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DOCTOR'S ADVICE

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The Health Care Workforce

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Surinder Devgun, MD
President
Monroe County
Medical Society

"There are few guarantees in life. Death and taxes are often quoted but there is always a guarantee that the practice of medicine will change over time."

Exploring the Changing Face of Health Care

As all of the readers of this column know, there has been a huge transformation in health care in the past decade. This issue strives to explore a few of those changes and to alleviate any associated fears.

One of the main drivers of change has been the implementation of federally mandated, computer based, electronic medical record (EMR) systems. From a physician's perspective they are cumbersome and not very user friendly.

While there are many negative perceptions of EMR systems, they can allow an easy and central repository for all of a patient's medical information. Therefore, when you visit with your medical provider next time and their head is buried in their computer, see it as if they are reading from your manila folder, paper chart or writing orders on a form to request X-rays or lab work. Many providers have used an assistant in the room to enter data into the EMR, often referred to as a 'scribe'. The presence of a scribe in the room can assist your provider by accurately and efficiently entering pertinent information into the computer system. Having said that, there have been numerous physicians who have decided, instead, not to embrace EMR technology and trade up their shingles for some rest and relaxation during retirement!

With an aging baby boomer generation, there has been a decrease in physicians available who are able to see every patient that seeks medical care. As a result, the next time you visit your doctor's office you may be assigned to a nurse practitioner or physician's assistant. These providers are often referred to as advanced practice practitioners (APPs), physician extenders, or mid-level providers. They are trained to provide the best in medical care and decision making and are invaluable to providing detailed, meaningful management of their patient's health care. APPs are licensed by the state, highly trained in their field of practice and always mentored/supervised by a physician. Instead of waiting for a physician's schedule to become available, they can expedite your care. In the future, we will likely see more implementation of telemedicine to enhance access to providers presently limited to voice or video, but soon to include limited, remote physical examinations as well.

There are few guarantees in life. Death and taxes are often quoted but there is always a guarantee that the practice of medicine will change over time. Looking ahead, health care will continue to change and develop so that patients can receive the best care that medicine can offer. Looking back over the past 10 years you can see the rapid pace of change in the health care industry. Imagine looking back at today in 10 years to see how far we've come!

Dr. Devgun has been a private practice physician at Rochester Gastroenterology Associates since 2005. In addition, he is an attending Gastroenterologist at both Unity Hospital and Rochester General Hospital of Rochester Regional Health. Dr. Devgun volunteers as teaching faculty at Unity Health System's Medicine Residency program and is an author of numerous abstracts and posters with his residents. Dr. Devgun has been a member of Monroe County Medical Society since 2005.

Jean V. Joseph, MD, MBA
Medical Editor
Doctor's Advice

"To have the knowledge and skills to counsel, prescribe a medication, or to perform a lifesaving procedure is a true blessing, and an impact very few are lucky to have."

Making the Most of Patient-Practitioner Interaction

Regardless of specialty, the influence or impact a practitioner can have on a person's life is unparalleled. To have the knowledge and skills to counsel, prescribe a medication, or to perform a lifesaving procedure is a true blessing, and an impact very few are lucky to have. While these will remain constant factors, attracting younger generations to serve as health care professionals, the health care environment has undergone a number of unprecedented changes, either brought on by new discoveries, or regulations, that will continue to affect the patient provider relationship.

In this issue of Doctor's Advice, our members address a number of these changes, providing answers to many unanswered questions and challenges, while raising new ones. These range from balancing the physician work force, to finding ways to practice more efficiently, to the process of retiring, or for a patient to transition to a new provider.

Changes brought on by health care reform have changed the nature of the patient encounter. One such change has been the adoption of electronic medical records by practices at academic and community practices across the country. This has led to increased accessibility, transparency, and transportability of the medical record. For efficient and timely recording of the office visit, practitioners routinely seek to electronically document the encounter during the visit. The computer has been seen by some as a challenge, or a hindrance to an effective encounter, with the provider focusing on typing into the computer the details of the visit, as opposed to maintaining eye contact with the patient, or observing visual cues that can be helpful in the diagnostic process to prepare a treatment plan. It is an important skill some practitioners develop with experience where the encounter is documented during the visit, and neither the provider nor the patient feels impacted by the computer interface.

