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On the cover: Dr. Benjamin Rush by Robert Thom, Collection of the University of Michigan Health System, Gift of Pfizer Inc, UMHS.21
Welcome to the inaugural issue of *Family Doctor, A Journal of the New York State Academy of Family Physicians*.

Few images are more evocative for family physicians than *Benjamin Rush: Physician, Pedant, Patriot*, which graces our cover for this issue. In my 18 year association with the Academy I have been consistently impressed with the people I have met whose commitment to family medicine began with the fundamental desire to care for people in need. In many respects the qualities that distinguish family physicians from others who practice medicine begin with the recognition that people matter more than science.

The image of Dr. Rush standing beside the bed of his patient and wearied from a presumably lengthy and arduous process of treatment underscores the essence of family medicine. The physician alone with his patient in obvious contemplation of the circumstances and invested in the outcome of his care on the most personal level is in stark contrast to the image of modern medicine with all the hi-tech equipment, plethora of drugs and fragmentation inherent in specialization that have become so closely associated with the profession.

Certainly, family physicians in the modern era are as skilled and knowledgeable as their sub-specialty colleagues, conversant and competent in all the current accoutrements of medicine. But medicine begins long before the prescription is written or the procedure initiated. It begins with the encounter between physician and patient when two people connect at a deeply personal level. It begins when someone places his or her own health or that of a loved one in the hands of another. It is at this point where the essential bond is formed that will enable effective treatment. At its core, family medicine has always been about trust. Once that connection occurs it is sustained if patients remain convinced that the physician can be relied upon to do all that is necessary to preserve and protect their health and understand their needs.

We hope this journal will establish a forum in which to convey information about current developments that will enrich the specialty in the great tradition of medical literature. Toward this end we will endeavor to include articles that are worthy of accreditation and which physicians may use to accumulate continuing medical education credits as necessary.

We also will attempt to include articles of special interest particularly by and about members of the Academy. Our greatest resource as an organization is the diversity of talent and perspective which our members possess. We invite contributions from members in their areas of professional, personal or creative interests.

Public policy intimately affects health care and medicine, so we will feature a policy topic of current interest in each issue. We will invite commentary on selected topics from authors with countervailing points of view so that our readers may make a fully informed opinion for themselves.

As always, we welcome comments and suggestions from readers. We welcome your feedback which will support our efforts to give you a publication that remains relevant and useful.

There is something compelling in the image of Dr. Rush leaning against that dresser, in the home of his patient and obviously deep in thought. One can only imagine the circumstances that placed him in that room at that time and with that patient whose lingering distress is also evident in the painting. As we launch this literary enterprise I offer this image of the family doctor as a tribute to those men and women who collectively define family medicine and who individually earn the respect and trust of the patients and families they serve every day.

*Vito Grasso, MPA, CAE* is the Executive Vice-President of the New York State Academy of Family Physicians.

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Advocacy is a major function of our academy. Two democracies control our advocacy efforts — the internal democracy in which the delegates determine the advocacy agenda of the Academy, and the external democracy to which we direct our petitions. The internal democracy, expressed primarily at our Congress of Delegates, functions according to the generally accepted principles of parliamentary procedure as codified in “Sturgis”. Majority rules, but Sturgis warns (p8-9): “The rights of the minority must be protected... The minority of today is frequently the majority of tomorrow... a member of the majority on one question may be in the minority on the next...”

Delegates are defined by many demographics: upstate/downstate, rural/urban, gender, ethnicity, conservative/liberal, academic/practice, hospital/office. If we were equally divided in two categories for each of these seven categories, there would be two to the 7th power = 256 unique possible combinations of demographics. In a room of 100 delegates, it would be unlikely that any two delegates could form a perfect caucus. To arrive at a majority decision we must therefore compromise, which requires listening, empathy, tolerance.

Quotable examples from our Congress demonstrate the complexity of the concept of majority. A conservative delegate, feeling defeated by the outcome of several resolutions, asked how we could declare a policy as representative of the family physicians of New York State if we did not all agree. Another member rose to declare “the tax dollars of vegetarians are spent on inspection of meat processing facilities — that is the nature of democracy.” Nothing divides a governing body more intensely than debate containing the word “abortion” and any subjects tangentially related — sexuality, family values, contraception. Thus our debate over a resolution to advocate for mandating HPV vaccine for school entry was one of the most intense in my experience. Our differing demographics rose to the surface — upstate versus downstate, inner city experience versus suburban perspective, affluent patients versus disadvantaged patients. At the close of debate we arrived at a tie vote. Only in this instance do our bylaws provide for a vote by the speaker, who defeated the resolution. The speaker did not have a strong feeling about the content of the resolution. He voted defeat of the resolution because of the concept of majority. How can NYSAFP declare as policy a concept supported only by 50% plus 1 of the delegates? This moves us toward the perspective of the conservative delegate who had felt so defeated.

This precedent suggests our policy is determined by consensus rather than by majority. When we debate a resolution containing the “a” word, we modify language to make the final resolution achieve the intended goals without offending the principled values of the minority. We agree that fully informing pregnant patients about options is a laudable goal. For each controversy there are delegates with passionate positions for or against, but we are also blessed with many others who maintain a cohesive organization by crafting compromise language. Any policy, which so alienates a minority that they reconsider their allegiance to the Academy, weakens the ability of the Academy to prevail on other matters of general agreement.

At three separate annual Congresses of Delegates we have affirmed the commitment of NYSAFP to the concept of a single payer health care system. But our conservative and liberal members each have a very different concept of the structure of such a system. Sometimes the crafting of language is sufficiently vague to allow the appearance of consensus where none exists.

Advocacy is hard work. We greatly appreciate the commitment that brings our delegates to the COD. We must also recognize the contribution of the other 99% - our dues paying members who not only support our advocacy financially, but by their numbers confer legitimacy. Every position paper presented to our state government concludes “The NYSAFP, representing 4,300 physicians residents and students, urges that...”

Thank you for your membership, thanks to the delegates for their service to their colleagues, and thank you to our staff and contributors for the effort to launch this NYSAFP Journal.


