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Unless specifically indicated as being such, the views and opinions expressed in this publication do not necessarily constitute official positions of the Monroe County Medical Society, the Seventh District Branch, MSSNY, or the Rochester Academy of Medicine; nor do they necessarily represent the views of all its members.
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Letter from the Executive Director

We’re In This Together

Keeping, and in many cases making, quality healthcare affordable and accessible continues to challenge even the savviest of thought leaders. Research indicates that one can pay less and still get more quality in healthcare…but how does that actually work in day-to-day practice? A cost/benefit philosophy works well in the business world. Outcome measures do too but are of limited usefulness in healthcare unless they are personalized to the individual patient and physician.

When it comes to healthcare reform, many factors are at play. Death, taxes and changing payment models are a certainty. Fee for service is sure to go the way of the buggy whip, leaving physicians in all practice settings struggling to figure out how they will survive in the new world. So-called value-based purchasing of healthcare services requires an incredible infrastructure to monitor and make sense of the complexities of providing care. Electronic health records have not yet proven to be the panacea that was promised. Instead, information overload is the new normal. Indeed these forces pose a threat to medicine, but they also offer new opportunities.

To respond constructively, I urge you to get involved in the myriad of projects at MCMS, which are focused on improving health and the practice of medicine. We must learn to separate the wheat from the chafe and build on proven strengths while maintaining the physician/patient relationship. I believe the art of medicine will emerge stronger, but not without a struggle.

This issue of The Bulletin provides thoughtful perspectives on issues related to healthcare reform. I encourage you to contact me at nadams@mcms.org or (585) 473-4072 with your perspective as you re-examine your past, present and future roles. Together we can achieve benefits that we most assuredly would not accomplish alone.

Don’t Forget to Return Your Directory Update

The Monroe County Medical Society (MCMS) is currently working on updating its member database, as well as production of the 2014 Directory of Members. All members should have received a member update form. If you have changes, please remember to return your form to MCMS as soon as possible. Please contact MCMS at (585) 473-4072 if you have questions.

“Together we can achieve benefits that we most assuredly would not accomplish alone.”

Nancy J. Adams
Monroe County Medical Society
Executive Director
During the 2008 presidential campaign, the question of death committees was raised by Governor Sarah Palin, the Republican vice-presidential candidate. As is so often the case, the national media misrepresented the discussion and made a political issue of the matter.

With ObamaCare now accepted by the US Supreme Court, new views on how to deal with chronic illnesses have come into the forefront. Most Medicare costs are incurred in the last six months of the patient’s life. Since the costs are paid for by taxpayer dollars, questions have arisen regarding who is financially responsible for the chronically ill patient who has no hope of a meaningful recovery. Initially, this was the family’s responsibility, but often the family is unwilling or unable to pay for the chronic care needed.

To deal with this problem, ObamaCare has called for the establishment of a 15-member panel composed of physicians and laypeople. The panel would be chosen in consultation with congressional leaders, and prospective board members would have to be confirmed by the US Senate. Skeptics have raised the question of who would want to be on this panel and what qualifications would be required of those individuals. Whether one could even fill such a board is a major concern.

Let us look at some cases the panel would have to adjudicate. Should taxpayer funds be used to support the life of a patient who is brain dead but is kept on a ventilator at the request of the family? Should the Panel have the right to overrule the family’s wishes?

Another example is the patient with chronic renal failure coupled with many comorbidities whose hope for recovery is negligible. The patient needs hemodialysis, but the family will not or cannot pay. Without dialysis, a patient can only live a few weeks at most. Refusing the dialysis requirement, would be similar to turning off a ventilator on a patient needing oxygen.

Currently, such a decision would have moral, ethical, economic and legal repercussions. That would not be the case with a government panel. Estimates have suggested that Medicare would have ample funds and not be in danger of bankruptcy, if such a death panel existed. Being a government board, legal action by suing would not be possible. The only option left to families would be to pay out-of-pocket for the expenses. Who could afford to do so?

Dementia is another case in point. Many patients with dementia are kept alive in nursing homes with extraordinary measures, such as feeding tubes, ventilators, central lines and other extreme measures. Other patients in nursing homes have no cognitive abilities and are unable to eat, walk, or wash themselves. Again, many are kept alive by artificial means with the current system.

Many such cases exist across this country. Multiple death panels would have to be formed in order to be available for decisions in nursing homes, hospitals and even in private residences. Again the issue of qualification of staffing would be a major problem and expense for the United States. I would, however, anticipate the discussion in Congress to be rigorous on the establishment of such death panels. How the public will react to such panels is unknown.

The subject of death panels was raised prematurely in the 2008 presidential campaign, but the matter is here now — and not in the far distant future. Congressional elections scheduled for November 2014 will give the public an opportunity for their input in this matter. Congressional and Senatorial candidates should be asked for their opinion on death panels.

(Note: The opinions expressed here are the author’s own and do not necessarily reflect the official position of MCMS.)
Sometimes traditional treatments for chronic wounds aren’t enough.

If you have patients with wounds that are not responding to traditional treatment, we can help. The Unity Wound Care Center is focused on healing chronic wounds. Our experts use advanced wound care techniques and the most sophisticated technology available, such as debridement, bio-engineered tissue substitutes, negative pressure wound therapy, and hyperbaric oxygen therapy for complex wounds. These treatments are proven to significantly improve healing rates. For more information or to refer a patient, call (585) 368-6820.
Collaboration is Key in New Era of Healthcare Delivery

In order to make this new paradigm of care work, physicians will require transparency of clinical and cost data.

Transparency of costs is another novel concept. How can a physician be accountable for the financial consequences of their medical decisions if they don’t know the costs of medical care? For instance, the cost of medications, laboratory and radiologic tests, surgical procedures, emergency room visits, and hospital costs are currently opaque and hidden, resulting in prices that are proprietary — known only to the parties involved. Physicians will need this access to cost data, in real-time, just like the payers.

Only through this sharing of information, between hospitals, commercial and governmental payers, and other relevant players in the health care market will the necessary degree of information, cooperation, and trust be possible to achieve the changes being sought by the Affordable Care Act. This is asking a lot from the existing health care system.

It cannot be business as usual, and it will not be easy to change our current roles. Can all the players step up to the plate? Will information transparency including costs become a reality? Will physicians be able to work smarter, not harder? Will the system eventually provide less healthcare and more health? These are the challenges that face us.
“Daddy, this is the best day of my life.” I held my 5 year old son Matt’s hand tightly after he said those words, and I looked into my practice partner Phil Bonanni’s eyes as together we walked out of Frontier Field on May 13, 1998 after watching the Columbus Clippers’ El-Duque Hernandez beat the Rochester Red Wings. With those words both my heart and Phil’s melted at the same time, recognizing a special moment. It was Matt’s first professional baseball game and Phil had bought the tickets and suggested we go. Phil retold that story many times over the years, and I share it with you because it highlights several things about Phil: his love of baseball (particularly the Yankees—Columbus being their farm team at the time), his generosity, his love of family and friends, and how Phil influenced countless people through his life and actions in so many ways. It is one story in a life of a great man: the life of Phil Bonanni is defined by the myriad of special moments he gave to his friends, his family, his colleagues, and his patients. Matt became a huge baseball fan—favorite team the Yankees of course—played high school varsity baseball, and still coaches a high school summer team. Phil helped ignite baseball love in a small boy on a beautiful May night 15 years ago, one of countless gifts Phil gave from his huge heart to others over his life. Who would have known that night that Matt would end up shadowing Phil at Unity a dozen years later and would be influential in Matt’s desire to want to be a physician? Matt will enter Phil’s beloved alma mater, the U of R Medical School, next year, joining scores of students, residents, PAs, NPs, and nurses over the past forty-plus years who have been inspired by an outstanding teacher and a master physician—Dr. Philip Bonanni. My only sadness in that is that, unlike the privilege I had at the U of R med school and in residency and to this day as an attending colleague—a privilege that many here today have likely shared—Matt will not be able to experience the gift that we received by learning directly from the master about what Phil called in his writing, “the greatest of professions.”

In his office were the expected textbooks of medicine, cardiology, and books on evidence based medicine. There were also books like “Sherlock Holmes” (remember Watson was a doctor), a biography of William Osler, and a book by that master diagnostician, Yogi Berra, who Phil quoted in one of the many of his publications that I read from files in his office. But the absolute overwhelming number of books were of a different sort. On his desk closest to him were several books with titles like, “The Best Care Possible” “Healing the Wounds” “How Doctors Think” “Bedside Manners” “The Laughter Prescription” and a bookcase crammed with similarly themed titles, along with a book entitled “Psychological Development in Health and Disease” by George Engel, with “Philip P. Bonanni, University of Rochester School of Medicine May 1962” written inside. Many of these volumes had multiple bookmarks sticking out of them, and many had Phil’s insightful notes written in the margins. On Phil’s desk were two thick packets entitled “The Doctor-Patient Syllabus Part One and Part Two.”

