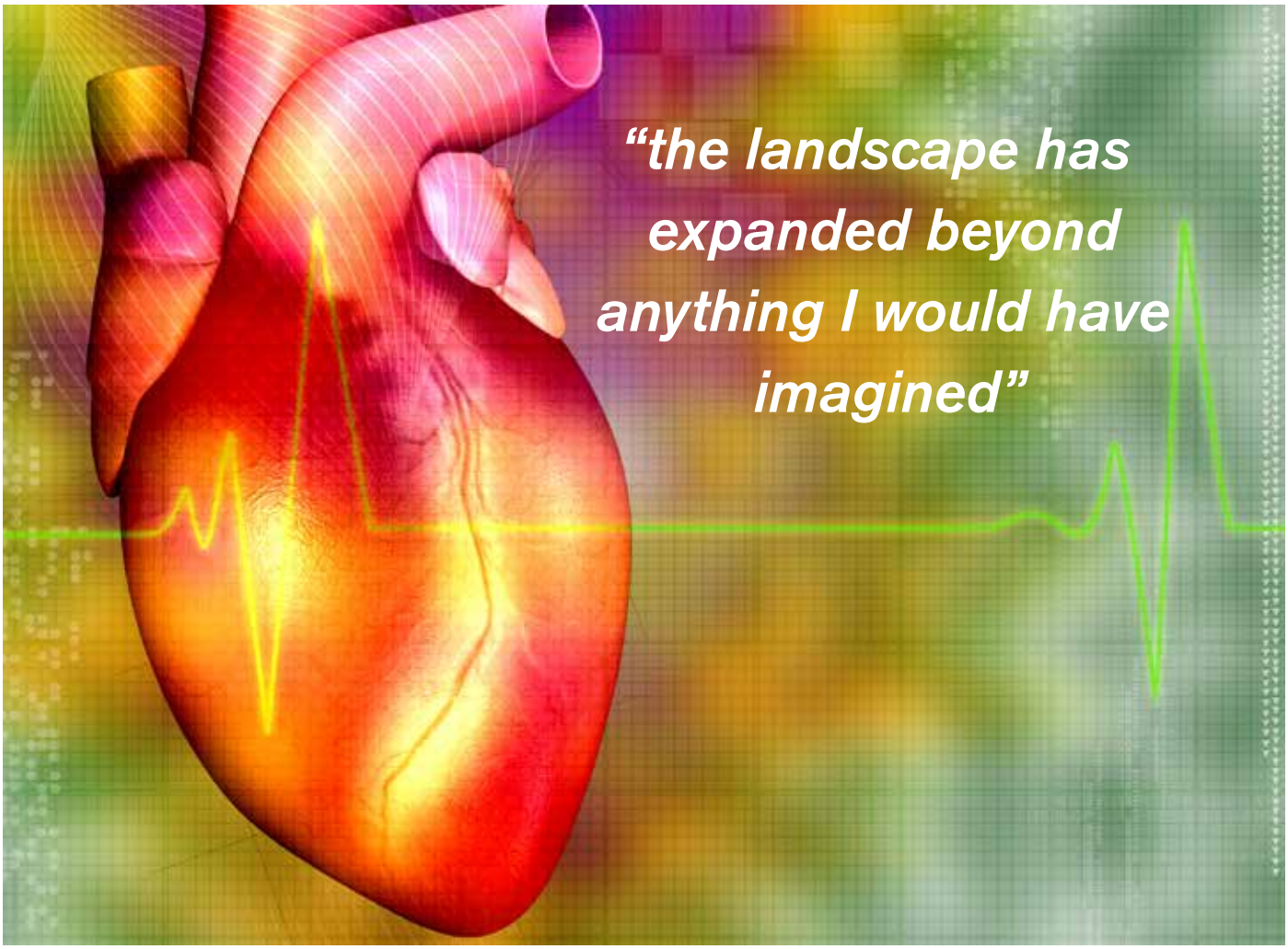
While less invasive treatment is often ideal, avoiding the onset of heart and vascular disease is the ultimate goal. As approaches to intervention continue to evolve, so do the principles for best practice.

Recent American College of Cardiology/American Heart Association guidelines were a drastic departure from previous iterations, and have been debated by experts in all areas of cardiovascular care. Foremost, the guidelines move to disregard lipid (LDL) targets. In the past, clinicians were advised to treat patients with cardiovascular disease to less than 100 mg/dL or the optional goal of less than 70 mg/dL. The expert panel stated there was simply no evidence from randomized, controlled clinical trials to support treatment to a specific target, according to the AHA. As a result, the new guidelines make no recommendations for specific LDL-cholesterol or non-HDL targets for the primary and secondary prevention of atherosclerotic cardiovascular disease (stroke, IHD, PAD).

This controversial shift will potentially increase the number of patients treated with statins such as Lipitor and Crestor, which some experts are concerned haven't shown a survival benefit when used for primary cardiovascular disease prevention.

"From a vascular standpoint, there's definitely been shown a benefit to keeping interventions open," Dr. Rhodes says. "While it can be debated how it's translated to survival benefits, there's little debate that it's improving quality of life."

Alternately, PCSK9 inhibitors have been shown to lower LDL cholesterol by about 47 percent on average, according to




review of 24 clinical trials. While not yet on the market, the FDA is expected to make a determination later this year on the first two medications in the class: evolocumab (Repatha) and alirocumab (Praluent).

Recently, URMC used 3D printing, along with TAVR, to replace a failing heart valve, very close to the mitrial valve. Ultrasound and computerized tomography images were captured, and doctors collaborated with LSI Solutions, a local surgical device firm, to transform those 2D images into a customized plastic 3D model of the heart.

"The 3D print derived from all the info in the CT scan allows us to essentially hold a perfect model of the patient's heart in our hands and actually test how the new valve would fit," Dr. Ling explains. "It is not necessary for all cases, but for complex cases, there is nothing like 3D visualization by an actual model you can manipulate in your hands."

This innovative and powerful tool allowed doctors to analyze a small area of the heart, with vessels just millimeters apart, according to URMC. Going forward, 3D printing will provide powerful insight to enhance meticulous planning for TAVR, and other, medical procedures.

*It's my hope that all the money spent on technology and trials, will not only allow us to live longer, but to also live better."*

"Over the past 20 years, the landscape has expanded beyond anything I would have imagined," Dr. Ling says. "There are constantly new medicines, new ways of treatments. I'm fortunate to offer therapy to so many patients, and for the chance to be a part of research that will eventually pave the way. It's my hope that all the money spent on technology and trials, will not only allow us to live longer, but to also live better."

## Jewish Senior Life launches Rochester's first MUSIC & MEMORY℠ Certified Program

***Music & Memory℠ brings personalized level of music therapy into the lives of the elderly, improving quality of life.***

Jewish Senior Life (JSL) has launched an exciting new evidence-based program called Music & Memory. As the first certified care community in the Rochester area, Jewish Senior Life's team of professional caregivers will utilize best practices for providing a personalized playlist delivered on iPods and other digital devices for residents with Alzheimer's, dementia and other cognitive and physical challenges to reconnect with the world through music-triggered memories.

Music helps connect our brains to certain events in our lives. According to the Alzheimer's Association of America, music, if used appropriately, has the power to shift mood, manage stress-induced agitation, stimulate positive interactions, facilitate cognitive function and coordinate motor movements.

"Personalized play lists provides a wonderful tool for some of our residents who are unable to verbally express themselves due to their diminishing abilities," said Michael King, chief operating officer/administrator for Jewish Senior Life. "When the Music & Memory℠ program was first introduced to the organization, we recognized the value in providing this service to our residents.