Philip Kaplan, MD, is the President of the New York State Academy of Family Physicians for 2013-14.
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For nearly two decades, the Academy has employed Weingarten, Reid & McNally (WR&M) to represent it at the state level and work to achieve NYSAFP’s budget, legislative and regulatory goals on behalf of its members. WR&M is an Albany-based government relations firm with a select group of clients in the areas of health, mental health, developmental disabilities, education, the environment, business and others. We work with the Academy to pursue its priorities through a combination of direct lobbying, grassroots action, media advocacy and political action.

The Academy’s advocacy efforts are derived from two primary sources: Academy members, and legislators and policy makers in Albany. Each June at the NYSAFP Congress of Delegates, a number of resolutions authored by members and local chapters are debated, passed and those which relate to changes in law or regulation, the budget and other advocacy efforts are referred to the Advocacy Commission. The Commission, which is chaired by Dr. Marc Price, meets throughout the year and, joined by representatives from WR&M, considers the resolutions and develops a plan of action to recommend to the Board for each.

Additionally throughout the year, WR&M closely monitor the bills which are introduced by state legislators, agency regulations that are proposed and other initiatives pursued by the Legislature, Executive branch, state agencies and others. WR&M flags those which may impact the Academy and sends them to Academy leadership and members of the Advocacy Commission for consideration. Members then determine whether the Academy should take a position and additional action on each proposal. Member resolutions and legislation/regulations which impact family medicine are then added to the Academy’s priority list to guide NYSAFP’s advocacy efforts during the annual lobby day and throughout the year.

As a result of this process and the commitment of its leadership, Advocacy Commission and full membership, the Academy has a strong track record of success in achieving its priorities in Albany. Recent successes including securing several million dollars in funding for primary care recruitment and retention efforts like loan forgiveness and physician practice support; passage of a law to allow for HIV testing of unconscious patients when a health care worker has been exposed; and the enactment of a law to permit the use of expedited partner therapy for chlamydia, to name a few initiatives.

Also during his tenure as Advocacy Chair, President-elect Dr. Philip Kaplan served as Academy liaison to the State Department of Health (NYSDOH) when implementing the statewide vaccine registry for children a few years ago. As a result of his efforts and participation in several meetings over a multi-year period, the Academy was able to ensure that the implementation of the registry was done by NYSDOH in a non-punitive way while providing extensive training and technical support for impacted physicians.

Most recently, under the leadership of President Dr. Neil Nepola, Executive Vice President Vito Grasso and Advocacy Chair Dr. Price, and the local actions by members including participation in the March lobby day, the Academy has been able to prevent the advancement of legislation to remove the collaborative agreement requirement for Nurse Practitioners. The Academy has also raised awareness with the State Commissioner of Health and State Board of Medicine on problems encountered by International Medical Graduates with licensure delays.

As the 2012 session continues, the Academy is working to achieve passage of legislation in both houses to allow physicians to collectively bargain with health insurers,
along with a number of other bills that we are working to advance or prevent this session based on their impact on family practice physicians. Also NYSAFP is working with NYSDOH, medical schools and other stakeholders to develop a plan for new initiatives to enhance the State’s primary care recruitment and retention efforts.

We urge members to get involved in the Academy’s advocacy process and have provided suggested activities for members who are interested in doing so. The more politically active the membership is, the greater the impact that the Academy can have on the process in Albany on behalf of the profession and your patients.

Marcy Savage is the Government Relations Counsel for the NYSAFP from Weingarten, Reid & McNally, LLC in Albany, NY.

HOW TO GET INVOLVED

• Write a resolution on an issue that is of interest to you and that impacts your practice and the patients you care for;
• Get to know your local legislators (nysenate.gov and assembly.state.ny.us). They want to know what is important to their constituents locally;
• Become a member of the Advocacy Commission;
• Participate in the Academy’s annual lobby day in Albany in March each year; and
• Take action by contacting your legislators via phone, letter or face-to-face when you receive Action Alerts sent out by Vito Grasso and his staff on pressing issues at the state level.

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DIVERSIFYING MEDICAL SCHOOL ADMISSION CRITERIA TO MEET NYS HEALTH GOALS

By Robert Ostrander, MD, and Ron Rouse

We have 16 medical schools in New York State with 9,000 students. Critical shortages in the number of primary care physicians compel reassessment of the impact of medical school admissions practices on the selection of specialty and the ultimate location of physicians in practice.

Medical school admissions almost entirely correlate with applicants’ scores on the Medical College Admissions Test (MCATs) and their undergraduate Grade Point Averages (GPAs). MCATs correlate with academic performance up to a point after which there is no distinction in likelihood of graduation among applicants. MCAT scores also correlate highly with upper socioeconomic and privileged urban/suburban backgrounds. This factor influences choice of specialty and location of practice.

Key groups including the Association of American Medical Colleges, the Associated Medical Schools of New York, and 36 leaders of medical schools around the country are expressing a substantial, growing interest in diversifying admission criteria beyond MCAT and UGPA to ensure that medical schools admit students who reflect our societal make-up, including those students who want to practice in underserved areas.

The Group concluded that “…While an applicant’s race or gender may not be considered in admissions, universities may give special consideration to such factors as the following:

- Service to groups historically under-represented in higher education
- Potential to contribute to the educational program through the candidate’s understanding of the barriers facing women, minorities, and students with disabilities
- Demonstrated drive and motivation to persist and succeed in spite of barriers that disproportionately disadvantage the applicant

CONTINUED ON PAGE 11
Communication skills and cross-cultural abilities to maximize effective collaboration within academic and healthcare communities.  

Preliminary recommendations of the 22-member advisory committee for the fifth revision of the MCAT, the first in nearly 25 years, include adding questions on disciplines like sociology and psychology, and testing analytical and reasoning skills in areas like ethics, philosophy and cross-cultural studies, which could include questions about how someone living in a particular demographic situation, for example, might perceive and interact with others.

There are mixed findings regarding the strengths of using Undergraduate GPA and MCAT score to predict medical school performance or personal and professional characteristics. Studies have indicated that, although underrepresented minorities have entered medical school with significant educational disadvantages and have continued to score lower than other students on some measures, their clinical performances were nearly equivalent to those of other students.