The use of scribes is a recent adaptation to the documentation process, to allow a provider and a patient to make the most of the interpersonal interactions, while documenting the encounter in the most efficient manner possible.

We invite you to explore further in this issue how our members tackle the incorporation of scribes into their practices, among other important topics in their quest to continue to improve the health care delivery process at every phase, and to make the most of the practitioner-patient relationship.

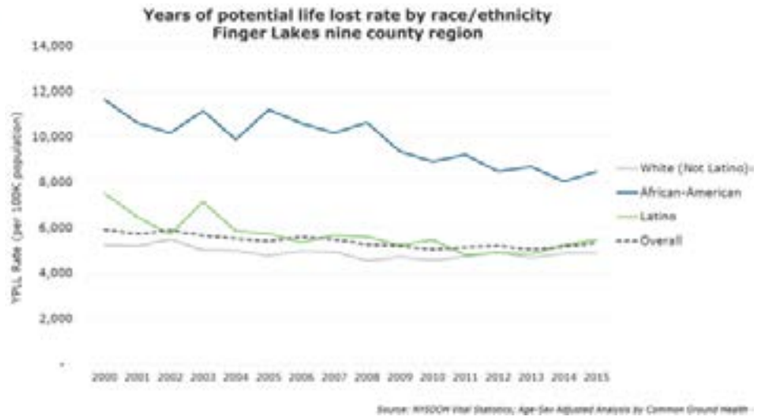
Dr. Joseph is the W.W. Scott Professor and Chairman of the Department of Urology. He is Director of the Center for Robotic Surgery and Innovation. He also serves as Professor of Oncology at the Wilmot Cancer Center of the University of Rochester Medical Center.

Variety is the Spice of Life

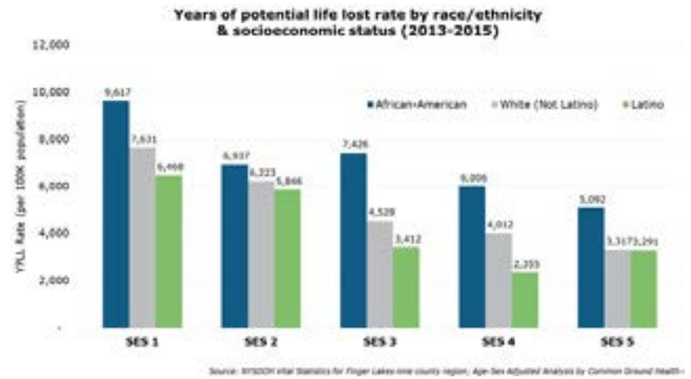
BY LINDA CLARK, MD

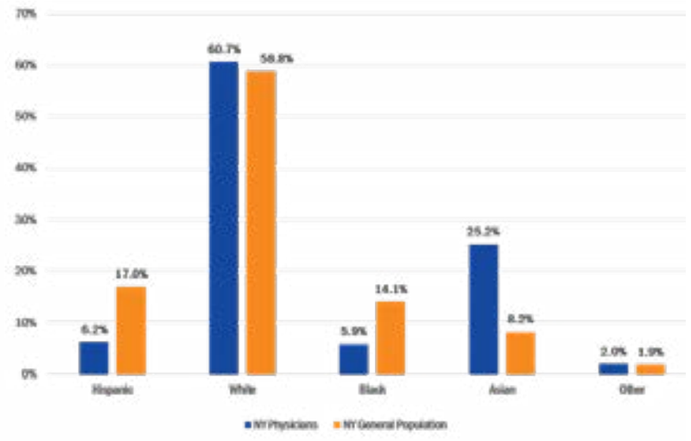
There are differences in the life expectancies of people depending on what race they are. This is a disparity. These differences in health are a problem in our nation and right here, in our own region. It is possible that having a greater variety of doctors may help decrease this disparity.