Jewish Senior Life is committed to the success of the program by establishing 'memory coaches' to help identify residents who would directly benefit from the program."

The personalized music developed through the Music & Memory program can tap into emotions and special events unique to an individual that otherwise may have been lost. Music enriches the lives of residents by helping to ease incidents of depression, anxiety and challenging behaviors.

"The residents of Jewish Senior Life have seen remarkable success by the thought behind the Music & Memory program," said Susan Price, Person-Center Care Manager for Jewish Senior Life. "All of our residents prefer different types of music for various reasons and with the help of our certified staff and family and friends, we can customize a playlist personalized just for them.

## RIT Partners with Rochester Regional Health System, Local Physicians to Care for Frail Patients

***RIT students train as health coaches: gain experience in community healthcare***

Rochester Institute of Technology (RIT) has partnered with Rochester Regional Health System and the Greater Rochester Independent Practice Association, a physician organization, to improve the health of chronically ill patients in the Rochester community.

RIT students considering healthcare careers are participating in a program designed to help frail patients continue to live in their homes. As health coaches, students remind patients to take their medicine, exercise and eat nutritiously. They also listen to their clients' concerns and questions, which in turn helps the coaches identify potential issues which might require additional medical care.

"These are the health professionals of the future," said Rochester Regional's Senior Vice President for Clinical Innovation, Bridgette Wiefling, MD. "Their experiences today, working with patients in their homes and communities, will help prepare these students to meet the demands and expectations of the new healthcare paradigm and the focus on keeping people healthy, in their homes, and out of the hospital."

"The health coaching program benefits everyone involved," Daniel Ornt, MD, RIT vice president and dean of the Institute and College of Health Sciences and Technology, said.

"The program educates RIT students in the complexity of care management and gives them invaluable self-awareness regarding their potential role in one of the many healthcare professional positions of the future. "The program highlights the strength of the RIT and Rochester Regional alliance," said Ornt. More than a dozen students are working as health coaches today and have had positive experiences.

"Most of the time I'm there to be a friend and to make sure they're doing okay," said Talia McKay, a third-year biomedical student at RIT from Windham, Maine. "The main goal is to keep them well and help them address their concerns."

"Chronically ill patients – those who have diabetes, high blood pressure or Chronic Obstructive Pulmonary Disease, for example – have very unique healthcare needs," says Eric Bieber, MD, president & CEO of Rochester Regional Health System. "Our goal in creating this program was to create a model of care that will enable these frail patients to stay in their own homes, near family and friends, and out of the hospital except when it's absolutely necessary. These student coaches help us identify issues early so patients can avoid unnecessary hospitalizations and doctor appointments."

Before visiting patients, students must complete the required seminar class, Community Health Care from Theory to Practice, developed in conjunction with Rochester Regional Health System. The class is offered during the fall semester and home visits begin during the spring term.

"The rapport students build in the field will be valuable for both patients and health-care providers," said Jeremiah Kirkland, adjunct professor in RIT's College of Health Sciences and Technology and project manager for Rochester Regional Clinical Innovation. Health coaches relay information about their patients' home environment, nutrition and health needs during weekly debriefings with the health care team. "We tell students they are the eyes and ears of the care team," Kirkland added. "They are not clinicians. They don't prescribe medicine or diagnose. They build a relationship with the patient and look at the home environment and help us determine our care plan."

# Five Proven Strategies for Goal Achievement

by Marty Martin, PsyD, MPH

For many, celebrating the New Year means making resolutions. As January fades away, so to do our actions regarding our commitments or resolutions. Many people resolve to lose weight, exercise more, save more, read more, or a host of other goals. January has come and gone, but when the winter chill begins to thaw, many individuals will start making the same or different goals for spring. Then, when summer subsides and the school year kicks off, there will be a recommitment to those existing goals, or a new set in their place. People have no problem setting goals: they have problems achieving them.

The key question to ask yourself is: "What happens after I make my goals?" Let's take two individuals—Maria and John, and their contrasting styles for ensuring they achieve their goals.

## Write It Down

Maria writes down her New Year's Resolution to increase the number of steps she walks from 3,000 to 7,500 each day after getting a fitness activity tracker as a holiday gift. John tweets out to his contacts that he is going to trim down for the spring and get back to his old college shape and stamina. Whose goal is more specific? Of course, you can measure Maria's goal and you can track progress. But John's goal is fuzzy and somewhat vague. The evidence is clear that specific goals are more likely to be achieved than fuzzy, vague goals.

## Focus Wins the Day

Maria decided to simply focus on that one specific goal—increasing the number of daily steps taken—for the first 3 months of the year. John, however, identified 5 areas of improvement for the next 3 months including getting back to his old shape. Who would you predict will reach their goal? Hopefully, you thought "Maria." And you are correct if you did. Why? The verdict is out and states that focusing on one goal at a time increases the probability of achieving that goal.

## Patience Paralyzes Quitting

Maria is patient with herself. She recognizes that it takes more than sheer willpower to develop a new behavior or habit. Ideally, Maria desires to reach this goal within 3 months but she will not beat herself up if takes 4 months. John believes that if you want it bad enough, if you're willing to endure some pain, then you will reach your goal. If you ask John when he wants to look like he used to, he will tell you yesterday. He is not patient with himself. If you were to make a bet, would you bet on Maria or John achieving their goal? If you picked Maria, you've earned some extra money. The research evidence published in the European Journal of Social Psychology states that it takes an average of 66 days to develop a new habit.

## The ABC's of Habits

Maria realized two things: wearing her fitness activity tracker and reading her email reminded her to get stepping, and to continue her long-held practice of giving herself little rewards throughout the day for making progress. These micro-rewards are as simple as self-congratulatory statements or reading a couple of pages of an engaging book or magazine.

John continues to say to himself that he has got to return to his old good-looking self. He is blind about his habit of snacking throughout the day-at work, at home, on vacation, and on business trips. John does not believe in rewarding himself until the "job is done." For him, the job is not done until he looks like he used to look. Once again, Maria has put herself in a better position to achieve her goal. But why? Psychologists developed

an A-B-C model of behavior. This model also applies to habits. The "A" stands for antecedents or triggers to behavior. The "B" is the target behavior. The "C" represents consequences (positive or negative) after engaging in the behavior.

This A-B-C model deserves a bit more attention. For Maria, there are two antecedents or triggers for her taking steps: (1) wearing the fitness activity tracker (physical/visual/auditory cue); and (2) email (physical/visual/auditory cue). These cues, triggers or antecedents occur more than once a day but not so often that they become meaningless or overwhelm her. The behavior is the physical act of taking the steps. What about the "C" or consequences? She stated that she congratulates herself (positive consequence) and takes a break to read something enjoyable (positive consequence). By giving herself positive consequences for engaging in the behavior rather than negative consequences for not engaging in the behavior, then Maria has stumbled upon another trick to get closer to realizing her goals.

## Leverage Strengths

Maria's self-congratulatory thoughts are known by psychologists as self-affirmations. There is a link between self-affirmations and behavior change. Affirming yourself as it relates to a particular resolution, goal, or desired habit enables you to review and catalog your strengths. The coaching and family therapy literature has shown the power of leveraging strengths when assisting individuals to change their behaviors and reach their goals. This does not mean that Maria should overlook or deny her weaknesses. It only means that she should do both but focus on her strengths more than her weaknesses.

These five evidence based tips will get you closer to achieving your goals. Just remember that it is far easier to make a goal, than it is to change a habit. The trick is to cultivate what psychologists call "goal adherent action." Quite simply, this means "do what you intend to do and do it and do it again and again." Goal achievement—and more broadly, realizing resolutions—is all about doing, not thinking, and not intending but doing.