Phil was a master of the art of medicine with his patients—and yet his office last night spoke of a perpetual student of that art, always fascinated by something he saw—and something he wrote about many times—as being sacred:

Continued on page 10
the bond between doctor and patient. No wonder one of his patients wrote a few years ago in a note to Phil: “I have come to think of you as the doctor I have most appreciated being a patient of—period. You combine the caring art and science of medicine in a way that I wish everyone could experience.” Having been Phil’s practice partner since 1989, I know that this statement could have been said by thousands who were lucky enough to be his patients. When I covered Phil’s patients and they needed to see me they would sometimes ask, “How long have you been practicing?” And even more often, “When will Dr. Bonanni be back?” They were polite enough, but really didn’t want to see me. And when Phil came over for his wonderful years at Unity in 2004 and we were at meetings together, I swear I would say something, and 5 minutes later Phil would say the same thing, and everyone around the table would nod their heads and agree with the wisdom of his words—words uttered by someone of incredible experience and credibility—saying, “Great idea Dr. Bonanni.” To keep the Yankees references going for Phil, those examples highlighted to me that I have been playing behind Derek Jeter since 1989.

Every year Phil and I taught in the physical diagnosis course at the med school, and Phil’s office is filled with books, articles, and teaching materials on physical diagnosis. He championed the critical importance of that skill. In a writing I found in his office, Phil wrote about many great physicians on lists of outstanding doctors who are indeed “wonderful . . . but have long forgotten how to detect the murmur of aortic stenosis with a stethoscope. Not to mention that conditions can be diagnosed by the physical exam—and a life (or many lives) can be saved because of that.” Even in Phil’s own perplexing illness of the past few weeks, he continued to teach in many ways: his case was presented and educated attendings, residents, and students at the City Wide Neurosurgery Conference a week ago today, and it was there that Phil’s own case was used to highlight the importance of a careful physical exam. Phil would have been pleased about that.

Phil was one of the most dedicated physicians to medical education in the history of Rochester medicine, and has received multiple well deserved honors for that. He recruited hundreds of medical students and residents, impressing them with his sincere interest in them as individuals as he judged their worthiness to enter his sacred profession, and then Phil walked the talk in doing the “on the front lines” training of them to become the best clinicians possible. A resident evaluation of Phil once stated, “Dr. Bonanni is one of my teachers who will leave an impression upon me for the rest of my life. Through him I discovered what continuity of care means, what the doctor-patient relationship means, what the patient-physician relationship should be like…a great person, a great teacher in every respect.”

Number 7. Mickey Mantle’s Number, of course, and also the number of photos in Phil’s office that involve the NY Yankees. Mantle, of course, wished his epitaph to read that he was “A Great Teammate.” That would certainly fit Phil Bonanni well. He defined what being a medical colleague should be, advocating for his patients and seeking out the expertise of others in their care. And that included not just physicians—Phil saw the extraordinary value that PAs, NPs, students, techs, social workers, therapists, and nurses had to offer in his patients’ care. He made everyone involved feel important and approached every patient encounter with the humility that he could also learn something new about their problem—and his patients benefited from not only his patient centered approach, but his multidisciplinary teamwork approach, long before those ideas became today’s mantras in care delivery.

In a drawer in Phil’s desk was a handwritten manuscript—20 pages clearly in draft form and unfinished, possibly written over several years. A diary of sorts expressing his ideas, and some frustrations, over the course of medicine as it sometimes seems to deviate from the clarity that Phil saw as its essential and ultimate focus: the care of the patient and the recognition of the uniqueness of every patient, even if they carried the same diagnosis. That spirit, the reflection of his teaching by Engel and Romano, echoes in the many published pieces by Phil that I read last night. He was their worthy heir. In the handwritten piece, Phil expressed thoughts such as “The role of the personal physician is one everyone should have the benefit of. It can—and does—make a difference . . . A doctor who will listen, who will be concerned and interested, who will detect, coordinate, “captain the ship” and be the patient’s advocate through the complexities of medicine . . .” Phil Bonanni made a difference.

Number 2. Derek Jeter (again!) and the number of two of the most prestigious awards that a physician can earn in Rochester which hang on the wall on Phil’s Office: The MCMS’ Edward Mott Moore Award and the RAM’s Albert David Kaiser Medal. In the history of Rochester medicine, only 14 physicians have won both of these awards, and Phil became the latest when he received the Kaiser Medal in 2011. Why did he receive these and so many other awards too numerous to mention here today? In large part the answer lies back in that handwritten manuscript in his desk drawer. Phil wrote, “My feelings about medicine are much the feelings of an idealist. The enthusiasm and excitement I see in first year students in med school that I help facilitate and orient to the profession during the first week of their school that is not a school. [They are] entering a profession akin to...
entering the clergy—that’s the feeling I had in 1960—that’s the feeling I see now in their eyes and actions—that’s the feeling I have now. It’s a love of the medical profession that continues to engender this feeling—I believe it is the truth.” Many may feel Phil Bonanni represents medicine’s heart, but going beyond that, I believe he was—and is—the medicine’s soul.

Another number: 61 (Really!). Yes Phil would remind you of Roger Maris’ home run record. But in an office way too small for Phil’s stature as a medical icon, I counted the pictures on the walls of Phil’s family. An unbelievable 61 of them (think about your own offices). And here we need to put aside all his medical accomplishments that have been inadequately highlighted by me in this talk this morning and say that, from what I have witnessed in knowing Phil for decades, but especially in what I witnessed in the past two weeks, Phil Bonanni is the role model friend, the role model brother-in-law, uncle, grandfather, father, and husband. I already knew of Phil’s incredible love for his family from watching him melt whenever any of them were sick or troubled, but the depth of their love for him was never as clear to me as while I watched them cry and hug together, and watched them caress, kiss, and whisper to Phil during his horrible illness. It was amazing and an incredible honor to witness depth of their feelings for this gentle man. In a roller coaster ride of his critical illness, they focused on him as one and made difficult decisions spectacularly on his behalf. He would be so proud of all of them, and he would have been especially proud and grateful to the love of his life, his wife of 51 years, Anita.

I apologize to the Bonanni family for my selfishness in spending so much time on Phil’s medical career, but I know from how much you wrote about that part of his life in his obituary, that you also realized that medicine was not just what Phil did, it was who he was. But in several articles I read last night, and in those pictures he looked at every day when he was away from you, and I am sure in the ordinary and extraordinary moments he shared with all of you over the years, Phil demonstrated his belief in the primary importance of and passion for his family as the only thing that exceeded his love for his career. One day many years ago, as they both made their way to Brooklyn College on the 18th Avenue bus (Phil would probably know that Whitey Ford wore #18 for one year), and undoubtedly with Phil looking dashing in his ROTC uniform, he gave up his seat on the bus to the woman he would come to adore and who would become his lifelong partner.

The MCMS conference room will be dedicated in memory of Dr. Bonanni. The plaque reads:

This conference room is dedicated to the memory of Philip P. Bonanni, MD 1939-2013
Healer
Teacher
Friend
May all who enter share his passion for serving others with dignity and kindness.

In good times and bad, Anita. On his office wall is the beautiful recent picture of the entire Bonanni clan taken at the RAM: His four (Lou Gehrig’s number) cherished children Jim, Chris, Elena, and Felicia, who with their spouses Jeanne Anne, Lori, David, and Taylor made up what Phil would likely call his eight (Yogi Berra’s number) children. There were his beloved ten (Phil Rizzuto’s number) grandchildren: John, Alex, Mary Kate, Anna, Isabella, David, Christopher, Taylor, Philip, and Maria. Phil would want each one mentioned by name, since his big heart had room for you all. Each of you could undoubtedly tell wonderful stories of tribute to Phil that would make my own pale in comparison. How lucky you were to have him—and how lucky he was to have you. At the end of our days, if we can experience half of the love I saw in Phil for family and which I saw in his family, we would be truly lucky indeed.

And if we are lucky, each of us here today have had someone special in their life who has molded who they are by mentorship or parenting, someone who taught us how to be better at what we do, how to be humble while doing it, and how to appreciate the uniqueness of each other and how to strive to always be kind. How do you make grown men cry? In the past week, I have been told about and have witnessed first hand that the way to do that is to mention the name of Phil Bonanni. The tears were partially for Phil and his tragic illness, but I think many of the tears were for knowing that his passing represents a loss because he carried the torch for all that is good in medicine, all that is good about friendship and family, and in our faith Phil represented daily the presence of God among us and he was a true instrument of God’s peace.