The top MCAT score is 45. The majority of medical schools in NYS prefer an MCAT score of approximately 33 and higher. However, once a certain MCAT score and UGPA is reached, increases beyond those thresholds make little difference in predicting graduation rates. Nearly every student who scored an MCAT score of 27 or higher and had a UGPA of at least 2.6 or higher graduated from medical school (range was 93% - 97%). This is the big point: once a certain threshold is reached (e.g., a 27 on the MCATs and a 2.6 or 2.8 UGPA), we can be assured that the medical students will graduate. Therefore, other selection variables can be introduced, such as those to predict who will be most likely to practice in an underserved area.

- Extensive work has identified a cluster of characteristics in medical school applicants that predict an increased probability of eventual rural or urban underserved practice. These include gender, older age at matriculation, rural or urban underserved community of influence, and relatively lower family income.
- Women and African Americans more often choose to practice in urban underserved areas, whereas men and underrepresented minorities other than African Americans more often choose rural practice.
- More than 20 years of experience in the Physician Shortage Area Program at Thomas Jefferson University have shown that two characteristics identifiable at enrollment – growing up in a rural area, and a plan to enter family practice on entering the first year of medical school – were strong independent predictors of rural recruitment.
- Attending public medical school is more predictive of primary care and underserved area careers than private medical school; in fact, it increases the odds of choosing Family Medicine by 77% and primary care by 27%.

We should be less interested in defining a qualified applicant as one who will be capable of navigating through medical school, and more interested in defining a qualified applicant as one who is likely to help meet society’s needs.

ENDNOTES

Robert J. Ostrander, M.D., FAAFP is a Clinical Associate Professor in the Department of Family Medicine at SUNY Upstate Medical University.
Ron Rouse is a health care consultant.
These statistics do not belie the fact that students from underserved rural and urban areas should have a strong presence in the applicant pool. AMSNY has worked in conjunction with the sixteen medical schools in the State to help this happen. Since 1985 we have sponsored Science Technology Entry Programs at 10 medical schools throughout the State. Each year, over 500 students from grades 9 through 12 are exposed to academic enrichment, time management and critical thinking courses, as well as ‘shadowing a physician’ or participating in lab research. We also provide MCAT Prep programs, mentoring and summer programs for college students and four separate post-baccalaureate programs—three of which offer master’s degrees.

However, one of our most enlightening programs was a conference we sponsored a few years ago for college health advisors. As part of the program the participants were split into small groups and given de-identified applications from students interested in attending medical school. The participants were asked, given the information before them, if they would recommend to the students that they apply to medical school. Almost every participant said ‘no’ to every application, and yet all of the students were then in medical school. The problems with finding physicians to work in underserved areas are much more complex than solely expanding the admission criteria of medical schools. When one looks at the Center for Health Workforce Studies’ NY Resident Exit Survey 2008, only 23% of the respondents said they were leaving the State due to proximity of family. Other reasons included: better jobs elsewhere, better salaries elsewhere, cost of living, and overall lack of opportunities in NYS, to name a few. In short, we need to work with the AHECs (Area Health Education Centers) to develop longitudinal programs that begin in junior high or middle school and support the students through high school and college; we need more educational workshops for high school and college counselors so they are more understanding of what medical schools are looking for in their students; and yes, we need a holistic approach towards admissions.

**ENDNOTES**

1 Center for Healthcare Workforce Studies, *New York Physician Supply and Demand through 2030*, 2010
2 Association of American Medical Colleges, *US Medical School Applications and Matriculants by School, State of Legal Residence and Sex*, 2011
3 Association of American Medical Colleges, *Applicants to US Medical Schools by In or Out-of-State Matriculation Status*, 2011

Jo Wiederhorn is the President and CEO of the Associated Medical Schools of NY (AMSNY) and the New York State Academic Dental Centers (NYSADC).

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When a woman first learns that she is having a miscarriage, it can be very upsetting news, even if the pregnancy was unintended. News of a non-viable pregnancy should be given clearly and empathetically and as early in the visit as possible. The patient’s feelings about the pregnancy and worries about what it means need to be heard. Her support system should be assessed. Communication must be sensitive and non-judgmental, with language appropriate to the patient’s understanding. Miscarriage should be normalized as a common occurrence and concerns for future fertility should be addressed. Women and their partners should be reassured that their normal daily activities have not done anything to cause the miscarriage.

Options for care include expectant management, medical management with misoprostol or an aspiration procedure done under local or general anesthesia. All options (except general anesthesia) are amenable to the family medicine practice. Expectant and medical management could be done in the initial visit.

Many patients will initially choose expectant management. Anticipatory guidance should be given about bleeding and pain; pain medication should be given. She can wait to pass the pregnancy as long as she is comfortable doing so, with regular follow up. Clear follow up should be arranged. Explicit information about how to reach her physician and receive attention for her concerns at any time should be provided.

For medication management, misoprostol 800mcg inserted in the vagina is a common protocol. A time convenient to the patient is chosen, after premedication with ibuprofen and with stronger pain medication available. A second dosage of misoprostol may be needed. Patient information handouts are found at www.Familydoctor.org and www.reproductiveaccess.org. The expected heavy bleeding for 3 to 5 hours should be reviewed, with additional spotting on and off for several weeks explained. Warning signs of heavy bleeding are soaking 2 pads per hour for 2 hours. Other side effects of misoprostol include nausea, fever and/or diarrhea. Rh negative women should be given rhogam.

In-office aspiration procedures can be done for miscarriages under 10 weeks. Procedures are done under local anesthesia (paracervical block) with 800 mg of ibuprofen. Aspiration procedures are quick and the patient generally experiences uncomfortable sensations of cramping and pulling. Sterile, flexible plastic instruments are used. The complication rate is very low. A procedure under general anesthesia would require an outside referral and is usually much more costly and carries the risks of the general anesthesia. Patients may change from one option to another i.e., from expectant to medical management, medical management to procedure, expectant management to procedure.

Even pregnancies that are miscarrying may not be intended, so there should be a mention about contraceptive needs post-resolution.