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*Dr. Marty Martin is a speaker and author of the forthcoming book Connected Health: Leveraging Digital and Mobile Technologies. Known for his state-of-the art content presented in an engaging, dynamic fashion, he has been speaking and training nationally and internationally for more than 30 years. Along with his role as a corporate speaker, Dr. Martin is the Director of the Health Sector Management MBA Concentration and Associate Professor in the College of Commerce at DePaul University in Chicago, Illinois and practices at Aequus Wealth Management. For more information or to contact Dr. Martin, please visit his website at http://www.drmartymartin.com.*

# IMAGING ADVANCES

## Innovative Breast Cancer Screening for Women with Dense Breast Tissue

### *Q&A with Dr. William Bowen*

William D. Bowen, MD

**Dr. Bowen is Chief of Women's Imaging for the Rochester Regional Health System.**

*Q. What percentage of women have dense breast tissue? Is there an increased risk of cancer development in dense breast tissue? What are the specific challenges for early detection in these women?*

**A**. About half of all women have "dense" breast tissue. It's more common in younger women.

Having dense breast tissue does somewhat increase a woman's risk of getting breast cancer at some time during her life – independent of any other risk factors.

The primary challenge for detecting cancer in these women is that dense breast tissue appears white on a mammogram; unfortunately, so do most breast cancers. This makes it more difficult to detect an early cancer as it may be camouflaged or obscured by normal tissue.

*Q. How does utilization of the FDA approved Automated Breast Ultrasound Screening (ABUS) tool improve breast cancer detection?*

**A.** ABUS (automated whole breast ultrasound) allows efficient and reproducible evaluation of the breasts with an imaging technique that is complementary to mammography. While many cancers will be seen with both ultrasound and mammography, some will be seen only with one technique or the other. Additionally, ultrasound can often provide helpful information that may indicate whether or not a biopsy is needed. For example, US can confidently diagnose a benign breast cyst.

*Q. What is the imaging technology behind the ABUS diagnostic and is it readily available to patients in the Rochester region?*

**A.** ABUS is an adaptation of existing medical ultrasound technology designed specifically to screen for breast cancer. It provides very high resolution ultrasound images of the entire breast (up to 1000 images of each breast.)

The newest generation ABUS is available at Rochester General Hospital.

*Q. Is the ABUS diagnostic a replacement for traditional mammography or an additional tool for improved accuracy?*

**A.**ABUS is a supplementary technique designed to enhance the early detection of breast cancer, especially in patients with dense breasts. It's important to emphasize that it does not replace screening mammography.

*Q. What is important for referring physicians to know about ABUS as a diagnostic for their patients?*

**A.** Most patients with dense breasts will be eligible for, and should be referred for supplemental breast cancer screening with either ABUS or conventional breast ultrasound. High-risk patients (patients with risk factors other than dense breasts) may be eligible for screening breast MRI.

# E-Cigarette Vapors, Flavorings, Trigger Lung Cell Stress

Do electronic cigarettes help people quit smoking? As the debate continues on that point, a new University of Rochester study suggests that e-cigarettes are likely a toxic replacement for tobacco products.

Emissions from e-cigarette aerosols and flavorings damage lung cells by creating harmful free radicals and inflammation in lung tissue, according to the UR study published in the journal PLOS ONE. Irfan Rahman, PhD, professor of Environmental Medicine at the UR School of Medicine and Dentistry, led the research, which adds to a growing body of scientific data that points to dangers of e-cigarettes and vaping.

The investigation suggests the harm begins when the e-cigarette's heating element is activated. The heating element is designed to turn a liquid solution (known as an e-liquid or "juice") into an aerosol that mimics cigarette smoke. The inhaled vapors contain heavy metals and other possible carcinogens in the form of nanoparticles – tiny particulate matter that can reach farther into lung tissue, cell systems, and blood stream.

Rahman's study also shows that some flavored e-juices (particularly cinnamon) create more stress and toxicity on lung tissue. Researchers observed in the laboratory that human lung cells exposed to e-cigarette aerosols released various inflammation biomarkers. Mice exposed to e-cigarettes with classic tobacco flavoring also demonstrated signs of pulmonary inflammation.

"Several leading medical groups, organizations, and scientists are concerned about the lack of restrictions and regulations for e-cigarettes," Rahman said. "Our research affirms that e-cigarettes may pose significant health risks and should be investigated further. It seems that every day a new e-cigarette product is launched without knowing the harmful health effects of these products."

In a joint statement issued January 8, 2015, the two leading cancer organizations in the United States – the American Association for Cancer Research and American Society for Clinical Oncology – said that e-cigarettes should be subject to the same Food and Drug Administration (FDA) restrictions as tobacco until more is known about possible adverse health effects. Insufficient data also exists on the value of the tool for smoking cessation.

The biggest concern is for e-cigarette users under age 18. Health experts believe e-cigarettes entice some young people to start smoking and will make it socially acceptable again. E-liquid flavorings marketed to kids and teens include fruit, dessert, and candy, and are widely available at convenience stores, gas stations, and online. Manufacturers contend it's a safer alternative to cigarettes, and consumers have pushed sales in the U.S. beyond $1 billion.

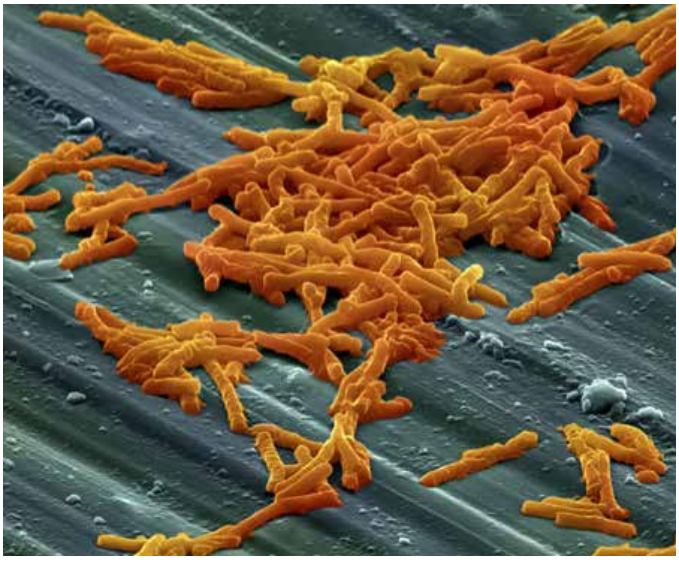
A trend known as "dripping" allows e-cig users to drip an e-liquid directly onto the cigarette's heating element instead of using a refillable chamber to hold the e-liquids. The smoker inhales the aerosols and gets a stronger hit, while also being able to more easily switch between flavors, brands or nicotine content. The UR study found that dripping e-liquids or e-juices to produce vapors likely generates a larger dose of toxins to the lungs.

Rahman's study notes that manufacturers typically don't disclose all materials and chemicals used to make e-cigarettes and e-juices. Without that information or long-term use studies, consumers have limited information about the potential dangers for human health and the environment, he said.

*Funding for the study came from The National Institute of Drug Abuse and a National Heart Lung and Blood Institute training grant. Study collaborators include: first author Chad Lerner, PhD, postdoctoral fellow in the Rahman laboratory; Scott McIntosh, PhD, associate professor of Public Health Sciences at UR, Deborah J. Ossip, PhD, professor of Public Health Sciences at UR; Alison Elder, PhD, associate professor of Environmental Medicine at UR; and Risa Robinson, PhD, professor at the Kate Gleason College of Engineering at Rochester Institute of Technology.*

# New Study Details Burden of C. Diff in U.S.

## *Inappropriate Use of Antibiotics Biggest Risk Factor for Infection*



A new study led by scientists at the Centers for Disease Control and Prevention, with support and data from researchers at the URMCr, estimates that Clostridium difficile or C. diff caused almost half a million infections in the United States in 2011.