Reasons for health disparities are varied; we know that factors, such as race, residence, and poverty are linked. Data recently analyzed by Common Ground Health in the nine-county Finger Lakes region continues to show race and poverty to be drivers of poor health outcomes. Years of potential life lost– dying early –is disproportionately shouldered by African Americans in our region. The following graph, produced by Common Ground Health, shows this disparity. The blue line shows how likely an African American is to die early, compared to people in other racial and ethnic groups from 2000 to 2015. That line is much higher, showing a big gap in early deaths compared to whites (grey line) and Latinos (green line).



The next graph, also from Common Ground Health, shows that you are more likely to die younger if you are African American, no matter how much money you make or how far you went in school. SES1 represents people without as much money or education, and SES5 represent those with more money and education. If lack of money and education were the only reason a person was more likely to die young, the bars would be equal in each socioeconomic strata represented (race wouldn't matter). But, the blue bar (African American) in most of these strata rises much higher (more likely to die young), no matter how wealthy or poor. (Graph on following page). So how do we close the gap in health disparities? The answer is complicated and must be attacked on multiple fronts.





One part of the solution might be to have more doctors who are traditionally underrepresented in medicine. Race concordance (the doctor and the patient being the same race or speaking the same language) has been shown to result in more patient satisfaction and more agreement with suggested preventive tests (like getting a colonoscopy when advised by their doctor).

However, the representation of physicians in medicine is skewed. In New York, African American and Latino physicians are not represented in the same ratios as they are in the population in general. This is not true of white and Asian physicians. The following data is from The Center for Health Workforce Studies, at SUNY's University at Albany; they are committed to collecting and analyzing data to understand workforce dynamics and trends.

In the graph to the left, we see that African American and Latino physicians are not represented in medicine in the same percentages as they are in the population of New York. For instance, Latinos are 17% of the state population, but only 6.2% of physicians. Blacks make up over 14% of New Yorkers, but only 5.9% of physicians in New York. These physicians are "underrepresented" in New York.

It is critical that everyone in the community encourage individuals from diverse backgrounds to pursue careers in the medical field. We have to begin with children at the grade school level from underrepresented backgrounds, and continue our commitment to them throughout their educational and professional career. Supporting underrepresented medical students, residents and ultimately, university faculty, are all critically important to working towards the elimination of health disparities in our region.

Linda Clark, MD, MS, has been a resident of upstate New York for over 20 years. She graduated from Brown University and the University of Virginia. She is a co-founder of the Black Physicians Network of Greater Rochester and currently serves as the board vice-president. She sits on the Board of Directors for Trillium Health and serves on the Medical Society of the State of New York (MSSNY) Worker's Compensation and No-Fault Committee. Dr. Clark has maintained an interest in local and regional community activities throughout her time in Rochester, focusing on issues related to health equity, including co-chairing the African American Health Coalition convened by Common Ground Health, and chairing the MSSNY Committee to Eliminate Health Disparities. She also sits on the newly formed Women Physicians Committee of MSSNY.

References: *Alsan, Marcella et al. Does Diversity Matter for Health? Experimental Evidence from Oakland. Working Paper 24787. National Bureau of Economic Research; June 2018. Revised September 2018. JEL No. C93,I12, I14. http://www.nber.org/papers/w24787● Center for Health Workforce Studies: http://www.chwsny.org/ ● Cooper LA et al. Patient-centered communication, ratings of care, and concordance of patient and physician race. Annals of Internal Medicine, December 2003; 139(11): 907-916.● Waibel, Sina & Wong, Sabrina & Katz, Alan & Levesque, Jean-Frederic & Nibber, Raji & Haggerty, Jeannie. (2018). The influence of patient–clinician ethnocultural and language concordance on continuity and quality of care: a cross-sectional analysis. CMAJ Open. 6. E276-E284. 10.9778/cmajo.20170160.● Kelly-Blake K et al. Rationales for expanding minority physician representation in the workforce: a scoping review. Medical Education, June 2018.*

Electronic Medication Discontinuation

BY DEB PEARTREE

A patient's medication list, as maintained in an electronic medication record, does not always correspond to the list of medications actually being taken by the individual.