In an era when many of fame—even on the Yankees—are not always figures to look up to, Phil Bonanni will always be one of my heroes. The immediate void he leaves will be replaced quickly by his legacy to all of us and to many in the Rochester community and beyond. His ideals live in us and we must honor him by showing that more in our lives. Professor of Medicine, Nursing, and Medical Humanities, his Kaiser Medal could go into Monument Park at Yankee Stadium, and is inscribed: Outstanding clinician, gifted teacher, talented physician leader. Role model for compassionate care and champion of the story of the patient. Add to that his profound love of family and friends, and you have defined the essence of Dr. Philip Bonanni.

Phil is #1—and much better than Billy Martin.

James M. Haley, MD
June 14, 2013
ACO or Independent: What’s Right For You?

By Jane Dodds, MPH, FACMPE

Physicians in private practice face a myriad of opportunities as healthcare in the US adapts to reforms, regulations, and reorganizations. How do you evaluate the contracts and affiliation agreements that are proposed and offered? Should you worry if the contract proposals don't arrive? Are you enticed by the purported benefits of collaboration? Do you want to continue as a private practice? What does “independence” mean, and what is it worth…. to YOU?

One technique for evaluating a business project is the standard SWOT analysis: Strengths, Weaknesses, Opportunities and Threats. In this model, the Strengths and Weaknesses reflect your own practice’s attributes; the Opportunities and Threats come from outside your organization. As with most things in life, there are two sides to almost every issue. Sometimes, what you perceive as strength may be perceived by outsiders as a weakness. What others see as a threat might be your best opportunity.

The American College of Medical Practice Executives (the credentialing arm of the Medical Group Management Association) outlines the Body of Knowledge for medical practice management. A competent managing partner works in collaboration with their practice administrator to assure that the practice is operating in a manner that satisfies the physician-owners’ professional goals. ACMPE lists four competencies for the management team: Communication Skills, Professionalism, Critical Thinking Skills, and Leadership.

When making decisions regarding collaboration and/or independence, physicians should be mindful of ACMPE’s eight domains of medical practice management. A successful medical practice requires satisfactory performance in these domains (or, at a minimum, no disruption!). In each area, an honest appraisal of your role in your own practice is essential. You'll need to evaluate your willingness to embrace (or abdicate) these responsibilities. Then, a clear understanding about how your role might change under a new arrangement can help you make the difficult decisions.

1. **Business Operations**: Are you comfortable with, and willing to monitor the people you hire to develop, implement and maintain your business plans? Do you derive satisfaction from hands-on monitoring of all aspects of the business? Are you familiar with the language of purchase agreements, maintenance contracts, physical plant leases, utility bills? Do you rely on personal references and your own gut-check when you need outside services (legal, accounting, financial advisors, architects)? Under what circumstances would you be willing to give up control of these aspects of your business?

2. **Financial Management**: Do you evaluate by the numbers? Do you understand your own practice financial reports, and are you comfortable with the reporting that will be available if you affiliate with another entity? Who will monitor the revenue cycle, to assure that the work you do is properly documented, reported, and reimbursed? How will your work be compensated under an affiliation agreement? Who are the stakeholders who will share the rewards of your productivity? Who will control the schedules, payroll and benefit plans for the front-line workers who handle the revenue you produce? Will your

ACMPE’s Eight Domains of Medical Practice Management

1. Business Operations
2. Financial Management
3. Human Resource Management
4. Information Management
5. Organizational Governance
6. Patient Care Systems
7. Quality Management
8. Risk Management

Consider your role in each domain. Ask yourself the hard questions, and ask potential collaborators to explain their expectations for you.
compensation and benefit package be significantly altered under a new agreement? Will you continue to shoulder the costs, and share the profits, of ancillary services (labs, diagnostics, and procedures)? What control will you have over your personal finances, your time off, the people who work with you on a daily basis, and your personal retirement contributions? Are you absolutely sure that the new arrangement will provide the balance of lifestyle and remuneration that you and your family require?

3. **Human Resource Management:** Often perceived as a headache, your staff is probably your most valuable asset. If your practice is working well, you’ve hired the right people, helped them learn the necessary workflows, and given them the tools and opportunities to develop into a well-functioning team. How might that change? Would you still be able to recruit, hire, train, develop, and utilize staffers according to your own goals and objectives? Will you be able to choose the people who surround you every working day? Can you count on shared values, and continued loyalties? Would you be willing to turn your staff over to another entity? Will you be asked or expected to do that?

4. **Information Management:** Yes, you need an electronic medical record system, and you need a practice management system that can manage the revenue cycle. If you’re running a business in 2014, you’ll need 2014 tools. Your colleagues, hospitals, labs, patients and payers will want to communicate electronically about your work as a physician. If you’re considering a collaborative agreement because you haven’t updated your PM/EMR system, be realistic about what that will mean for you and your staff. If you haven’t kept up, don’t expect the new entity to magically provide the skills and education you’ll need in the new organization. If you have already implemented a robust PM/EMR system, look for assurances that your system can successfully integrate, so that you recoup the value of the resources you have already developed.

5. **Organizational Governance:** Physicians in private practice utilize a variety of legal entities ~ sole proprietors, professional corporations, limited liability partnerships, limited liability companies, and business corporations. Decisions about a private practice are made by individuals, partners, shareholders, or elected boards, within the governance structures the doctors have established and agreed on. Decisions can be often made and implemented quickly. In larger organizations, such as hospitals, IPAs, or academia, there may be layers of governance that preclude quick changes. Physicians may be required to serve on boards and committees, with expectations for participation and attendance. Be realistic when you evaluate your willingness to advise and mentor your new colleagues. Be sure you understand the organizational structure, and that you are comfortable with the people and processes that will be making decisions about your future.

6. **Patient Care Systems:** ACMPE says “A critical component of medical practice management is the effective and efficient processes surrounding the patient encounter. How do you ensure that patients receive the best possible care, focus on patient safety, and strive for efficient operations?” What are the hallmarks of your private practice that make you most proud? What is the legacy you inherited from your mentors, and what are you sharing with your young peers? If you join a larger entity, will you be able to practice in a manner consistent with your training and experience? Will any portion of the patient experience be uncoupled from your professional judgment? Will you maintain control (clinical and/or financial) of ancillary services, diagnostic testing, labs and consultations? Will your patients recognize your practice with their continued loyalty? Will you be expected to expand your patient base or change your referral patterns in the new system? Are you willing to change your practice patterns to conform to organizational standards that are different from yours? Are you willing to work to find the right balance as you move forward?

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7. **Quality Management:** In a private practice and small groups, providers often enjoy a degree of familiarity and interpersonal communication that actually facilitates quality. Clinical, financial or personnel problems are glaringly evident if the doctors have established sound and supportive policies and procedures. If your staff trusts that “All for one and one for all” protects them when they identify problems, then they’ll help you solve those problems. In larger organizations, it’s necessary to develop formal systems to establish benchmarks, standardize workflows, monitor performance, and measure results. Many new reimbursement structures will incorporate quality measures and patient-centered evaluations. Doctors will be expected to actively participate in the quality process, so you’ll need to understand where your responsibilities are determined and how your performance will be measured.

8. **Risk Management:** You already evaluated your practice, by establishing an environment that you believe is safe for your patients, staff, and visitors. You understand clinical risks, and you comply with local, state and federal regulations. Your staff knows how to react in a professional manner to adverse legal events. Your teams are trained and prepared to respond to emergencies and natural disasters. You have identified people who can keep track of the alphabet soup that surrounds your ability to practice medicine (HHS, OIG, OPC, NYSDOH, CMS, HIPAA, OSHA, CLIA, CDC, PPACA, GAAP, IRS, IRA, HSA, HDHP, WCB, ADA, FMLA, EEOC, ERISA, NLRA, FLSA, COBRA, CPT, ICD9, ICD10, MSSNY, and thankfully, MCMS). If you choose to join another organization, which of these will be within your control, and which will you cede to others?

When you evaluate collaboration opportunities, take the time to ask detailed questions, look for the fine print, and be clear about the changes you are willing to make. Be sure you’re making choices that will satisfy your needs – as a physician, a colleague, a business owner, a family member, and community participant. Your professional career is your personal journey – be mindful of the path you choose!

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**MORE DATA = BETTER DECISIONS.**

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A lot of thoughts went through my mind when MCMS asked me to write an article on this topic. “Consolidation” of what?

• Leaving private practice to be an employee of a larger organization?
• Joining an as-yet-to-be-defined ACO?
• Networking your EMR with other practices?
• Collaborating with colleagues in similar or complementary specialties on treatment protocols?
• Sharing back-office administrative overhead with others?

“Consolidation” sounds better when it’s presented as an opportunity rather than a difficulty.