C. diff, a bacterial infection that can cause life-threatening diarrhea, is most often associated with hospitals. But, this latest analysis estimates that only a quarter of health care-associated cases (cases in which an individual had some interaction with a health care facility) occurred in the hospital, suggesting that the majority arose in other settings, such as nursing homes or following a doctor's visit.

Study author Ghinwa Dumyati, MD, director of the communicable diseases surveillance and prevention program at URMC's Center for Community Health, says that taking antibiotics is the most important risk factor for developing C. diff. Antibiotics are life-saving medications, but, in the process of wiping out disease-causing bacteria, they also eliminate beneficial bacteria that are normally present in the gut and protect against infection. This gives organisms like C. diff an open playing field to replicate.

"If we are going to prevent this infection we have to take a broad approach by targeting antibiotic use in the hospital, in long-term care facilities and in doctor's offices and other outpatient care settings," said Dumyati, an associate professor and infectious diseases physician who treats patients at UR Medicine's Strong Memorial Hospital. "Though a vaccine is in development and fecal transplants are showing some promise in treating C. diff infection, we can't wait for these to come to fruition; we need to address the problem now and the best way to do that is by improving the appropriate use of antibiotics."

Dumyati is leading the charge in Rochester on multiple fronts. She heads the Rochester Patient Safety Collaborative, a citywide effort that has reduced the incidence of C. diff in area hospitals by almost 30 percent through improved infection control, environmental cleaning and an antimicrobial stewardship program to limit the use of a group of antibiotics that predisposes patients to C. diff infection. With a grant from New York State, she is also targeting C. diff in nursing homes by improving antibiotic use, focusing on the overuse of antibiotics for urinary tract infections.

Scientists estimated that C. diff caused approximately 453,000 infections and was associated with approximately 29,000 deaths in the United States in 2011. They also found that the infection was more likely to occur in females, whites and people 65 years old or older.

This national estimate is higher than previous U.S. estimates, but study authors say comparisons are difficult because different surveillance methods, more sensitive testing and updated definitions of C. diff were used in the new analysis. Prevention remains a national priority, and over the next five years the CDC, in collaboration with partners in health care, public health, academia and others, will work to combat C. diff and antibiotic resistance as part of the National Strategy to Combat Antibiotic Resistant Bacteria.

Dumyati says that patients can help to prevent C. diff infections by taking antibiotics only as prescribed by their doctor and completing the prescribed course of treatment. Understanding that an antibiotic is not recommended in many cases, such as for most sore throats, colds and the flu that are caused by viruses, is also important. Dumyati encourages patients to tell their doctor if they have been on antibiotics and get diarrhea and to wash their hands before eating and after using the bathroom, as well.

# Community HIEs:
## The Case For Better Information & Better Patient Care

Ted Kremer, MPH

Three research studies published in the past twelve months in peer-reviewed academic journals confirm that community health information exchanges (HIE) can improve patient care and increase health system efficiency.

The Rochester RHIO has been the subject of multiple research studies recently performed by Weill Cornell Medical College researchers looking at the impact of community HIE. The studies were published by Dr. Joshua Vest, assistant professor of healthcare policy and research at Weill Cornell, and Dr. Rainu Kaushal, chair of the Department of Healthcare Policy and Research, the Frances and John L. Loeb Professor of Medical Informatics at Weill Cornell, and public health physician-in-chief at New York-Presbyterian Hospital. The three studies found that use of a community HIE results in:

### Less Repeat Medical Imaging

There is a significant decrease in the frequency of repeat medical imaging when health care providers have immediate access to patients' medical history through the use of a community HIE. Published in the American Journal of Managed Care (Am J Manag Care. 2014; 11 Spec No. 17), this study was based on a review of data from insured adult patients in the 13-county region served by the Rochester RHIO. After examining the number of repeat imaging tests—including X-rays, CT scans, ultrasounds, mammograms, and MRI—performed within 90 days of the initial test, researchers concluded that providers who used the HIE were 25 percent less likely to perform the same test again.

### Reduced Hospital Readmissions

Researchers found that accessing patient information through the RHIO within 30 days of discharge resulted in patients being 57 percent less likely to be readmitted. The study examined the link between HIE system usage and 30-day same-cause hospital readmissions. Results were drawn from the analysis of claims files from regional health plans Excellus and MVP, and included more than 6,800 patients. Published in the Journal of the American Medical Informatics Association (J Am Med Inform Assoc 2014;0:1–6), the study was conducted at 11 hospitals that utilize the Rochester RHIO secure HIE.

### Decreased Hospital Admissions from the Emergency Room

Emergency department physicians are less likely to admit patients to the hospital when they have readily available electronic access to community-level patient health information. Conducted at seven hospital emergency departments that use the Rochester RHIO's HIE, and published in Applied Clinical Informatics (Appl Clin Inform 2014; 5: 219–231), this study determined that hospital admissions were 30 percent less likely when emergency department doctors consulted RHIO records, enabling more effective and efficient patient care.

These studies represent some of the first empirical evidence that community HIEs can provide measurable value to the healthcare system. While many earlier promoters of improved information exchange assumed that the ability for patient data to follow the patient would be beneficial in a myriad of ways, few HIEs have evolved sufficiently or had the data available to support rigorous evaluation. With usage, clinical and claims data available from 2008 to present, Rochester RHIO provided researchers with the depth and breadth of data required to measure the impact and value of HIE.

In reviewing literature on HIE, the researchers at Weill Cornell Medical College made the important distinction between community and private HIEs. The Rochester RHIO, as a "community" HIE, provides value that accrues across the healthcare ecosystem, in contrast to "private" HIEs, which support a specific institution or integrated delivery system. This distinction in mission leads to a difference in scope and the nature of the value delivered by the HIE. It also requires, as the researchers point out, a degree of collaboration between various stakeholders to realize these types of value propositions.

Both the federal government and New York State have invested significantly in promoting health information exchange between care providers. The type of research conducted by Weill Cornell Medical College, working with the Rochester RHIO, helps to validate these public investments. "Our studies show that providing physicians, nurses and allied health care professionals real-time access to community-wide, longitudinal health records does in fact benefit patients," said Dr. Vest.

Rochester RHIO continues to collaborate with Weill Cornell Medical College researchers to further study the impact of health information exchange on the quality and efficiency of health care delivery. The next research effort will focus on the clinical use of the RHIO's Image Exchange.

# The Heart of the Matter

## UCVA cardiologist practices patient-focused care

by Jenn Bergin

Growing up in a small town on Schroon Lake in the Adirondacks, Dr. Daniel Williford always knew he wanted to be a cardiologist. "The notion that the heart is the seat of the soul, the place in our body that emotions emanate from, it was all so exciting," he says. "I realized that's where I wanted to be."

Today, Dr. Williford is a highly-esteemed physician at UCVA and Fellow of the American College of Cardiology. But back then, he wasn't even sure he would get into medical school.

He started off in a five-year pharmacy program and earned a bachelor's degree through Union College. "I never wanted to be a pharmacist," he explains. "But I wanted to make sure that I had a job."

Next was Georgetown, where he designed his own MD/PhD program. Not only did he get into the medical school, he was also accepted to the graduate school and earned a doctorate in pharmacology.

He arranged to do post-doctoral research, combined with medicine and cardiology training, in the Harvard system. But once in Boston, he felt his colleagues were primarily interested in the research he planned to do, not in providing the training he wanted.