REFERENCES
Office Management of Early Pregnancy Loss. Prine L W, MacNaughton H Am Fam Phys July 1 2011 Vol. 84 No. 1, borrowed with permission from the Reproductive Health Access Project

Ginger Gillespie, MD is Assistant Professor of Family Medicine at Beth Israel Residency in Urban Family Practice. Linda Prine, MD, is Associate Professor of Family Medicine and Women’s Health Director at the Institute for Family Health.
KEYS TO BILLING
BASED UPON TIME

By Ronald J. Pope

1. Must spend greater than 50% of the visit with counseling, education and coordination of the patients care. This includes talking to the subspecialist on the phone.

2. Other than the phone call to the subspecialist, the rest of the time needs to be spent face to face with the patient or in the case of a child < 18 years of age, can include the parent or legal guardian.

3. You must document what the education, counseling or coordination of care entailed. There is no minimum or maximum requirement in documenting, but, it must make sense to an auditor that you actually needed this time. Chatting about your kids and personal interests should not be part of the billable time. If you are a very long winded socialite in the office, that is your time, not billable time. So, just document what you discussed, how long you spent with the patient/family and what percent of the total time was spent on the counseling/education/coordination of care piece.

4. It is a good idea to document who was in the room with you, although not required.

5. In adult patients, meeting with the family without the patient does not constitute billable time (exception: ICU setting, to be addressed in a future journal issue).

6. Look at the next table to see which level of service to bill, when doing time based billing on the outpatient side.

Ronald J. Pope, D.O. is President of Coding Consultants of NY, LLC.

<table>
<thead>
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<td>Established Patient – Office</td>
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In Patient and Nursing Home times differ from these office related time billing (covered at a later time).
As medical care has become increasingly sophisticated, many, if not most, patients will have more than one healthcare provider participating in their care. Advances in diagnostic, therapeutic and informational technology increase the need for multiple providers with specialized knowledge and increase the amount of information to be managed for each patient. Excellent explicit care coordination is central to providing quality care.

There is no universally accepted definition of care coordination. For the purposes of this discussion, care coordination is defined as processes designed to efficiently and effectively share information and enhance collaboration among those involved in the care of a patient. This will be approached from the perspective of the primary care team. For care coordination to be effective, complementary (not identical) processes need to be in place with other providers of care and the patient or family. The use of high-performing care coordination processes by the primary care team can drive the development of these complementary processes.

There is little outcomes based research on care coordination, either as an intervention to promote certain goals (decreased morbidity or mortality, lower costs, improved satisfaction) or as an outcome itself. There is a strong suggestion in various studies that enhanced care coordination either alone or as a key feature of a family centered medical home improves satisfaction, improves prescribing practices and decreases emergency room utilization in children and/or adults with chronic medical conditions. Consultation.

Case: J.D. is a 33 year old man with several weeks of upper abdominal pain, with an equivocal relation to meals. His exam is non-specific and a basic laboratory evaluation is unrevealing. He still has some symptoms despite a trial of a PPI. You have decided to send him to a gastroenterologist for consultation.

Discussion: Patients assume that providers communicate with one another. In fact, considerably less than one third of consultants receive any information from the referring physician and only three fourths of primary care providers received return communication in one pediatric study. This leaves the patient as the sole conduit of information, without any explicit discussion that this is the case. Failure to communicate adequately leads to missed information, redundant testing, unclear roles and conflicting treatment regimens. Paradoxically, when sharing does occur in this era of electronic medical records, it is often transmitted non-selectively, with key information obscured by the sheer volume of material.

For J.D. you review with him your reasons and expectations for the consultation and fill out a “fax back” form to which the medical records staff attaches selected portions of your record. (See Figure 1.)

Co-management.

Case: C.P. is a 58 year old woman with difficult to control Type 2 Diabetes, hypothyroidism, coronary artery disease status post stenting who has had a nephrectomy for a localized renal cell cancer. In addition to you, she is followed periodically by an endocrinologist, a cardiologist and a urologist.

Discussion: Coordination of care in a patient with multiple chronic conditions results in a complex web of potential interactions among providers and the patient. The responsibility of each participant for surveillance, diagnostic testing and therapy needs to be clear. Mechanisms for sharing data and information about modifications in treatment regimes must be in place. Because of the complexity, redundancy is an important safeguard. Engaging the patient as a...
partner in care coordination can fill this role. Regional Health Information Organizations (RHIOs) when available can play an important part in sharing information about diagnostic tests, but should not be relied on as the only channel of information sharing. Individualized Care Plans, as opposed to standardized disease-based care plans, (See Table 1.) and portable medical summaries have been used successfully in these patients, especially in the care of Children and Youth with Special Healthcare Needs, where much of the pioneering work in this was done. 3, 3, 8, 13.

For C.P. at the time of referral you communicated by phone or letter with each of the consultants about surveillance and management.

You will be monitoring and managing lipids and hypothyroidism (sharing results and medication changes with the cardiologist and endocrinologist, triggered by a reminder alert sheet on your electronic medical record). The cardiologist will arrange any cardiac testing, the endocrinologist will manage and order testing for diabetes and the urologist will coordinate laboratory and imaging follow up for the renal cancer. You have educated your nurse about care coordination so that laboratory requisitions have a notation to send copies to the appropriate consultants, and at the time of each visit recent consult letters are reviewed for medication changes and C.P. is asked about any changes other doctors have made. You and C.P. have developed a personalized care plan, (See Table 1.) which, along with her current medication list, she carries with her to all appointments and emergency or urgent care visits and which you send to her co-managing consultants. C.P. is asked to write down any tests ordered by her providers with a brief description of any results she has been given, so they can be reviewed if necessary.

Transitions of Care.

Case: L.D. is a 70 year old man with chronic obstructive lung disease and diabetes. He comes into the office feeling worse despite three days of antibiotics and oral steroids for a COPD exacerbation. He is tachycardic and tachypneic and his oxygen saturation is 85% when he first comes in, but 89% after sitting. You conclude that he has failed outpatient management and likely needs admission to the hospital, after initial evaluation in the emergency room. Since you no longer do inpatient work, you will need to coordinate transitioning primary responsibility for his management to the hospitalist and again back to you after discharge.