Lots of articles have been written about the benefits and pitfalls of a career as an independent or employed physician. The authors cite the same issues about income security, administrative headaches and autonomy, or lack thereof. As tactics about healthcare financing evolve, the large organization that offered a generous hiring package may not be able to meet the contract’s terms in the future; employment may not be more secure than private practice.

It won’t help to grumble about “us vs. them” within our physician ranks. The real “us” are physicians and our patients; “them” are the undetermined schemes to deliver and pay for care that disregard physicians and patients. Physicians may not have job security, but we have career security if we keep our act together.

The first flurry of PPACA activity is consumed with enrolling some people in health insurance on the exchanges. The health insurance policies offered in 2014 will look a lot like what patients and doctors are familiar with. These plans are designed to reduce costs by reducing utilization with higher out-of-pocket expenses that will make everyone think twice about getting or giving a service. Patients will have higher expectations for service and efficiency. Even if their premiums are subsidized, patients will expect that their $40 specialist copay (after meeting their $5000 deductible) buys good service.

The future of health-system reform is supposed to include accountable care organizations (ACOs) or other “shared-savings contracts” to provide care to a population of patients at a given price. Right now, the ACO movement is a free-for-all, with many disjointed parties making it up as they go along. Best to get our own houses in order, strengthen our practices and prepare to adapt.

Do you book travel, bank or read newspapers the same way you did 10 years ago? Do you use products or services that didn’t even exist 10 years ago? Our neighbors who work in other industries have transformed the way they do business to serve their customers’ needs. Perhaps instead of “consolidation,” we should use the word “adaptation.” Adapt or die.

Independent shops can thrive in the shadow of a big-box retailer by following sound business practices. There’s no need to jump to conclusions that all physicians will be cogs in a big machine because patients won’t stand for that. Some patients might appreciate a big system, but many are overwhelmed by large departments with layers of personnel and parking lots between them and their doctor.

The high quality of care that independent practices provide has gone unnoticed because we simply don’t promote it. We don’t have a big apparatus for collecting data and communicating our performance, yet independent practices are essential to the health care delivery system because they offer physicians and patients a choice for work and for care. Answer these

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Staying Independent

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questions to preserve your independent practice:

• What do you want? What’s most important about your practice and career? What consolidation/collaboration/adaptation opportunities will enhance your ability to do that?

• How will your patients’ needs and expectations evolve? There are many unknowns, but you know your own patients. You know medicine. What opportunities to work with other clinicians will enhance your ability to care for your patients?

• What capability gaps exist in your practice? What can you offer patients and employees, relative to your competition? What investments are required to close those gaps, support innovation and remain competitive? Could you merge or align with colleagues who do complementary work?

• What’s going on? Uncertainty around legislation and payment will impact your options, regardless of your practice size or level of independence. Pay attention to developments. Support policies that allow patients to choose their physicians or reduce administrative burdens like mandates that don’t offer value to patients. MCMS and the Private Practice Committee are your allies.

• Where are we going? What is the range of possible future market scenarios? What core strategies can be applied across multiple scenarios? What elements need to be developed under certain conditions? Which do you want to pursue? Choose to succeed on your own terms and select an appropriate path for your practice. What do you want?

Rochester is a town that’s big enough to support many specialties and practice styles, but not so big that we’re cutthroat competitors willing to compromise our integrity and patients’ care for an “edge”. The key to staying independent is to acknowledge the need for interdependence.

“We often miss opportunity because it’s dressed in overalls and looks like work.”
- Thomas A. Edison
ACOs — It’s All About the Funds Flow

By Lisa Smith

It’s all about the funds flow: who pays whom, when, where, and how much. "Physicians and hospitals are facing unprecedented pressures from healthcare purchasers to deliver increased value, i.e., higher-quality, more cost-effective care."¹

Often when the term ACO is used people only think of Medicare fee-for-service. The Centers for Medicare & Medicaid Services (CMS) describes an ACO as “a group of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare patients.”² The goal of coordinated care is to ensure that patients, especially those who are chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors. When an ACO succeeds both in delivering high-quality care and spending health care dollars wisely, it will share in the savings it achieves for the Medicare program.

More broadly, the ACOs that are being developed are contracting for Commercial, Medicaid, Medicare Advantage, and Self Insured patients in addition to the Medicare fee-for-service patients. When a provider group decides that their organization wants to create an “accountable” network, they will often call it an ACO. At times an existing provider group, maybe an integrated delivery system or an independent practice association, may choose to call their contracting strategy ACO, using the term as an adjective instead of a noun.

The funds flow can come from Medicare, Medicaid, an insurance payer, or a self-funded employer. The funds flow to the healthcare provider then includes both an upfront reimbursement as well as a retrospect share in the gain/loss.

Current reimbursement models can be considered in a risk spectrum as follows:

- Fee for service (not typically used in an ACO contract)
- Fee for service with shared savings
- Episode (bundled) payment
- Partial fee for service and performance based
- Capitation

This type of risk spectrum is the traditional lens through which we analyze risk, and it requires the provider to determine the level of risk they are willing to accept. Another way to think about reimbursement is to recognize that while today a provider is reimbursed when a patient comes in the door, soon there will be a shift towards a provider being paid when a patient is healthy enough not to walk in the front door. Although preventive visits will continue, acute visits are expected to be less frequent. Even with reduced visits, it takes staff and physician time to keep the patients from coming in the door. How will the provider be paid for this work? New payment mechanisms called value payments are being developed which would pay the provider. These mechanisms are in development at the ACOs at this time.

To prepare for these value payments, a physician can determine how they define quality care and how they can measure it. Is there a health status that can be measured? Is it in the Electronic Medical Record (EMR), and is there a national benchmark it can be compared to? These are tough questions and they vary specialty to specialty and take time as well as focus to determine. Consider how you will answer the question: Why do we want you in our ACO?

“Independent physicians are less likely than their employed peers to believe accountable care will benefit their practice, according to athenahealth’s 2013 Physician Sentiment Index. Compared to employed physicians, independent physicians are:

- 16% less likely to believe accountable care will improve the quality of care
- 61% more likely to think shifting to accountable care will make it more difficult to get paid
- 43% more likely to believe ACO models will have a negative impact on profitability³

So why might you want to join an ACO? First, you may choose to join if you are confident that in joining, there is potential to enhance the quality of care. Second, you may want to join because the ACO covers members who are, or will be, your patients. Depending on the contracting relationship and the insurance product design, the ACO may offer you the access you want. Third, you may wish to be a part of the formation and design of the new care and reimbursement modeling. Lastly, you may wish to join because of the possible financial reward either in the prospective reimbursement or retrospective gain sharing.

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The Greater Rochester Independent Practice Association (GRIPA) has been ahead of its time for many years. It is in a unique position to improve care in the greater Rochester community and to help its physicians succeed in the new world of health care reform and care delivery. Having secured a favorable Advance Advisory Opinion from the Federal Trade Commission (FTC) for Clinical Integration in 2007, GRIPA has built the foundation to succeed in this new period of Health Care Reform and Accountable Care. As evidence of this movement, GRIPA most recently signed an agreement with Excellus BlueCross BlueShield that rewards physicians for providing high-quality, value-based care. Furthermore, GRIPA has submitted an application to participate in the Medicare Share Savings Program established by the Centers for Medicare & Medicaid Services as an Accountable Care Organization (ACO). We expect a favorable outcome and to begin functioning as a Medicare ACO in 2014, as one more step in the transformation to population health management and performance-based contracting.

The physician members of GRIPA have available to them the full range of services necessary to succeed in Accountable Care. This includes state-of-the-art integrated technology to identify patients with gaps in care, experienced care management, and robust provider relations services continually working to maintain network alignment. This article will explore each area in more detail and show how the GRIPA program has already demonstrated success.

As background, clinical integration is defined as “An active and ongoing program to evaluate and modify the clinical practice patterns of the physician participants so as to create a high degree of integration and collaboration among the physicians to control costs and ensure quality.” 

FTC/DOJ Statements of Antitrust Enforcement Policy in Health Care, #8.B.1 (1996). And, very concretely, the FTC looks for:

- Collaborative network of physicians
- Evidence-based guidelines and performance reporting
- System to integrate clinical data across network
- Provide higher quality care, minimize administrative burden

GRIPA’s successful effort to become clinically integrated represents one of the few organizations to receive this ‘gold standard’ of health care and marks the beginning of GRIPA’s entry into Accountable Care. Since receiving the favorable FTC Advance Advisory Opinion, GRIPA has continued to enhance its already nationally-known program to provide even higher quality care to members, and, as a result, reduce the cost of care. GRIPA has done this by closely following the basis on which the FTC Opinion was originally awarded. One example is GRIPA’s role in managing the care of the employees of many local companies. Through the aggregation of clinical data as well as the application of care management services, GRIPA has been able to control costs, while at the same time improve quality of care delivered.