Frustrated with the experience, he began to look into other residencies, including at the University of Rochester. "Every time I went to a smaller program, I liked it better – it was more me," he says. Until then, his only contact with the University of Rochester was when he wasn't accepted as an undergraduate. It was the last place he interviewed, but it became his first choice.

He came to Rochester in 1983, and was given the opportunity to design his own clinical investigator pathway. He wanted to be the "triple threat" and combine clinical care, pharmacology research in cardiology and teaching. But as clinical cardiology needs began to grow, he went from spending 80 percent of his time on research to full-time clinical work, and no longer had time for the lab.

"With two young children at home, it seemed like the path of least resistance," he says. It turned out to be the right one.

### The road less traveled

"Few people are successful as the triple threat," he says. "They're smarter, quicker, faster and more energetic than me. They're able to juggle more than I ever could. It's better that my career evolved into doing one thing, as opposed to trying to do everything, because you can't do them all well."

One thing he does do exceptionally well is engage with his patients. He is known for his incomparable bedside manner – and as a thorough problem solver, who will look beyond his own specialty for answers rather than simply passing the patient along. "I try very hard to see it from their eyes," he explains. "I consider what it must be like to sit across the table from a doctor who's trying to figure out what's wrong with you. And I try to give the care that we would all like under those circumstances."

Patients routinely ask, "If this was your father, what would you do?" and Dr. Williford can answer honestly every time.

*"I consider what it must be like to sit across the table from a doctor who's trying to figure out what's wrong with you."*

He has considered that exact question and takes the same approach with each patient that he would take with a member of his own family. And it's not just patients who are positively impacted by the interaction. "I like it too," he says. "It's like meeting an old friend. I don't just treat them as if they were family, they are family."

He connects with patients by making a conscious effort to know them in some important way, outside of their illness. "In this profession, we have a terrible way of labeling our patients," he explains. "We'll refer to someone as the acute heart attack in Room #4. We need to change that. It's important for us to remember – that's Mr. Smith, and he's someone's father."

Nurse practitioner Deborah Hamilton, MS, GNP, ANP has worked closely with Dr. Williford for 8 years. Not only does she respect him as a cardiologist, she likes him as a friend. "He has the ability to remember not just the patient, but also the patient's mother, father, brother and sister. He knows the patient as a person," she says. "It's natural to him. He remembers everything the patients say, even the most obscure facts – and they love it."

While some may be caught off guard, it's rare that a patient is uncomfortable with his amiable approach to care. "They come to realize that the process can be much more enjoyable," Dr. Williford says. "It gives them a chance to talk about things other than their illness and makes them very comfortable calling or asking questions."

Extra time is built into the schedule for patients that he wants or needs to spend more time with. "We do our doctorly thing and then we spend some time catching up," he says. Many of his patients know as much about Dr. Williford's grandkids and golf game as he does about theirs. "That's the difference," he explains. "Many physicians aren't willing to share that."

He makes a point to go out of his way, with both patients and colleagues. "You never feel bad going to him and asking a question," Deborah says. "Although sometimes you know you're delaying him, he never makes you feel that way. He's gives good attention and good care. He makes an impact that he doesn't even realizes he makes."

## A culture for connection

"We've all experienced colleagues with an approach that's not very patient-centered," Dr. Williford says. "They may give good care, reach the right diagnosis and give the right treatment, but it's not necessarily done in a kind or comforting way for the patient."

The doctor-patient connection is even more critical in today's digital age, particularly with the prevalence of electronic medical records. "We're staring at the computer screen, not talking face to face," he explains. Recently, a long-time patient referred a friend to Dr. Williford. "He actually looks at you," she said.

While he appreciates the accolades, Dr. Williford credits UCVA with cultivating a practice-wide, patient-focused approach to care. "It's a cultural thing, and some systems simply don't have that culture," he explains. Creating that culture requires an understanding of each person's role in terms of helping people. It goes from the top down and the bottom up, he says.

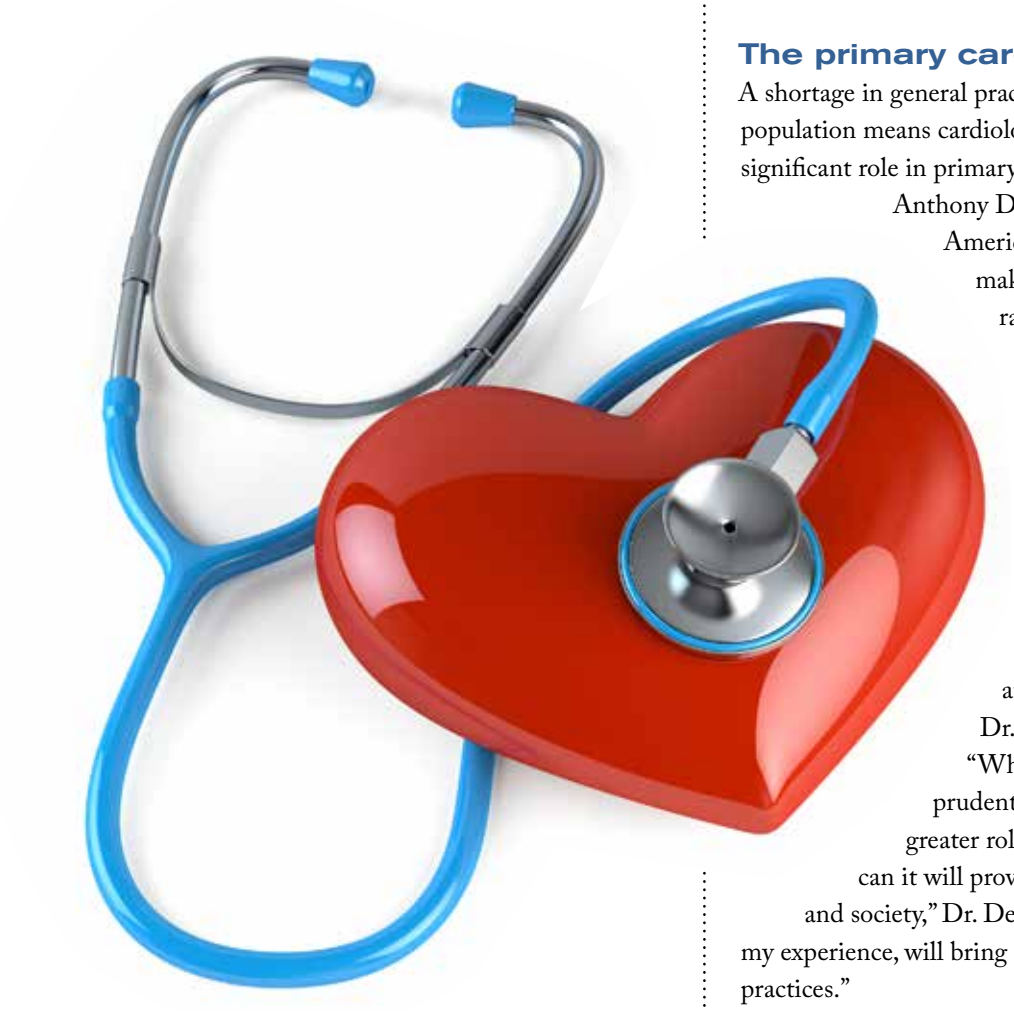
"And it's a mindset," Deborah adds. "That's why this practice is well-known in Rochester. People want to come here because of the things they've heard."

Some physicians have the notion that their time is more valuable because they're busy or educated, but that's not the way that it should be, Dr. Williford says. "People that get caught up in that, I'm sorry for them," he says. "Because they probably don't have as much fun as we do."