Discussion: The need to transition care occurs in many different situations. Just a few of these are from outpatient to inpatient care (as in our example), to another primary physician when a patient moves, to adult providers as children move through adolescence to adulthood (which can be especially challenging for Youth with Special Healthcare Needs.) Anticipating the transition and advance planning are important. As with co-management, the patient’s role as an active partner in the process cannot be over emphasized. The entire primary care team needs to understand the importance of care coordination and have procedures in place to make it as efficient and effective as possible.

L.D is well aware of the challenges of communication with hospitalization because you have educated him through your website, handouts in the waiting room and at routine visits. He knows to review his medications from his list with the hospitalist during his exam and his nurse once he gets settled in to be sure no crucial medications are missed. He keeps a small notepad by his bed to write down what tests are done and what results have been shared with him. At discharge he compares his usual medications with those on his instructions, and asks questions if anything is not clear. He knows he can call your office at any point during the hospitalization and ask his caregivers there to communicate with you about any concerns he has.

As he leaves the office you call the Emergency Department and review the key points with the triage nurse. You fax a copy of the office note from three days ago and today’s office note (which contains his med
Dear Dr. GI:

I am referring J.D. for the following:

Upper abdominal pain. I am especially interested in what further tests you think are needed. I will defer to you whether to proceed to EGD.

Enclosed please find copies of

- Office Notes 2/3/12 to present; med list; PFSH summary
- Labs last 3 months
- X-ray reports

Your help is appreciated.

Very truly yours,

ROBERT J. OSTRANDER, M.D.
CONSULTATION SUMMARY

Dear Doctor,

Thank you for evaluating J.D. in consultation and for sharing your expertise in the management of the problem at hand.

For the purpose of efficient communication and good coordination, would you please take a moment to fill in the information below and return it via fax transmission to my office. Please forward a copy of your office notes, when completed by fax.

Diagnosis:

______________________________________________________________________________
______________________________________________________________________________

Investigations suggested: ______________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Treatment started or modified:_____________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Follow-up suggested: ____________________________________________________________

Today’s date: ________________________________

Thank You

Fax# (555)555-5555

Dr. Signature ____________________________

REFERENCES:

1 McPhail LH, Neuwirth EB, Bellows J. Coordination of Diabetes Care in Four Deliver Models Using an Electronic Health Record. Medical Care 2009; 47:993-999.


12 Gulley SP, Rasch EK, Chan L. If We Build It Who Will Come? Working-age Adults with Chronic Health Care Needs and the Medical Home. Medical Care 2011; 49:149-155.

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**CME POST-TEST**

**Instructions:**
Health care professionals seeking AAFP credits will receive 1 credit for the year in which the quiz is taken upon completion of this quiz online at [www.nysafp.org](http://www.nysafp.org) under the Education and Events tab. Health care professionals seeking Category 1 AMA credits are eligible to receive 1 credit in Category 1 of the Physician’s Recognition Award of the AMA.

NYSAFP staff will notify those who take the quiz of their scores.

Physicians are responsible for reporting their own CME credits to their respective organizations.

**Choose all that apply:**
1. Care coordination has been show to:
   A. Lower overall health care costs
   B. Improve patient satisfaction
   C. Result in better outcomes in the general population
   D. Reduce emergency room utilization in children with special healthcare needs.
2. Which of the following can be useful tools in coordinating care?
   A. Simple fax tools for information exchange
   B. Written care plans that define roles and responsibilities
   C. Educating the patient in being part of the care coordination process
   D. Regional Health Information Organizations (RHIOs)

**Choose the one best answer:**
3. With regard to care coordination and consultations:
   A. Patients assume that the physicians participating in their care communicate effectively and efficiently.
   B. When Regional Health Information Organizations (RHIOs) are in place, it is reasonable to rely on them for sharing diagnostic data.
   C. The referring physician should send as much information as possible as it may contain overlooked clues to the diagnosis.
4. With regard to care coordination and co-management:
   A. The most important thing is to be sure subspecialists have access to diagnostic tests that have been done.
   B. The primary care provider should assure that there is one mechanism in place for each care coordination task (e.g., diagnostic data sharing, treatment plan sharing, etc.).
   C. The roles and responsibilities of everyone involved in a patient’s care need to be identified and shared as clearly as possible.
5. With regard to care coordination and transitions:
   A. Transitions are only an issue involving hospital admission and discharge.
   B. Educating and involving the entire primary care team in transitions makes the process smoother and safer.
   C. Because each situation is different, transition planning should be done as the need arises.

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**Robert J. Ostrander, M.D., FAAFP** is a Clinical Associate Professor in the Department of Family Medicine at SUNY Upstate Medical University in Syracuse. He is a 1983 graduate of Upstate Medical College in Syracuse and the founding partner of Valley View Family Practice in the rural Finger Lakes. He serves on the Medical Home Workgroup and the Follow Up and Treatment Subcommittee for the Secretary of Health and Human Services Advisory Committee on Heritable Diseases of Newborns and Children.

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To complete the test go to: nysafp.org > Education & Events
Crisis averted: how a medical home pilot is saving health care in New York’s north country

By John Rugge, M.D.

IN THE ADIRONDACKS, in the summer of 2007, things were looking bleak for the health care system. “The Adirondacks are hemorrhaging doctors,” proclaimed an article in the Albany Times Union.

And the newspaper was right.

Between 2001 and 2005, the number of physicians in the north country of New York State had declined by eight percent, while the rest of the state had seen a five percent increase. To those of us who had to recruit new physicians, it felt even worse.

Burned out by long hours and low reimbursement, doctors — especially family doctors — were leaving the Adirondacks to practice in other areas for better pay, more vacation time and fewer nights on call.

“One physician told me that he had come to the area knowing that he would make less money, but wanted a rural lifestyle,” said Stephens Mundy, CEO of Champlain Valley Physicians Hospital (CVPH) in Plattsburgh. “But he never had time to enjoy the mountains. He said that he would leave, make a lot more money and bring his family back to the Adirondacks on vacation.”