GRIPA is continually expanding its network of physicians and today includes a total of 915 physicians, representing 271 primary care physicians and 644 specialists from all parts of the community. These physicians follow evidence-based guidelines as reviewed and approved by GRIPA's Clinical Integration Committee, and the physicians’ performance against many of the related clinical measures is regularly reported.

In order for these physicians to provide the best care to their patients, GRIPA built a robust data exchange many years ago and has continually refined and enhanced the capabilities of this system. The way a data exchange works is simple: the exchange takes in and consumes data from a variety of sources including individual physician and group practice management software, lab data, radiology data, RHIO data, hospital data, and payor claims data. The GRIPA data exchange then aggregates all the data on each individual patient and creates the most comprehensive patient profile available in the community. With all these data sources, GRIPA is able to compile member information regardless of where the person seeks care. This is critical to succeed in an Accountable Care Organization as patients continue to seek medical care at multiple health care systems and provider practices. While many information systems are limited to the data collected within a health care system or individual practice office, GRIPA is able to compile all information on a patient from all places of service.

GRIPA also goes one step further by providing actionable data to its physician members and care management team. GRIPA makes available a Patient Outreach Report (POR) that is refreshed on a timely basis with the most up-to-date information available. This report, easily accessible on the secure GRIPA Portal and available only to GRIPA

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physicians, clearly identifies those patients with gaps in care and or at risk for more severe medical issues. This report allows physicians to identify those patients and address issues to avoid hospital and emergency department visits.

GRIPA has been successful in demonstrating that putting actionable information into the hands of its providers and care management team leads to higher quality health care. As evidence, GRIPA’s current contracts with several local employers in which GRIPA integrates the care of employees demonstrates success. Employees and dependents that are part of the GRIPA program have enjoyed a significantly higher quality of care as evidenced by better controlled chronic conditions as well as a reduced cost of care. The results are published annually in the GRIPA Value Report available at www.GRIPA.org.

In support of the physicians’ efforts, the GRIPA Care Management team works closely with the physicians and spends more time with those patients who need extra attention understanding their conditions and learning the best ways to manage their health on a day-to-day basis. Often, physicians are not able to spend the extra hours required with each patient to help them understand all the aspects of their condition, and a GRIPA care manager is available to step in and work one-on-one with the patient. GRIPA’s care managers are assigned to physician and practice offices so that the care managers become familiar with the physician and his or her patients.

GRIPA’s care managers work as a team and include nurses, certified diabetes educators, social workers and clinical pharmacists. This team has proven to be effective in assisting patients with chronic conditions and driving down the cost of care by providing higher quality care. This ability to work with the highest cost, most complex patients is a critical element required to succeed in an Accountable Care Organization.

Additionally, during 2012, GRIPA concluded a national search and hired a Chief Medical Officer to lead the provider relations and clinical initiatives at GRIPA. Dr. Mark Belfer is a Family Medicine Physician and comes from the Mid-West. Dr. Belfer has held a variety of leadership positions at various health care systems and is a great addition to the GRIPA team.

In conclusion, GRIPA continues to Move Forward in building a progressive model for Accountable Care that will support its physician members as they transition to a practice of population management. With state of the art technology, robust care management and a proven program, GRIPA is uniquely positioned to succeed in Accountable Care and Health Care Reform.
ACA’s Impact on Free and Charitable Clinics

By Randy Rahiman, Nirav Gohel and Vitesh Patel - Final year pharmacy students at St. John Fisher College, and Christine Birnie, PhD

The Affordable Care Act (ACA) has fueled major debates among not only political parties, but also within different sectors of health care. Although there are countless viewpoints on the risks and benefits of this act, questions such as how it will affect the free and charitable clinics still remain unanswered. Many believe that these types of clinics will no longer exist once the ACA is fully implemented. This thinking is not entirely unwarranted considering the fact that many of the individuals who frequent these clinics will become eligible for insurance starting January 2014. However, once it is implemented millions will still be without insurance because they are either exempt from the mandate or are part of the population not covered under ACA. The real question is how will these types of clinics adapt as the health care system begins its inevitable overhaul.

The Affordable Care Act (ACA) was adopted to meet the needs of the high number of uninsured individuals in the United States. The Congressional Budget Office (CBO) estimates that over 50 million Americans are currently without health insurance. The ACA will not only allow many to obtain coverage, but it will reduce waste caused by abuse and fraud. Some aspects of the ACA are currently in effect while others will be phased in over the next seven years. Local clinics such as Mercy Community Services Outreach Center and St. Joseph’s Neighborhood Center are examples of organizations that will be impacted by the ACA. These two clinics are non-profit organizations, committed to caring for the underserved in the Rochester, NY area. St. Joseph’s Neighborhood Center’s mission is to raise the health status and quality of life of individuals and families serving the medically uninsured or underinsured individuals and families throughout Rochester and Monroe County and eight surrounding counties. The Center relies on volunteers to function year-to-year and is funded through donations, grants and modest fees. Mercy Community Services Outreach Center has a similar mission statement, providing access to quality affordable healthcare for uninsured adults through a team of volunteer physicians, specialists, nurse practitioners, nurses and dental professionals. Both of these clinics provide a multitude of services such as health screenings, dental, dermatological, gynecological, cardiac, pulmonary, chiropractic, acupuncture, massage, laboratory, psychiatric, mental health counseling, benefits eligibility advocacy, adult literacy and GED tutoring.

The need for clinics like St. Joseph’s Neighborhood Center and Mercy Community Services Outreach Center may, arguably, grow over the next several years. Despite the expansion of Medicaid, Medicare and the emergence of exchanges, individuals not filing tax returns, undocumented immigrants, and those qualifying for exemption from the ACA will still be left uninsured. The latest estimates by the CBO reveal that 44 million will be without insurance in 2014 and this number is not expected to drop below 30 million over the next decade.

Another complicating factor to the successful implementation of the ACA is the likely shortage of healthcare professionals. The National Monitor estimates that there will be a shortage of 52,000 primary care physicians by 2025. This is due to the Act feeding many people into the primary care networks and other factors such as our aging population, leaving millions without access to healthcare. These patients may very well end up at the doorsteps of clinics like St. Joseph’s Neighborhood Center and Mercy Community Services Outreach Center. There are many challenges these clinics will face in the very near future. In addition to providing necessary medical services, they will also need to be equipped to assist patients in navigating the ACA guidelines in determining eligibility and health insurance coverage. Clinics like Mercy Community Services Outreach Center have expressed their commitment to their patients in the Rochester community. “Our Outreach Center will continue to help uninsured individuals determine their eligibility for health insurance and access appropriate plans. Adults who do not qualify for insurance will receive care from our dedicated volunteer providers who ensure that access to health care is not
ACA’s Impact on Free & Charitable Clinics
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determined by economic status,” says Ellen Lewis, Outreach Center site manager.

They may need to expand certain services such as dental care since many adults will not have coverage under ACA. There has also been concern regarding the continuation of vital programs such as Prescription Assistance Programs (PAP), where patients in lower income brackets are able to receive high cost medication for free or at a significant discount from the drug manufacturers. Fortunately, there seems to be no evidence that any of the large drug manufacturers, such as Abbott, GlaxoSmithKline and Novartis, plan on curtailing their prescription assistance programs. AmeriCares, a non-profit emergency response and global health organization, will also continue to distribute medicines to clinics in under-served communities, which in turn can be given to patients at no charge.

It is clear that clinics like Mercy Community Services Outreach Center and St. Joseph’s Neighborhood Center will still be greatly needed in the future. Maybe even more than ever as their role as a safety net for the community continues to grow.

“As the Affordable Care Act is enacted, we will stand ready to assist people in their health care choices, and as always, to catch those people who will still fall through the cracks,” says Christine Wagner, St. Joseph’s Neighborhood Center executive director.

Support from the community is essential to the success of community health centers. Health care providers including physicians, physician assistants, nurse practitioners, therapists, and dentists are urged to answer the call of civic duty and help make a positive difference in the community. Just a few hours a week or even one day a month would make a tremendous impact on these clinics and the lives of many.

About the Authors:
Randy Rahiman, Nirav Gohel and Vitesh Patel are all final year pharmacy students at St. John Fisher College who have both volunteered and participated in a service learning clinical rotations at St. Joseph’s Neighborhood Center or Mercy Community Services Outreach Center. Christine Birnie, PhD is an Associate Professor at the School, and served as the preceptor for the service learning rotation.