*"That's why this practice is well-known in Rochester. People want to come here because of the things they've heard."*

Dr. Williford has watched patients attempt to navigate the system in local hospitals, and understands that it can be difficult. After a recent visit to Cleveland Clinic, he was impressed – and inspired.

"If you're not walking with a clear sense of purpose, evident that you know where you're going, someone will appear out of nowhere and ask how they can help," he says. "People strike up a conversation when you check-in at the desk and ask how you are or where you're from. They've worked hard at that.



> *"You're willing to accept that the patient is important to you, and if something happens you will feel it."*

And the employees they attract buy into it, and realize that it makes their day better, too."

He recognizes that it takes time and consistent effort to make a long-term change on a larger scale. "Unless you involve people from the bottom to the top – and most importantly, the people at the top lead by example – it doesn't happen," Dr. Williford says.

But once that culture changes, he believes everyone benefits – including doctors and staff. "We like what we're doing more," he says. "Everyone is happier to step up and go the extra mile. Everyone has a smile."

## The primary care cardiologist

A shortage in general practitioners and increase in the aging population means cardiology is a specialty poised to play a significant role in primary care, according to an article by Dr. Anthony DeMaria, editor of the Journal of the American College of Cardiology. This may make patient-focused care expected, rather than the exception.

Patients with heart failure, for example, require frequent follow up, which means many see their cardiologist more than their primary care physician. Dr. DeMaria bonds with his patients, who often also come to him with minor medical issues and for referrals. Patients develop an attachment to him – and much like Dr. Williford, he embraces them.

"While it may not be practical or prudent for many specialists to play a greater role in primary care, for those who can it will provide a great service to our patients and society," Dr. DeMaria says. "And, based upon my experience, will bring an enduring satisfaction to our practices."

Dr. Williford agrees, and is leading by example. No one is surprised, except maybe the doctor himself. "Back when I was doing research, I would sit in a darkroom doing fluorescent studies for 14-plus hours without human contact," he says. "I once wanted to be a professor and win the Nobel Prize by the age of 45. Those were my misdirected goals."

## Accepting the attachment

Dr. Williford often attends calling hours for his patients, and invariably he cries. But he takes the opportunity to tell families how special their loved ones were to him. He opens himself up to his patients, and understands the implications.

"As a medical student, you train yourself not to get so close to a patient that you're hurt when something bad happens," he explains. "You don't want to feel an emotional attachment because despite giving the best treatment, you could get hurt.

"But then you find out, that's what makes the relationship so special for all those years. You're willing to accept that the patient is important to you, and if something happens you will feel it."

He hasn't yet won the Nobel Prize, but Dr. Williford has certainly been rewarded with an inimitable understanding of the human heart.

# What is My Liability?

## I Enter into a Contract: Part II

James E. Szalados, MD, MBA, Esq.

## Issue

In my last column, I discussed liabilities associated with Letters of Intent and Contracts and suggested that contracts pose significant liability for providers. The time to worry about the risks inherent in a contract is before the contract is signed, since the punitive liabilities may only be manifest when the contract is violated.

Previously, I emphasized that contract verbiage, which might appear on first blush to be plain English, may actually represent 'legal terms of art' which have special meaning - shorthand for legal concepts. In law school, such 'legal terms of art' were frequently referred to as 'magic words' by law professors, and the point of the lesson was to delineate out and define these terms so as to better understand and allocate the risks embodied within contracts. Legal 'terms of art' unavoidable add complexity to the interpretation of the contract. However, because contracts reflect the complexities of the transactions they embody, specialized terminology is used by attorneys to efficiently express that complexity. These 'terms of art' seem to read as plain English, but in actuality, their meaning refers to a legal concept which may not be apparent to the casual reader.

Contract clauses are frequently of a 'boilerplate' nature – meaning that these clauses are generic and may appear superficially identical to similar clauses in other contracts; sometimes the clauses are in fact identical to those in other contracts and sometimes they are only similar. Thus, a superficial reading, even by those experienced in contract law, can result in an erroneous interpretation. Experienced attorneys will read, and then re-read, contracts both word-by-word and sentence-by-sentence to find the inherent meaning and the inherent risks within each covenant, or promise, to the party that particular attorney represents.

There is an inherent advantage for the party that writes the contract. The party who receives the contract for consideration must decide whether to accept clauses as they are written, or to challenge clauses or even re-write elements of the contract in a more favorable fashion. The attorneys who have written the contract will have done so in a manner to best represent the interests of the party offering the contract. On the other hand, the attorneys representing the party considering the contract can only advise their client regarding the meanings and risks within the contracts, and potentially rewrite or negotiate clauses, but the decision to accept or reject the contract in part or in its entirety, will ultimately rest with the client. The contract negotiation will ultimately rest within a balance or key interests and risk tolerance. Contracts, by their nature, shift, or assign risk.

Frequently, when I review a prospective contract, the elements or clauses that are not in the contract are as important as those that are. For example, a contract which is silent on potentially important issues such as limitations on liabilities, advancement to partnership, or specific benefits may not include such promises, even though parties believed these promises to be already agreed upon, implied, or implicit. The exceptions to this rule are usually limited to separate rules of law which govern working conditions, medical benefits, or family leave provisions.

There are a number of doctrines which may represent liability pitfalls in contracts that courts commonly adhere to in their interpretations. The first such doctrine is the doctrine of "Incorporation by Reference" which means that writings which are referenced in a contract are considered to be integral parts of that contract. For example, a contract which references, inter alia, a Code of Conduct, Medical Staff Bylaws, Rules and Bylaws, a fee schedule, or a separate Agreement, will contain contractually binding elements of the documents referenced. Therefore, when I either write or review a prospective contract, I will carefully draft or review any and all documents referenced, since a contract review is incomplete without considering the ramifications of the entire binding Agreement. A corollary

of the 'Incorporation' doctrine is the "Parol Evidence Rule" which basically states that courts which interpret the contract will look at the contract within the '4 corners of the contract' – the edges of the pages, when looking at the limits of the agreements or the liabilities. Thus, any verbal agreements, correspondence, group meetings, or letters of intent which are not specifically referenced within the contract are not part of the final binding Agreement and thus do not represent contractual obligations. The tentative agreements resulting from preliminary negotiations are considered to be subsumed by the provisions of the executed contract through a doctrine known as "Integration" which essentially states that the signed Agreement represents the final and complete expression of the parties' understanding of their risks, benefits, and liabilities.

My clients typically focus on only two elements of a contract – the term and the compensation – a risky approach because these elements are often clouded within terms of art.

First and foremost, a contract of employment, whereby providers enter into a contract as an employee, rather than as a partner, need to be aware that in most states, employment is 'at will' and may therefore be terminated by the employer without cause, upon a reasonable notice period. Medical staff membership and clinical privileges are usually predicated on employment status, and therefore in the event that the provider loses employment status, he or she will also lose medical staff privileges and all benefits thereof. Employment contracts typically specify both a starting date and an ending date thus defining a term, or duration for the contract. Nonetheless, because of the 'employment at will' doctrine, if the contract stipulates a three year term with a ninety day notice period, then the contract is actually a ninety day contract. Most states recognize employment at will meaning that the employer can dismiss the employee at will. The employment at will doctrine (which is not written into the contract) may be modified by other clauses such as clauses which discuss termination with and/or without cause. Termination without cause is especially dangerous because it means that the contract can be terminated by either party on a whim, without recourse. In addition, it is important to understand whether the contract is 'evergreen' - automatically renewable, or is specific and definitive in its term. Contracts which renew automatically require vigilance so that opportunities for maturing or modifying the contract based on cost of living, working condition changes, or merit, are not lost. Similarly, compensation is typically a fluid element within a contract and may require close examination for clauses which may allow for 'clawback' provisions, clauses limiting outside activities, or the realistic nature of incentives, for example.