At the time, CVPH had 20 openings for physicians, more than 10 percent of the medical staff at the 400-bed hospital.

Alarmed by the trend, local leaders organized a summit to raise awareness among health care professionals, community leaders, and local and state elected officials. The growing shortage of health care providers presaged a crisis as surely as black clouds on the horizon.

Today, five years later, the storm has been averted. Adirondack-based health care providers are stable and have emerged as leaders for policy makers by creating an “experiment” to restructure how primary care is delivered and paid for. The initiative, the Adirondack Medical Home Pilot, has largely precipitated the turnaround.

PATIENT CENTERED MEDICAL HOME

The Medical Home (PCMH) has been the subject of much discussion and program development over the past several years. The AAFP, other medical organizations, government and the insurance industry have backed many of these initiatives. Dr. Rugge’s article describes his experience with one Medical Home program which has had some success, with the help of public and private support.

We would like to encourage our Members’ comment regarding their experiences with the Medical Home concept. Send articles or comments to journaleditor@nysafp.org, subject line PCMH. Editor
THE POLITICAL WILL TO PROCEED

“The health care summit of 2007 was a wake-up call for the region and for state health officials,” said Catherine Homkey, CEO of the Adirondack Health Institute (AHI), a partnership of Adirondack Medical Center, CVPH and Hudson Headwaters Health Network, which coordinates the pilot. “People saw that the system could collapse without enough compensation to retain physicians and recruit new ones.”

The summit participants called upon the Governor to take action, and media attention got the ball rolling. Over the next two years, providers, state health officials and private payers met to find ways to address the regional crisis. From these meetings emerged the Adirondack Medical Home Pilot, an initiative that covers a rural area the size of Connecticut, with a population of more than 200,000.

The Pilot became “real” in 2009, when NYS Governor Patterson placed $4.5 million in the state budget to cover increased Medicaid payments to participating primary care practices, while the Legislature enacted a law to extend anti-trust protection to the participants. After much wrangling, the private payers also agreed to increase reimbursement. On January 1, 2010, the clock started ticking; the Pilot has a five-year window to prove it can deliver both higher quality and lower costs.

In all, the Pilot includes dozens of primary care practices (representing some 100 physicians and a like number of physician assistants and nurse practitioners), five hospitals, seven commercial health plans, Medicaid, the New York State Department of Health, the Medical Society of the State of New York, and the New York State Association of Counties. Medicare signed on in 2011, thanks to one of eight demos handed out nationwide by the Center for Medicaid and Medicare Services, making the initiative one of the nation’s only all-payer medical home pilots.

ADOPTING THE PATIENT-CENTERED MEDICAL HOME MODEL

The Patient-Centered Medical Home (PCMH) concept has been around for decades, at least in theory, and its premise is simple. Instead of care based on episodes of illness and patient complaints, the PCMH emphasizes coordinated care and a long-term healing relationship between the patient and his/her primary care physician. Thanks to better care and coordination of services, patients are expected to stay healthier. Costs are then reduced because of fewer emergency room visits and hospitalizations.

Because chronic diseases account for more than 75% of health care costs, the Adirondack Pilot focuses on six of them, based on regional health data: diabetes, hypertension, coronary artery disease, and pediatric asthma, obesity and prevention.

That the Pilot’s approach could yield impressive value in the real world had been demonstrated by the Geisinger Health System, a large rural health care organization in Pennsylvania. In 2008, Geisinger reported that its medical home program reduced hospital admissions by 20%, saving 7% of total medical costs. Moreover, Geisinger’s approach eliminated common health care delivery problems such as unjustified variation (different approaches to care in different locations), perverse payment incentives (more money for more work with irrelevant outcomes), and lack of coordination among caregivers.

While the Geisinger experience had dramatic results, it differs from the Adirondack pilot in one crucial way. Geisinger is a highly integrated health care system, meaning it controls the various components of the health care system; Geisinger itself represents the payer, hospitals, specialists and primary care. The challenge for the Adirondack Pilot, and for health care providers throughout most of the nation, is to repeat Geisinger’s results when reimbursement and the range of clinical services are not controlled by a single entity.
“The pilot is a contract between insurance companies and primary-care physicians,” said Heidi Moore, M.D., who chairs AHI’s board of directors. “It’s based on the premise that if given higher reimbursement, doctors will use the extra resources to deliver higher quality, lower cost health care.”

As with any contract, there are deliverables. For Pilot physicians, this means meeting clinical standards for patient-centered medical home practices set by the National Committee on Quality Assurance (NCQA). As part of the NCQA requirements, each Pilot practice has implemented an electronic medical record (EMR) system. The EMR is essential to tracking quality, with physicians capturing 45 measures across the six chronic disease states targeted by the pilot. EMRs also help track whether patients are following “doctor’s orders” (i.e., prescriptions are filled, referrals are acted upon) before the next office visit.

At Hudson Headwaters Health Network where I practice, enhanced prevention, case management and communication are the main strategies for meeting the Pilot’s broad goals. Diabetes is a case in point. Hudson Headwaters’ practitioners systematically monitor different aspects of the disease and its treatment, including blood pressure, hemoglobin A1C, eye health, cholesterol levels, foot exams, and protein in the urine. When any of these measures indicate that a patient’s diabetes has not been controlled to NCQA standards, case managers get involved. They call patients, and in some cases conduct a home visit -- services that are not covered under traditional fee-for-service reimbursement. Additionally, our certified diabetes educators offer patients extensive education, especially for those new to the disease.

Results have come quickly. In just 18 months, Hudson Headwaters is seeing progressively lower numbers and better control of diabetes. Measuring how much this has reduced ER visits and hospitalizations has not yet occurred and promises to be challenging. Data on our results, as well as what other practices are achieving, is being collected and evaluated by AHI.

On the communication side, we’ve made most of the information in our medical records available to patients online through our website’s “patient portal.” Patients use the online capability to direct clinical questions to their provider, request appointments and prescription refills, or search a comprehensive database of medical information.