A major cause of problem of this problem is that, unlike the transmission of a new prescription order, a doctor's order to stop a medication is not typically transmitted to the patient's pharmacy. When automatic transmission of orders to discontinue a medication are sent, not all pharmacies are able to receive them. The consequences of this fragmented system are an unnecessary expense to both patient and payer and more importantly, serious risk to patient safety. This problem is not confined to our community.

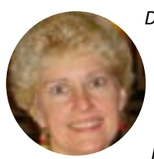
The American Medical Association recognized that there is an obvious absence of an effective electronic medication discontinuation system for use by providers and pharmacists within our county. The problem is further complicated by the reality that patients increasingly utilize non-traditional means (mail order, web-based, medisets, etc.) for the purchase and administration of their medications.

Presently there is no known or recognizable model of e-discontinuation in place anywhere in the U.S. This provides both a challenge and an opportunity for the upstate NY region to develop and demonstrate an effective, integrated system for e-discontinuation.

A Medication Reconciliation & Communication Workgroup was formed by the Monroe County Medical Society's Physician-Pharmacy Committee. It was created to develop electronic discontinuation communication methods that can be tested, and lobby for change to require national chains to reliably receive and process electronic medication discontinuation orders. The workgroup plans to focus on electronic and 'person to person' communication as well as physician practice and pharmacy workflows.

It is important for patients to be aware of this issue and the efforts to correct it. **Patients should be alert to any medications that are discontinued by their providers and let their pharmacy and doctor know when they receive a medication they thought was supposed to be discontinued.**

By working together with providers and pharmacies, patients can help prevent potential medication errors and unnecessary medication costs while identifying the effectiveness of improvement efforts.



Deb is currently serving as the Executive Director of the Rochester Integrated Health Network, Inc. and as a consultant supporting the PCMH Collaborative. She was selected by the Center for Medicare and Medicaid Innovation to serve as one of 72 Innovation Advisors. She is also an Institute for Healthcare Improvement certified Improvement Advisor, holds a Bachelor of Science Degree in Biology and Nursing from the State University of New York at Brockport and a Masters Degree in Health Systems Administration from Rochester Institute of Technology.

Get Connected to the Services and Supports You Need

BY HEALTH HOMES OF UPSTATE NY

Do you need help getting the medical services you need, or do you need help linking to food, housing or transportation? What about managing health conditions like diabetes, high blood pressure, asthma, mental health or substance use concerns? You may be eligible to join a Health Home.

What exactly is a Health Home? It's not a building or a place. It is a group of health care and service providers working together to make sure you get the care and services you need to live a healthy life. The Health Home program will pair you with a specially trained Care Manager who will make sure that all your doctors and other people helping you are working as a team to support you.

What can a Care Manager do for you? They coordinate your care by working with you to create a customized care plan that will help you manage your life, become self-sufficient, and coordinate your journey to better health. If you're looking for a primary care physician, or a mental health or substance use provider, your Care Manager can help you find one that's right for you. They may even be able to connect you with someone who has had similar life experiences as you. Your Care Manager can help with making and reminding you about appointments, managing your medications, and keeping your treatment on track. They can help you better understand all your health concerns and help you to lead a healthier life.

Your Care Manager is familiar with your community and can help link you to resources like social services and legal assistance. They can also help connect you to other non-medical services such as job training, child care, and transportation. Do you want to connect to social activities in your community, or do you want to better manage your money? Maybe you need help finding affordable housing. Your Care Manager can help. All this means better care for you and greater access to services and programs for added support, all with a team of people behind you.

Most Medicaid recipients can join a Health Home at no cost. Enroll in a Health Home today. Contact Health Homes of Upstate New York (HHUNY) at 1-855-613-7659 or visit www.hhuny.org, and click on 'Make a Referral'.