Indemnification is a contractual term of art which prospectively allocates liability. To indemnify another is to personally guarantee (or insure) against any loss stemming from the contractual relationship (hold harmless) which the other party might suffer. Indemnification frequently represents an uninsurable risk to the party agreeing to indemnify. The liability risk stems from the fact that in the ordinary course of clinical activities, these clauses often result in one-way indemnification whereby physicians protect their employers, their contract groups, or their hospitals. For example, if a patient files a medical malpractice case against the physician, wherein the plaintiff alleges vicarious liability against the hospital, and the physician has agreed to indemnify the hospital, he or she will be liable for the hospital's attorney fees, court costs, and any jury verdict rendered against the hospital. In addition, medical malpractice insurance policies do not typically provide coverage for indemnification agreements. Indemnification may be limited or unlimited, or, unilateral or mutual; the way the contract is typically written is to provide the most protection to the party who wrote it.

Ambiguity is important since it frequently results in litigation. Courts have reasoned that in instances where neither party knew, or had reason to know, of the ambiguity, or where both parties knew or had reason to know of it, the ambiguous term is given the meaning which each party intended it to convey. As a practical matter, this means that if the parties interpreted an ambiguity differently then there may be no effective contract, since there was no 'meeting of their minds'.

In summary, an employment contract is one of the most important financial decisions a provider will make in his or her career; misunderstandings may result in unforeseen and painful consequences. Legal counsel is vital to minimize misunderstandings and liability. In the end, the right for individuals to enter into legal contracts is protected and therefore, assuming the risks is a protected choice; however, not fully understanding the risks or not choosing to negotiate terms is a personal choice. The cost of a contract review with an experienced attorney before a contract is signed is usually a good investment.

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*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. Dr. Szalados is an attorney with healthcare law firm of Kern Augustine Conroy & Schoppmann, P.C.*

## CMS ANNOUNCES DRAFT STAGE 3 RULES FOR ELECTRONIC HEALTH RECORDS INCENTIVE PROGRAM

Question: What is the new draft Stage 3 Rule the CMS recently announced concerning Electronic Health Records?

Answer: The CMS recently announced a proposed rule that would require nearly all providers to report on a full calendar-year cycle beginning in 2017 and would require electronic reporting of clinical quality measures beginning in 2018.

It is projected that physicians and other eligible professionals who fail to meet the requirements will pay approximately $500 million in Medicare penalties between 2018 and 2020 under the proposed rule. It is further estimated that it will cost physicians $54,000 to upgrade their EHR to meet the new requirements of the draft rule, plus $10,000 in annual maintenance costs. Hospitals face steep costs as well, with the CMS estimating hospital EHR upgrades to cost $5 million, plus $1 million for annual maintenance. Still, the CMS said it expects all hospitals to achieve meaningful use by 2018.

The rule would give providers three options for ensuring patient engagement with their care, of which providers must fulfill two: access to their own records; secure messaging between patients and providers; and collection of patient-generated health data.

Critics of the draft Stage 3 question the CMS for making compliance stricter when it is estimated that approximately only 35% of hospitals and a small fraction of physicians have even met the far less stringent Stage 2 requirements.

For more information on the Stage 3 proposed rule and instructions on submitting comments to the CMS by the May 29, 2015 deadline, you may go to: http://ow.ly/KKspB.

## MEDICARE LOWERS PAY RATE WHILE TEMPORARILY PUTTING CLAIMS ON HOLD

Question: How will Medicare's lower pay rate and hold on claims affect my practice?

Answer: It was recently announced that the Centers for Medicare and Medicaid Services (CMS) will be asking its claims processors to hold all claims for payment for dates of service from Thursday, January 1, 2015 through no later than Wednesday, January 14, 2014.

The hold on the payment of claims during the first 2 weeks of January is to allow CMS to implement a decrease in the Medicare pay rate, even though a final 2015 physician payment rule had been published in November of 2014. CMS officials claim this temporary hold will only have a minimal impact on providers' cash flow as currently, clean electronic claims are paid no sooner than fourteen (14) calendar days and paper claims are paid no sooner than twenty nine (29) days.

The reduced conversion factor is approximately five (5) cents lower than the one in final 2015 physician payment rule. The conversion factor is the dollar multiplier used to calculate physician payments under the current reimbursement system. CMS officials stated that the reason behind the 0.13% reduction is "budget neutrality adjustments." CMS should release a correction notice in the near future that will detail the exact nature of the corrections that have been made.

Still looming for Medicare providers is the 21% pay cut that is set to take place in April unless Congress changes the sustainable growth rate (SGR) payment formula currently in effect.

## NEW HOSPITAL RATINGS SYSTEM

Question: How is the new CMS Hospital Quality Rating System calculated?

Answer: CMS' new star rating system for hospitals is based on an average of a hospital's performance on eleven publicly reported measures from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey. The HCAHPS survey includes patient evaluations of the hospital staff responsiveness, care transitions, how well information about medications is communicated, and cleanliness and quietness of the facility. The inaugural ratings came from patient responses gathered between July 1, 2013, and June 30, 2014.

However, healthcare organizations are not convinced that patient experience should be the primary way they are ranked on quality. At the moment, the patient experience ranking is the only five-star rating displayed on the site, even though CMS plans to include additional rankings in the future for achievements like patient safety and clinical outcomes. Industry leaders are worried that patients will see the rating and select a facility based only on one single, subjective measure of hospital quality, regardless of how they may fare clinically.

Under this patient-driven ratings system, only seven percent (7%) of hospitals received the coveted five stars rating, while three percent (3%) achieved only one star. Thirty four percent (34%) received four star ratings, while forty percent (40%) received three stars and sixteen percent (16%) received only two stars. Meanwhile, about twenty percent (20%) of the nation's hospitals are not ranked due to insufficient patient surveys. Under the new ratings system, thirteen states and the District of Columbia do not have any five-star hospitals.

## STATES UNDER PRESSURE TO EXPAND MEDICAID

Question: What is the potential impact of the government's push to expand state Medicaid benefits?

Answer: President Obama's administration has made it clear that it is seeking to expand Medicaid benefits across the United States. Specifically, the administration is tying renewal of funding provided under the federal Medicaid waiver to states expanding Medicaid coverage. Similarly, CMS has delivered the message to the non-expansion states that receive similar Medicaid supplemental funding, detailing a defined criteria for receiving continued dollars.

The latest actions by HHS Secretary Sylvia Mathews Burwell and acting CMS Administrator Andy Slavitt suggest the administration may go as far as withholding the extra funding, at the risk of causing disruption of safety net care, to get people covered through the expansion while President Barack Obama is still in office.

If a state refuses to expand Medicaid, that state will lose its uncompensated-care funding, causing patients to lose access to coverage and possibly forcing hospitals to close. In the case of states like Florida, which receives between $1 billion and $2 billion annually to help its safety net providers with uncompensated-care costs, a loss of funding would seriously affect patients and hospitals across the state.

The National Rural Health Association plans to reach out to state hospital associations to pressure the administration into backing down from such a drastic move and in hopes of reaching a better alternative to this ultimatum.

If you have any questions, please contact our Managing Partner, Michael J. Schoppmann, Esq at 1-800-445-0954 or via email at MSchoppmann@DrLaw.com.

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# WHAT'S NEW in Area Healthcare

## ROCHESTER REGIONAL HEALTH SYSTEM

### Rochester Regional Physicians Organization Achieves High Quality Score

The Greater Rochester Independent Practice Association (GRIPA), a physician organization that partners with Rochester Regional Health System, is pleased to announce that it has achieved the highest overall level of health care quality from Excellus BlueCross BlueShield's Accountable Cost and Quality Arrangement (ACQA).