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Soon, the Patient Protection and Affordable Care Act of 2010 will be in effect. The increase on access to health care will depend on many variables, but a person’s income will be a primary driving factor. In New York State individuals and families below 133% of poverty already qualify for Medicaid, so there will be no increase in the number of the very poor going to primary care physicians’ offices as will occur in many other states. In those states many of the very poor will qualify for Medicaid for the first time. These are persons who are at the lowest Socio-Economic Status (SES), or “Low SES”.

In New York State the Affordable Care Act will provide subsidies to purchase health insurance to individuals and families whose annual income is between 133% and 400% of the Federal poverty guideline. For an individual 133% of poverty is $15,281.70 while 400% is $45,960. For a family of four 133% of poverty is $31,321.50 whereas 400% is $94,200. Individuals and families struggle financially at these levels and are still considered “Low SES.” These people will now be eligible for subsidized health care through the Insurance Exchange, and it can be presumed that this will facilitate greater numbers of people enrolling in health plans and accessing Primary Care.

Persons with low SES not only have the highest smoking rates in the State, but they have demonstrated significant disparities in terms of observed declines in smoking. Overall, adult smoking prevalence is now 16.2% thanks to increased taxes and efforts from the New York State Bureau of Tobacco Control’s efforts – which include the State Quitline, Tobacco Cessation Centers, Community Partners, Reality Check, state-wide media efforts, and other initiatives. But the groups who have benefited the least from these tobacco control efforts in New York include individuals with less than high school educations and those earning less than $15,000 per year. Within these groups are higher proportions of African Americans and Hispanics, and these racial/ethnic groups also have both higher prevalence of smoking historically (compared to Whites) and a lower observed decline in smoking in New York State.

Decreasing barriers to access to health care is a major overarching goal of Healthy People 2020, and many objectives are directly addressed by the Affordable Care Act, such as increasing the number of those who are insured. One of the objectives under Access to Health Care (AHS) addresses the goals of smoking cessation: AHS-7: (Developmental) Increase the proportion of persons who receive appropriate evidence-based clinical preventive services.

Asking, Advising, and Assisting your patients to quit smoking are elements of an evidence-based approach that combine systematic screening (Asking) with your clinical advice (Advice) and then referring them to evidence-based treatment (Assist). These elements are important to have established in your practice, and will be needed even more with new patients seeking health care; new patients whom we can expect will have higher smoking prevalence.

At the Smoking Research Program at the University of Rochester Medical Center, we have two resources for physicians and their offices: GRATCC and WATI. GRATCC is the Greater Rochester Area Tobacco Cessation Center, funded by the New York State Bureau of Tobacco Control. GRATCC provides free training and resources – currently focusing efforts with Federally Qualified Health Centers. GRATCC also focuses on practices with high prevalence of smokers from lower SES backgrounds, so if your practice has such patients – please contact GRATCC for more information at 585.275.0598 or marlene_goehle@urmc.rochester.edu.

WATI is Web Assisted Tobacco Intervention, and is a research study for Community College students who smoke. If you have patients who are in Community College, you can refer them to this study where they will have access to a smoking cessation intervention website, and will receive up to $45 for participation. Such patients can contact WATI at (585) 276-6243 or email wati@urmc.rochester.edu.

Finally, to best be prepared for increased numbers of smokers accessing health care, patients should be referred to the New York State Smokers’ Quitline (1-866-697-8487) and Quitsite (nysmokefree.com).
Accountable Health Partners (AHP) is actively building our physician network and negotiating payer contracts for 2014. We are thrilled at the response we have received in the community and are anticipating having a full contingent of primary care physicians and specialists by the end of the year.

Why was AHP created?
We believe that physicians have a choice to either suffer annual reductions in physician reimbursement or take the leap to value-based care and the rewards that go with it. AHP is working to protect physician income in a changing environment, give physicians a voice and reduce hassle. We want to create a partnership between URMC and community physicians to improve the care of our patients. We are committed to our shared success.

The vision of Accountable Health Partners is to bring together community and faculty physicians, hospitals and other affiliated providers to develop a clinically integrated care network with aligned financial incentives, to improve population health, to provide patient-centered care and to promote efficient use of resources.

AHP aspires to create a community healthcare partnership for shared success. We will deliver specific added value to each of our key stakeholders.

- **For doctors:** AHP will enable doctors to preserve professional autonomy, have a voice in the restructuring of health care delivery and payment, and actively support their efforts to provide high-quality, integrated care to their patients.
- **For patients:** AHP will facilitate the provision of clinically integrated services that enable high-quality, patient-centric care that effectively manages the health of its population and increases the value of care. We will help them stay well, alert them to personal risk factors that they can work on to reduce the risk of disease, and help them manage a chronic condition.
- **For payers:** AHP will be a value-added health care provider that facilitates high-quality care at a lower cost.

How will AHP work?
AHP will govern itself through a unique collaboration of participating hospitals and physicians. Four classes of board members will be created: those representing Strong Memorial Hospital, community hospitals, community physicians, and the physicians of the University of Rochester Medical Faculty Group (URMFG). A unanimous vote of all four voting classes is required for board decision-making, which we believe will ensure the organization makes decisions that are truly in the best interests of all parties.

AHP will have strong ties to the private physicians in its network so that they are engaged and strongly represented. We will have functional and regional advisory committees that will have the dual purpose of enabling us to perform essential functions while also engaging and giving a voice to a wide breadth of network physicians. We will frequently and effectively communicate with physicians. Community physicians will have a strong voice.

AHP will establish and execute a comprehensive and integrated care management program that puts the patient at the center and strives for the best interests of the patients. We will strongly emphasize and support the importance of primary care and the value of patient-centered medical homes. We will create clinical protocols that are evidence-based and informed by best practices. We will use data to support targeted efforts to help improve the health of our patients. We will continuously create and implement programs that improve the quality of patient care, coordinate care among different medical and social service providers, and decrease unnecessary care and cost.

Why should a physician join AHP?
We believe there are many reasons for you to consider joining AHP.

- We will have payer contracts with supplemental income opportunities available as early as January.
- Our purpose is to protect your autonomy and your revenues in a changing healthcare market.
- We are non-exclusive. We are creating a partnership between community physicians and faculty physicians. We are eager to partner with you and provide excellent service and high quality care as a resource for community physicians.
Lead Change: Transform Resistance Into Action

By Jennifer E. Wilson, PT, MBA, EdD

Rapid, continuous change is the predicted landscape for health care professionals practicing in all types of environments. Evidence indicates that change demands leadership as well as taking risks. Yet often, health care professionals are risk-averse and become anxious when changes are discussed, explored, and implemented. Fortunately and most likely, you work with some colleagues who embrace change enthusiastically. However, it’s expected that practice owners, administrators, and managers must learn how to lead change; become proficient at fueling and re-fueling the collective energy for change; and overcome apathy and resistance to change, in order for health care practices to transform.

In their book *The Practices of Adaptive Leadership*, Heifetz, Linsky, and Grashow (2009) discuss the myth - a widely held or false belief - driving many change initiatives into the ground: that change needs to occur within an organization, team, or system because it’s broken. These experts argue that any social system, including health care organizations and systems, is the way it is because the people in that system, particularly those individuals and subgroups with the most leverage, want it that way. To some, the system is working ‘just fine’ even though to others, it may appear dysfunctional in some aspects, and even though it faces a tsunami of significant challenge just over the horizon.

In the dictionary, change as a verb is defined as: to cause to be different; to transform or to give something a completely different form or appearance; to replace with another; or to switch. The cause, or the reason and motive for action and change, can be a person or thing that acts, happens, or exists in such a way that something specific happens as a result. A change agent is a person who indirectly or directly causes change; they may be assigned this role or may assume this role naturally. A change agent may initiate change, assist others in understanding the need for change and what is entailed, recruit support, manage the change process and/ or assist in resolving conflict. In some cases the agent of change may be a team on a mission to achieve a shared goal. Interestingly, individuals and teams also experience being “recipients” or receivers of change and make conscious and unconscious decisions to reject or embrace change.