Interestingly, our patients are generally unaware of practice changes, other than the tablet computers in the exam room and the portal (which they love). Most changes have occurred in the infrastructure of care, policies and procedures and improved coordination with specialists and our local hospital. We continue to tweak how we deliver care to improve patient care and provider efficiency.

While pay has inched up, hours spent at the job haven’t gone down, though computer access to patient records has enabled remote tasking from home (a mixed blessing!). For most providers, learning the new EMR was the biggest change in their professional lives. At Hudson Headwaters, we’re still learning how to mobilize the power of information technology – even tasks as apparently simple as managing the information coming to our electronic inboxes.

When the pilot was initially conceived, year three was targeted as the “crossover,” when the pilot would begin to answer the core questions: Will this kind of investment pay off? Do clinical outcomes improve? Can costs be avoided by reducing emergency room visits and avoiding hospitalizations? Have we improved provider and patient satisfaction? And, of course, have we stemmed the flow of physicians out of the region?

Except for the last question (a yes), we won’t have the data until after the end of 2012, and maybe beyond. Thus far, the payers have been patient and remain committed to seeing the pilot through. The pilot’s coordinating body, AHI, is working to develop rapid cycle evaluation methods to help determine what’s working and what isn’t.

“The Adirondack health care issue was like the canary in the coal mine, a first alert for the rest of the state,” Homkey said. “If primary care, the foundation of the health care system, fails here, it can fail elsewhere, even in more affluent areas. And if the foundation crumbles, what will hold up the rest of the health care structure?”

Because chronic diseases account for more than 75% of health care costs, the Adirondack Pilot focuses on six of them, based on regional health data: diabetes, hypertension, coronary artery disease, and pediatric asthma, obesity and prevention.
FAMILY PHYSICIAN LEADERS ARE BEING convened to develop strategies to address the shortage of primary care in New York State. The first meeting, held on April 20th, 2012, focused on the shortage in the downstate area and was attended by 21 physician leaders, including medical school chairs and residency program directors, and one medical student, who are continuing to work together to address this challenge in that part of the state. A similar meeting among family medicine leaders planned for Friday, June 15th will address the same issue statewide.

We all agree that the state and nation need more primary care physicians. What can be done to accomplish that? What are the barriers that stand in the way of creating more family physicians, and how can they be addressed? How can more primary care physicians be supported to stay in this field, and even expand our availability to better serve patients’ needs?

Much has been written about how to address these vexing questions, because the solutions hold the key to improving health outcomes and addressing the rising cost of medical care. Recently, the national Council on Graduate Medical Education (COGME) issued a comprehensive report analyzing these challenges and proposed a number of policy recommendations to address them (COGME 20th Report: Advancing Primary Care. December 2010). These included payment reform and practice transformation, policies designed to create a pro-primary care environment in which medical students are taught, graduate medical education incentives to produce more primary care physicians, and an enhancement of steps being taken to address the geographic and socioeconomic misdistribution of physicians.

But what can we ourselves as family physicians do to address this shortage? That is the subject of a new initiative, spearheaded by the New York State Academy of Family Physicians’ (NYSAFP) Education Commission, strategic planning for developing family medicine. It involves first asking that question of the family medicine leaders in the state, and then leveraging the unique position of the Academy to enhance collaboration among these leaders to address the shortage of primary care physicians.

There are four major approaches that could be taken to strengthen family medicine in downstate New York. First, we need to recruit more New York City metro area medical students into family medicine. This would include increasing the availability of clerkship sites where medical students there can have access to good family medicine role models and mentors, ensuring that each New York City metro area medical school has a functioning family medicine interest group, changing medical school admission criteria, etc.

Second, we need increased collaboration among downstate educators to access available funding needed to develop and maintain high quality undergraduate and graduate family medicine education. This includes seeking philanthropic, corporate and governmental funding collaboratively for family medicine development activities and joint projects among the downstate family medicine departments, medical groups, residencies, and federally qualified health centers. We need to strengthen these family medicine organizations as well as the ties that bind them together… all of which results in stronger institutions that are better poised to deliver on the mission of leading the production of well trained family physicians for the downstate area.

Third, we need to provide career guidance and networking opportunities for recent family medicine graduates and match them to available downstate positions. Many who graduate from the downstate area’s 11 allopathic and two osteopathic family medicine residency programs have difficulty finding appropriate jobs in
New FM residency graduates face financial constraints in starting practice in New York, even though there are practice opportunities available. The start-up costs for practice are high, joining an existing practice does not guarantee a stable initial income, and job offers in other less expensive areas of the country offer significantly higher financial incentives. There is a need for a uniform listing of available family medicine positions that includes sufficient details so graduates can make intelligent choices; and an interactive, electronic way for applicants to access this information.

Fourth, we should assist our upstate colleagues to recruit downstate graduates into their positions. Similar to other states, New York has a misdistribution of physicians and an acute shortage of primary care physicians in the rural counties. For those who chose family medicine because they were interested in working in a rural area, there ought to be a way to facilitate their recruitment to upstate counties instead of losing them to other states.

The next meeting of family medicine leaders from across the state is open to all four constituencies: hospital department directors; medical school chairs; program directors; and other family medicine leaders, such as clinic and medical directors. It is being held the night before the annual Congress of Delegates, thereby affording attendees the opportunity to stay on to meet with their counterparts: e.g., at the New York State family medicine program directors’ meeting; and/or the NYS family medicine hospital department directors meeting. The event will also conclude with a meeting between these assembled family medicine leaders and the NYSAFP Executive Committee. In addition to the opportunity for collective action to strengthen family medicine for the benefit of our patients, the meeting will provide a networking opportunity for sharing of vital information, and the chance to capitalize on our collective wisdom to help each other in our own roles.

The message: at a time when family physicians have long since become the largest providers of primary care in the nation, we are being asked to rise to the occasion of being the family doctors for more of the state’s population. There is already a shortage of us in New York State, the NYSAFP is asking our leaders to work together to address this shortage while strengthening family medicine all over the State of New York. Better now than tomorrow. Better tomorrow than later.