The ACQA is designed to achieve enhanced care coordination, improve patient satisfaction and outcomes and reduce health care costs. The ACQA assesses quality performance by using national quality measures, which include performance thresholds for diabetes, blood pressure and coronary artery disease, amongst others. Physicians must meet quality standards to ensure that savings are achieved through improving care coordination and providing care that is appropriate, safe and timely.

Participation in an Excellus BlueCross BlueShield ACQA is voluntary. This is the second year in a row GRIPA has earned this distinction.

GRIPA team members have worked diligently with patients to improve physician-patient engagement and outcomes through such efforts as improving access to primary care medical services (to manage chronic illnesses such as diabetes and reduce the need for emergency room visits), improving medication adherence rates, and limiting duplication of services.

"The Excellus BlueCross BlueShield ACQA has recognized GRIPA's focus on improvement initiatives important to the care and outcomes of our patients," said Joseph Vasile, MD, president and CEO of GRIPA. "We appreciate the Excellus incentive program's support of our quality goals and the recognition of the creative and hard work of our team that positively impacts the people in our community who come to us for care."

### Rochester General Hospital Introduces New Technology to Treat Peripheral Artery Disease (PAD)

Rochester General Hospital, an affiliate of Rochester Regional Health System, is the first in the area to use the Lutonix Drug Coated Balloon Catheter to treat Peripheral Artery Disease (PAD).

PAD is a life-threatening condition that affects millions of Americans by narrowing arteries and reducing blood flow to the limbs. Worldwide it is estimates that 200 million people suffer from PAD.

"Minimally-invasive endovascular procedures such as angioplasty balloons and stents, medications and vascular bypass surgery are some of the accepted ways to treat PAD," said Jeffrey Rhodes MD, a Vascular Surgeon at Rochester General. "What makes the Lutonix Catheter unique is the drug coating, which is designed to prevent scaring once the arteries are opened by the balloon catheter."

Left untreated, Peripheral Artery Disease (PAD) can result in the loss of limbs. In fact, PAD is the leading cause of amputation in people over the age of 50 and accounts for up to 90% of amputations overall.

### O'Banion Joins Rochester Regional Health as New Senior Vice President for Integrated Health Care Delivery

Emily O'Banion has been named Rochester Regional Health's first

Senior Vice President for Integrated Health Care Delivery. "Emily will help to establish and build system-wide service lines, and identify and execute a variety of clinical and operational performance-improvement initiatives," said Eric Bieber, MD, president and CEO of Rochester Regional Health System. "Her national perspective and extensive experience in building high-performance, patient-focused organizations will be invaluable as we continue to work to provide extraordinary care that meets the needs of our patients and community."

O'Banion joins Rochester Regional Health from OhioHealth in Columbus, OH, where she served as system vice president for process excellence and led the development of system-wide continuous improvement strategies. Prior to that, she was a senior manager with Deloitte Consulting.

She earned a master's degree in Health Administration from The University of Iowa College of Public Health, and a bachelor's degree in Biology from Luther College in Iowa.

**URMC**

### Korones Receives National Honor for Pediatric Palliative Care Work

David Korones, MD, pediatric oncologist and palliative care physician at UR Medicine's Golisano Children's Hospital, has been awarded the 2015 Hastings Center Cunniff-Dixon Senior Physician Award, a national award for physicians who care for people at the end of life. Korones specializes in treating children with brain tumors and is the founding director of Golisano Children's Hospital's pediatric palliative care program.

"David is a physician who embraces many disparate, challenging worlds, and he does so with the utmost knowledge, skill and compassion," said Timothy E. Quill, MD, Georgia and Thomas Gosnell Distinguished Professor in Palliative Care, in his nomination of Korones. "He does not shy away from difficult problems that his patients present, nor does he limit himself to well-defined, more predictable realms of medicine. David is drawn to domains in medicine where there is great need, which others tend to steer away from."

### Wilmot Cancer Institute to Build New Interlakes Hematology and Oncology Clinic in Geneva

WILMOT CANCER CENTER

UR Medicine's Wilmot Cancer Institute is beginning construction on a new building for its Interlakes Oncology and Hematology clinic in Geneva, Ontario County.

Interlakes has provided chemotherapy and infusion services for patients with cancer in Geneva since 1996, and it will be able to expand those services in the new building at 511 W. Washington St.

"We are excited about the collaboration with the Wilmot Cancer Institute and the opportunities and advantages that it provides for our patients and their families in the Geneva area." said Dirk Bernold, MD, of Interlakes Oncology and Hematology, PC. "It allows us to maintain the personal approach of a small community practice with access to cutting edge treatments and technologies."

At approximately 5,000 square feet, the new one-story building will be twice the size of the current clinic, and it will feature:

- Nine infusion chairs and a private infusion room.
- A laboratory draw station.
- Four exam rooms.
- A conference room with videoconferencing capabilities that will allow for meetings and training, as well as for physicians to participate in multidisciplinary conferences.
- Convenient, on-site parking.

The expansion will accommodate the growing number of patients who are seen at the clinic, and it helps to ensure high-quality cancer care for patients in Geneva and surrounding communities.

"From diagnosis through survivorship, cancer care has become so much more complex," said Jonathan W. Friedberg, MD, MMSc, director of Wilmot Can-

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cer Institute. "Expanding our services in Geneva means that patients — no matter where they live in our region — can benefit from the expertise and specialized skills that Wilmot Cancer Institute can provide."

### Paul Rubery, MD, Named Chair of Orthopaedics at University of Rochester Medical Center

Paul T. Rubery, MD, chief of the Division of Spinal Surgery, has been named chair of the Department of Orthopaedics at the University of Rochester Medical Center, pending approval by the University Board of Trustees.

Rubery had served as acting chair since September 2014 following the departure of Regis J. O'Keefe, MD, PhD, who was named chief of orthopaedic surgery at Washington University School of Medicine in St. Louis.

Rubery joined URMC's faculty in 1994 and has led the Division of Spinal Surgery since 1999. He has been Director of the Strong Health Spine Center since 2000 and was named the department of orthopaedics associate chair for clinical affairs in 2007. He earned his medical degree from Cornell University Medical College with Alpha Omega Alpha honors, and completed an orthopaedic surgery residency at the Hospital for Special Surgery in New York, and fellowship in spine surgery at URMC.

Rubery specializes in scoliosis and spinal deformity in both children and adults, with a research focus on applications of gene therapy in orthopaedics. He will maintain his clinical, research and teaching responsibilities in addition to his duties as chair of the department. Rubery teaches medical students, residents and fellows as well as CME courses.

"I am extremely pleased Paul Rubery will lead the department as chair," said Mark Taubman, CEO of URMC and Dean of the School of Medicine and Dentistry. "I'm confident Paul will continue the department's tradition of excellence; under his direction, orthopaedics will continue to flourish in the areas of patient care, physician and scientist education, and research."

### Wilmot Cancer Institute's Blood and Marrow Transplant Program Receives Prestigious Accreditation

The Blood and Marrow Transplant (BMT) Program at UR Medicine's Wilmot Cancer Institute was recognized for its high level of care and detailed quality management processes with a three-year re-accreditation from the Foundation for the Accreditation of Cellular Therapy (FACT).

Wilmot's BMT program was accredited for all types of adult and pediatric blood and marrow transplantation, as well as collection and processing procedures. Continuously accredited since 2000, Wilmot's BMT Program performs 130 to 140 transplants annually for conditions such as leukemia, lymphoma and non-cancerous hematologic conditions including aplastic anemia and sickle cell anemia. It is one of the largest FACT-accredited programs in New York state.

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