Leaders influence other people to achieve common goals. Often leaders, managers, and administrators use various approaches to minimize resistance to change or to motivate people to change and engage actively in the change process. Unfortunately, instead of breaking through resistance to change, many times resistance is actually created! Bregman (2009) argues that people don’t resist change but they do resist being changed, micromanaged and controlled. Ultimately, leaders can be effective leading change when they give others control, choices, and an opportunity to participate in decision-making. (Bregman) Kotter (2007) identified 8 steps for leaders to use to transform an organization or system, including: establish a sense of urgency; form a powerful guiding coalition; create a vision; communicate this vision (many times!); empower others to act on the vision; plan for and create short-term wins; consolidate improvements and produce more change; and institutionalize new approaches. Ongoing communication, a key theme underlying all 8 steps, is necessary to ensure sustainable change. In order to institutionalize new behaviors, the leader needs to explicitly articulate and reinforce the connections between these new behaviors and desired outcomes achieved. The leader also plays a critical role in helping to identify and get rid of obstacles to change while actively supporting and encouraging team members to take risks and to explore nontraditional ideas, activities, and actions. (Kotter)

According to Heifetz, Linsky, and Grashow, a successful adaptation enables an entity, such as a health care system, to thrive in a new and challenging environment and they claim that thriving requires adaptive responses that distinguish what’s essential from what’s expendable, and innovates so that the social system can bring the best of its past - its traditions, identity, and history - into the future. Adaptive cultures engage in 5 distinct practices; specifically, they: name the elephants in the room, or the difficult issues commonly known to exist in an organization or system but not discussed openly; share responsibility for the organization’s future, exercise independent judgment, develop leadership capacity, and institutionalize reflection and continuous learning. (Heifetz, Linsky, and Grashow)

So, when you hear the word “change”, how do you respond? Do you put your head down and keep moving; do you sense a dark cloud looming overhead creating anguish and anxiety, or do you jump for joy? Making a choice to be an integral part of the dialogue for change and a transformative process makes a significant difference in achieving a sustainable outcome of change. For an organization, active engagement from each person on the team is the difference between passive resistance to energized alignment and inspired collaboration. (Bregman)

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I-STOP Mandates Severe Penalties for Noncompliance

By Michael J. Schoppmann, Esq.

The Internet System for Tracking Over-Prescribing (I-STOP) Law requires practitioners who prescribe controlled substances to consult New York State’s Prescription Monitoring Program (PMP) registry prior to prescribing Schedule II, III and IV controlled substances. The duty for physicians to comply is strict and mandatory, carrying severe potential penalties for any failure to comply, including but not limited to, loss of license, civil penalties and/or criminal charges. Here are a few common questions regarding penalties for non-compliance.

Q. What are possible penalties for violating I-STOP Law?

A. The I-STOP Law, Public Health Law section 3343-a imposes upon physicians and other practitioners a duty to consult the prescription monitoring program registry, unless an exception applies. The statute does not address what ultimate decision the physician makes as to whether to issue or not to issue the prescription in a given case. The purpose of requiring the physician to access the registry is for the physician to obtain information regarding the patient’s controlled substance history, so that the physician will make “an informed decision” when deciding whether to prescribe a schedule II, III, or IV controlled substance to a patient. In reference to possible penalties for violating Public Health Law 3343-a, the violation of the statute may lead to charges of professional misconduct. Education Law 6530 provides definitions of professional misconduct applicable to physicians, and subdivision 9 (e) of section 6530 provides that professional misconduct includes “Having been found by the commissioner of health to be in violation of article thirty-three of the public health law”.

Thus, a violation of Public Health law 3343-a, could lead to charges of professional misconduct. In addition, Public health law section 12 provides fines for violations of any provision of the Public Health Law, or its regulations. Fines may range from $2,000 to over $10,000 per violation depending upon whether there have been prior violations, and whether there has been patient harm. A willful violation of a provision in the Public Health Law is a misdemeanor, punishable by a fine up to $5,000 per violation and imprisonment up to 6 months, or both.

Q: Does I-STOP law impose a duty on physicians to report any suspicious patient conduct to the authorities?

A. I-STOP does not impose any new patient reporting obligations. However, the Public Health Law requires physicians and other health care professionals to report information to the New York State Department of Health in certain situations. These requirements in effect prior to the enactment of I-STOP are not changed by I-STOP:

—Public Health Law 3372 entitled “Practitioner Patient Reporting” provides as follows:

“It shall be the duty of every attending practitioner and every consulting practitioner to report promptly to the commissioner, or his duly designated agent, the name and, if possible, the address of, and such other data as may be required by the commissioner, with respect to, any person under treatment if he finds that such person is an addict or a habitual user of any narcotic drug. Such report shall be kept confidential and may be utilized only for statistical, epidemiological or other research purposes, except that those reports which originate in the course of a criminal proceeding other than under section 81.25 of the mental hygiene law shall be subject to ...(confidentiality requirements).

—NYS Department of Health regulations 10 N.Y.C.R.R. 80.108 imposes the same obligation upon the physician to report patients to the NYS Commissioner of Health;

—NYS Department of Health regulations 10 N.Y.C.R.R. 80.110

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Painkiller overdoses nationwide killed nearly 15,000 people in 2008.

In New York, the number of prescriptions for all narcotic painkillers has increased from 16.6 million in 2007 to nearly 22.5 million in 2010 - prescriptions for hydrocodone have increased 16.7 percent, while those for oxycodone have increased an astonishing 82 percent.

In New York City, the rate of prescription pain medication misuse among those age 12 or older increased by 40 percent from 2002 to 2009, with nearly 900,000 oxycodone prescriptions and more than 825,000 hydrocodone prescriptions filled in 2009.

ACOs - It’s All About Funds Flow

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Locally there are three organizations that are actively involved in the ACO market. Accountable Health Partners (AHP), Greater Rochester Independent Practice Association (GRIPA), and Excellus Health Plan (EHP) announced, earlier this year, that they are forming an ACO. To date, none of them have been approved for a Medicare ACO program. AHP and GRIPA have actively been meeting with physicians to share information on who is eligible to join, any fees to join and types of payer relationships for which they plan to contract. As the healthcare market continues to change, be sure to keep up to date with how these changes affect you.


I-STOP Mandates

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requires “Persons licensed or certified pursuant to Article 33 of the Public Health Law and persons authorized under law to possess controlled substances in connection with authorized activities to promptly notify the NYS Department of Health of:

“each incident or alleged incident of theft, loss or possible diversion of controlled substances manufactured, ordered, distributed, or possessed by such person”

The regulation requires reporting to the Bureau of Narcotic Enforcement of NYSDOH.

—Public Health Law 910.5 requires practitioners to undertake safeguards and security measures to assure against the loss, destruction or unauthorized use of NYS prescription forms. Practitioners must immediately notify the NYS Department of Health upon obtaining knowledge of any diversion or suspected diversion of drugs pursuant to the loss, theft, or unauthorized use of prescriptions.

Accountable Health Partners

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• We will give physicians an active voice in AHP decision-making through regional and functional advisory committees, coupled with a strong, proactive and customer-focused physician relations team.
• We will give physicians a voice in medical policy and clinical protocol development – protocols to improve clinical quality will be created with the active involvement of AHP doctors, not by administrators.
• We will give physicians assistance with your in-office EMR.
• We are creating a process to offer advanced access to URMC specialists.
• We are creating a process to offer expedited problem resolution.
• We will be announcing shortly additional value-added benefits available exclusively to AHP members that will save money and improve your practice.

We are actively negotiating payer contracts for 2014, so it is important not to delay.

Lead Change

Continued from page 24

The next time you face an opportunity for change, consider your role in helping to ignite change - to cause change to start burning with passion and excitement or identify what you need as a change to engage and support change instead of resisting it.

References:


MCMS Medical Memo

New Members

Tresa Almy-Albert, MD
Pediatrics

Aitezaz Ahmed, MD
Rheumatology

Robert Caifano, MD
Internal Medicine

Joseph Gasparino, MD
Internal Medicine

Shelly Kane, MD
Internal Medicine

Byron Kennedy, MD, PhD, MPH
Public Health

John RT Monson, MD
Colorectal Surgery

Catherine Nelson, MD
Surgical Critical Care

Patricia M. Newcomb, MD
Obstetrics & Gynecology

Matthew Schiralli, MD
Surgery

Nancy Shedd, MD
Internal Medicine

Afreen Tariq-Fazili, MD
Obstetrics & Gynecology

Rachael Wojtovich, MD
Pediatrics

Guan Wu, MD
Urology

Sara Zaka, MD
Internal Medicine

Change of Address?
Please give us a call so we can update your information.
(585) 473-4072

Passages

James T. Adams, MD
05/09/13

Philip P. Bonanni, MD
06/10/13

Salvatore J. Dalberth, MD
07/01/13

Sarwat S. Malik, MD
07/07/13

Joseph M. Plukas, MD
09/14/13

Victor J. Tofany, MD
04/18/13

Rocco M. Vivenzio, MD
04/26/13

In the News

Brian Watkins, MD, a board-certified general surgeon with Genesee Surgical, is now performing da Vinci robot surgery at Rochester-area hospitals. The operations he can perform with da Vinci technology include Nissen Fundoplication/Hiatal Hernia; Partial/Total Gastrectomy; Splenectomy; Distal Pancreatectomy; Colon and rectal procedures. Dr. Watkins can be contacted at (585) 383-8830 for appointments.

John S. (Jack) McIntyre, MD has been elected Chair-elect of the Council on Medical Service at the AMA House of Delegates. The Council on Medical Service recommends AMA policies and actions for consideration by the AMA House of Delegates on the socioeconomic factors that influence the practice of medicine, including issues of health care reform.