Montgomery Douglas, MD, is the Chair of the NYSAFP Education Commission and Associate Professor and Chair of the Department of Family and Community Medicine at New York Medical College.
2012 Family Doctor of the Year

Bruce Elwell, DO, of Marcy has been honored as Family Physician of the Year by the New York State Academy. Dr. Elwell was nominated for the award by several of his patients. They cited his compassion, understanding and diligence in pursuing a complete diagnosis.

“I feel that Dr. Elwell goes beyond what is expected of a family practice doctor,” one 91-year-old patient wrote. She explained that he routinely makes himself available to her as needed.

A resident of Marcy, NY, Dr. Elwell is a graduate of Colorado State University where he received a BS in microbiology and chemistry. He received his DO from the Chicago College of Osteopathic Medicine and completed a family medicine residency at the US Air Force Medical Center at Scott Air Force Base in Illinois.

Dr. Elwell has practiced family medicine since 1988. He is currently Medical Director for St. Luke’s Home in Utica and is also affiliated with Adirondack Community Physicians in Barneveld.

2012 Family Medicine Educator of the Year

William Bennett, MD, of Bayville has been honored as Family Medicine Educator of the Year by the New York State Academy. He was nominated for the award by several of his colleagues, who cited his commitment to medical education over the course of his career and his effectiveness as an educator, mentor and colleague.

“We have worked together on the family medicine clerkship curriculum for our new medical school here on Long Island, and he was part of the task force that helped create our department of family medicine,” wrote Tochi Iroku-Malize, MD, chair of the Department of Family Medicine at Hofstra North Shore LI School of Medicine.

Dr. Jana Galan wrote, “Dr. Bennett not only teaches and practices medicine, he inspires and stimulates his residents and his peers.” Dr. Elzbieta Tworzydlo wrote, “Dr. Bennett has a wonderful rapport with people of all ages. His ability to connect with his students and his talent at teaching, are both truly superior.”

Dr. Bennett is a graduate of Providence College where he received a BS in general science. He received his MD from the University of Bologna in Italy and completed a family medicine residency at Glen Cove Hospital.

Currently Director of the Glen Cove Family Medicine Residency Program, Dr. Bennett is also Director of Family Medicine Teaching Services and attending physician at North Shore University Hospital in Glen Cove; assistant clinical professor in Family Medicine at SUNY Stony Brook; adjunct clinical associate professor in the Department of Family Medicine at the New York College of Osteopathic Medicine; and Director of Medical Education for St. Georges at Glen Cove and associate professor at St. George’s University School of Medicine.
The rapidly growing and constantly morphing health system seems to bewilder even those that work with it and within it every day. With so much change it would seem that any source of familiarity would vanish in a constant dance of which specialist to go to for the latest treatment. However, the most striking themes that were introduced and reiterated when I entered medical school were, “they are people before they are patients” and “preventing is the best and easiest treatment.”

While it is easy to walk through a hospital and see people busily trying to treat, help, and comfort, it is a bit harder to find the few who might know the patient’s life story, transitioning the patient from someone to treat to someone to understand and make better. Although many specialties have aspects of this philosophy, family medicine takes this to a whole new level.

I first took an interest in family medicine based on going to my own family doctor. It was easy to feel safe and comfortable there because she knew every detail of my health and, moreover, details of my life that I thought had nothing to do with my health. She used all of this information to try and make me better by the time I left her office. My family doctor knew what to ask and I shared this knowledge without question because she had gained my trust through her medical wisdom and, additionally and more meaningfully, through her concern and compassion.

Currently I have the opportunity to see both the clinical aspect of family medicine and the long-term benefits the expansion of this practice would have. One of the issues in medicine is access to care. If you live in a rural area or need to travel hundreds of miles to see a doctor the chance that you will go early and often to someone you trust is smaller. More family doctors in places that need that “first line of defense” could reduce the severity of a person’s health issues, or even prevent the issues in the first place. Access to health care cannot be reduced to a simple equation; as a framework for moving forward it could be as simple as this: more family doctors in more places that need them would lead to more prevention and possibly less serious health issues.

All specialties in medicine are significant and necessary, each contributing to the picture of overall health. The unique aspect of family medicine is the power that comes with the knowledge about medicine coupled with the level of knowledge about the person.

Kristy Semenza, B.A., is a medical student in SUNY Upstate College of Medicine’s class of 2016.
Help Your Patients Enjoy Dairy Again

Many health authorities agree that low-fat and fat-free milk and milk products are an important and practical source of key nutrients for all people – including those who are lactose intolerant.1,2,3,4,5

In fact, the 2010 Dietary Guidelines for Americans (DGA) recognizes dairy foods as an important source of nutrients for those with lactose intolerance.6 Milk is the #1 food source of three of the four nutrients the DGA identified as lacking in the diets of Americans – vitamin D, calcium and potassium – and the DGA recommends increasing intakes of low-fat or fat-free milk and milk products to help fill these nutrient gaps.

A Solutions-Focused Approach

People who are lactose intolerant should know that when it comes to dairy foods, practical solutions can help them enjoy the recommended three servings of low-fat and fat-free dairy foods every day*, without experiencing discomfort or embarrassment:

• Gradually reintroduce milk back into the diet by drinking smaller amounts of milk at a time, trying small amounts of milk with food, or cooking with milk.
• Drink low-lactose or lactose-free milk products, which are real milk just with lower amounts or zero lactose, taste great and have all the nutrients you’d expect from milk.
• Eat natural cheeses, which are generally low in lactose, and yogurt with live and active cultures, which can help the body digest lactose.

Visit nationaldairycouncil.org for more information, management strategies and patient education materials.

Most people with lactose intolerance say they are open to dairy solutions as long as they can avoid the discomfort associated with consuming them.7 And research shows that people like lactose-free milk more than non-dairy alternatives.8

These health and nutrition organizations support 3-Every-Day™ of Dairy, a science-based education program encouraging Americans to consume the recommended three daily servings of nutrient-rich low-fat or fat-free milk and milk products, to help improve overall health.


* The 2010 Dietary Guidelines for Americans recommends 3 daily servings of low-fat or fat-free milk and milk products for those ages 9 and older, 2.5 cups for children ages 4 to 8 years, and 2 cups for children ages 2 to 3 years.
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