Dr. McIntyre is Clinical Professor of Psychiatry at the University of Rochester and immediate past Chair of the Department of Psychiatry and Behavioral Health at Unity Health System. He has served as both President and Speaker of the Assembly of the American Psychiatric Association (APA) and has served in the APA Assembly for 25 years. Dr. McIntyre is Chair of the Section on Quality Assurance of the World Psychiatric Association. Dr. McIntyre has maintained a private practice of psychiatry for 30 years.
Rochester Academy of Medicine Presents 2013 Annual Awards

By Norma Leone

The Annual Awards Meeting of the Rochester Academy of Medicine was held on May 15, 2013 in the Academy Auditorium. The event recognizes and celebrates the accomplishments and contributions of those in the medical community.

The meeting began with a welcome by Joseph F. Kurnath, MD, 2012-13 President of the Academy Board of Trustees, and was followed by the presentation of awards.

The 2013 Albert David Kaiser Medal was awarded to Marilyn R. Brown, MD, who was introduced by Elizabeth R. McAnarney, MD. The award was initiated in 1939 to recognize the work of Rochester pediatrician Albert David Kaiser, MD and is given annually for distinguished service in the fields of medicine, public health and community welfare. It is the highest honor a physician can receive for outstanding service to the community and medical profession.

Distinguished Service Awards for outstanding service to the medical profession were introduced by Joshua Hollander, MD and presented to:

- Robert J. Agostinelli, MD, introduced by Bernard Farnand, MD
- Robert F. Klein, MD, introduced by Geoffrey C. Williams, MD
- Wanda Polisseni, Community Philanthropist, introduced by John R. Valvo, MD
- Gwen K. Sterns, MD, introduced by Steven J. Rose, MD
- Hechmat Tabechian, MD, PhD, introduced by J. Richard Ciccone, MD

The Pulsifer Awards were presented by T. Jeffrey Dmochowski, MD, 2013-14 President of the Academy Board of Trustees, to Alaina Webb, MD, Rochester General Hospital, Geetha Koushik, MD, Unity Hospital, and Ezekiel Volkert, MD, University of Rochester Internal Medicine Residency.

The award is named for Libby Pulsifer, MD, whose attributes of quality and compassionate care set the standard for the awards. The awards are presented to an outstanding resident at each of Rochester’s three major hospitals who plans to continue his or her medical career in the area. Bill and Barbara Pulsifer were present for the award presentation.

James M. Haley, MD, Chair of the Prize Awards Committee, presented awards to Susan Blaakman, PhD, RN, Bonnie Choy, Sheetal Gandotra, MD, Benjamin P. George, MPH, Aarati Poudel, MD, and Imran Uraizee.

The Awards Meeting was attended by more than 100 members of the community and was followed by a reception in the historic Academy home.
Rochester Academy of Medicine
2013 Prize Award Winners

Asthma Medication Adherence among Urban Teens: Barriers, Facilitators, and Experience with School-Based Care
Susan Blaackman, PhD, RN

Role of Frozen Section Analysis of Surgical Margins During Robot-Assisted Laparoscopic Radical Prostatectomy: A 2,608-Case Experience
Bonnie Choy

Justifying the “Ashley Treatment” - An Application of Act-Utilitarian Theory to the Pillow Angel Case to Demonstrate Ethical Decision-Making in Medicine
Sheetal Gandotra, MD

United States Trends in Thrombolysis for Older Adults with Acute Ischemic Stroke
Benjamin P. George, MPH

Aarati Poudel, MD

Relation of N-terminal pro-B-type Natriuretic Peptide with Diastolic Function in Hypertensive Heart Disease
Imran Uraizee

To request an electronic copy of these papers, please email suzanne.welch@frontier.com
Group medical visits, sometimes also called shared medical appointments, are gaining in popularity among both physicians and patients. In a group setting, over a 90-minute to two-hour period, the physician performs a series of one-on-one patient encounters, to manage the health of each patient and educate and advise the group of patients. Sometimes offered as a cooperative health clinic to patients with a single disease focus (e.g., diabetes, high blood pressure or high cholesterol), and sometimes offered on a drop-in basis to patients with multiple diagnoses, these programs have been found to provide patients with increased access to their physician, improve the quality of their care through enhanced education and support, make patients more active participants in their care and offer patients peer support. From the practice perspective, this model can improve physician and staff productivity, decrease costs and reduce patient scheduling congestion.

The first legal issue to consider is patient confidentiality and privacy. Each patient wishing to participate in a shared medical appointment must sign a HIPAA compliant release and waiver acknowledging that their protected health information will be shared with other participants in the group visit. The patient should also pledge confidentiality as to the protected health information of other participants, agreeing not to share any protected health information of other patients outside the group setting. The patient should also acknowledge that while each patient in the group visit has signed a similar confidentiality pledge, neither the physician nor the physician group can guarantee the confidentiality of protected health information received by the other group members. Finally, where the shared health information may include HIV or mental health status, there are special New York State rules to follow for a valid waiver and release agreement.

From a patient care and risk management perspective, the physician should document the visit in each participating patient’s medical record in the same manner as an individual visit. Vital signs should be recorded, patient evaluation, counseling and education noted, and each medical decision and advice to the specific patient documented. The chart notes should reflect all individual medical examinations and services provided to the patient, as well as the services provided to the group as a whole. The chart details will serve the physician well for purposes of back-up of the billing to a third-party payor or in the event of a malpractice claim. The physician should be mindful that in the group setting the other patients may be witnesses in the event of any malpractice claim by a group participant. To the extent practice staff assist the group, their activities should be within the scope of their respective licenses (nurse, nurse practitioner or physician assistant).

Next, the physician will need to carefully consider the coding and billing of the shared medical appointment to third-party payors. The American Academy of Family Physicians web site provides guidance on these matters. Since no official payment or coding rules have been published by Medicare, the AAFP asked CMS for guidance. The response from CMS was, “...under existing CPT codes and Medicare rules, a physician could furnish a medically necessary face-to-face E/M visit (CPT code 99213 or similar code depending on level of complexity) to a patient that is observed by other patients. From a payment perspective, there is no prohibition on group members observing while a physician provides a service to another beneficiary.” The reply letter went on to state that any activities of the group (including group counseling activities) should not impact the level of code reported for the individual patient. It is important to note that medical insurance company coverage and payment rules may very well differ from this Medicare guidance. The physician should seek written advice from each insurance plan in which they are a participating provider to confirm that shared medical appointments are covered services and as to how to properly code and bill a medically necessary, physician-patient encounter conducted as a group medical visit.

Group visits should be voluntary and not mandatory, even where the physician believes the patient would benefit from the group. Traditional office visits should be available for patients who refuse the group, or decide to leave the group. Moreover, the shared medical appointments should not completely replace individual visits, and when necessary or desirable to the patient, individual medical appointments should remain available. Finally, the physician should receive written confirmation from his or her malpractice insurance carrier that full coverage will be available in the event of a HIPAA compliance claim or malpractice claim arising in the context of a group medical visit.

Material in this column was prepared for informational purposes only. It is not intended to constitute legal advice, the provision of legal services, or the creation of an attorney-client relationship. Readers should not act on this information without seeking the advice of an attorney.
The Bulletin

For more information on these new improvements to your Medical Society Endorsed Disability Income Program, please contact the specialists with 93 years of service:

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FAX: (716) 627-5420 – Toll-free FAX: 1-800-462-1121
E-mail: insurance@sellersinsurance.com – Web Site: www.sellersinsurance.com

MONROE COUNTY/SEVENTH DISTRICT BRANCH MEDICAL SOCIETY ENDORSED DISABILITY INCOME INSURANCE

PROGRAM IMPROVEMENTS

- **Longer Benefit Payment Period**
  If you are disabled prior to age 64, this new, optional longer benefit period makes benefits payable until your Social Security Normal Retirement Age (SSNRA), the age used by the Social Security Administration to determine when full Social Security retirement benefits are payable. If you were born in 1960 or later, this is age 67.

- **Added Protection for Catastrophic Disabilities**
  If you suffer a catastrophic disability, with this option, your benefit payment will be increased by 30%. This extra benefit, which can be used in any way you wish, can help you with the added expenses that such a life-changing disability can bring.

- **Additional Cost of Living Adjustment Options**
  Your Medical Society Endorsed policy now has two new Cost of Living Adjustment (COLA) options (total of three options) with varying benefit and premium levels. You can now select the most appropriate COLA option for your personal financial situation.
Change is coming to healthcare and it’s heading your way.

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**OPTIONS**  ▶  What can you do to optimize your practice?
**ACTIONS**  ▶  How do you implement it?

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