Health Homes of Upstate New York is a management services organization (MSO) formed in 2013 that provides administrative support and governance to four affiliated Health Homes and over 65 Care Management agencies in New York State. Many Medicaid beneficiaries suffer from multiple or severe chronic conditions and benefit from organized coordination and management of the health and long-term services they receive. HHUNY, through New York Care Coordination Program's (NYCCP) extensive work in practice transformation research and implementation initiatives, has been at the forefront of adopting a person-centered, recovery-focused delivery service model for its members. HHUNY is a subsidiary of New York Care Coordination Program who since 2002 has engaged in transformation initiatives in efforts to accomplish its mission of creating a person-centered, recovery-oriented system of care.

Pool Safety Tips from healthychildren.org

Powered by pediatricians. Trusted by parents. from the American Academy of Pediatrics

Follow these tips from the American Academy of Pediatrics to protect children from drowning.

● Never leave children alone in or near the pool or spa, even for a moment; close supervision by a responsible adult is the best way to prevent drowning in children.

● Whenever children under age 5 are in or around water, an adult – preferably one who knows how to swim and perform CPR – should be within arm's length, providing "touch supervision."

● Install a fence at least 4 feet high around all four sides of the pool. The fence should not have openings or protrusions that a young child could use to get over, under, or through.

● Make sure pool gates open out from the pool, and self-close and self-latch at a height children can't reach. Consider alarms on the gate to alert you when someone opens the gate. Consider surface wave or underwater alarms as an added layer of protection.

● The safest fence is one that surrounds all 4 sides of the pool and completely separates the pool from the house and yard. If the house serves as the fourth side of the fence, install an alarm on the exit door to the yard and the pool. For additional protection, install window guards on windows facing the pool. Drowning victims have also used pet doors to gain access to pools. Keep all of your barriers and alarms in good repair with fresh batteries.

● Keep rescue equipment (a shepherd's hook – a long pole with a hook on the end — and life preserver) and a portable telephone near the pool. Choose a shepherd's hook and other rescue equipment made of fiberglass or other materials that do not conduct electricity.

● Avoid inflatable swimming aids such as "floaties." They are not a substitute for approved life jackets and can give children and parents a false sense of security.

● Children over age 1 may be at a lower risk of drowning if they have had some formal swimming instruction. However, there is no evidence that swimming lessons or water survival skills courses can prevent drowning in babies younger than 1 year of age.

● The decision to enroll a child over age one in swimming lessons should be made by the parent based on the child's developmental readiness and exposure to water, but swim programs should never be seen as "drown proofing" a child of any age.

● Avoid entrapment: Suction from pool and spa drains can trap a swimmer underwater. Do not use a pool or spa if there are broken or missing drain covers. Ask your pool operator if your pool or spa's drains are compliant with the Pool and Spa Safety Act. If you have a swimming pool or spa, ask your pool service representative to update your drains and other suction fitting with anti-entrapment drain covers and other devices or systems.

● Large, inflatable, above-ground pools have become increasingly popular for backyard use. Children may fall in if they lean against the soft side of an inflatable pool. Although such pools are often exempt from local pool fencing requirements, it is essential that they be surrounded by an appropriate fence just as a permanent pool would be so that children cannot gain unsupervised access.

● If a child is missing, look for him or her in the pool or spa first.

● Share safety instructions with family, friends and neighbors.

Growing the Infant and Early Childhood Mental Health Workforce:

Why it Matters for Kids and their Caregivers

BY STEPHANIE DAVID, JD, MPH

Social-emotional health. ACEs. Trauma. Resilience. Whether you are a parent, health care provider, social worker, early childhood educator, or advocate, these words are becoming embedded in our shared language around child development. Our improved awareness of the lifelong impact that the presence or absence of these factors have on a child's health and wellbeing, paired with the extraordinary degree of brain development during the first three years of life, point us in a clear direction: strong, nurturing relationships are essential from the moment of birth.

With increasing, multidisciplinary interest in the development, wellbeing and health of infants and young children, the field of Infant and Early Childhood Mental Health (IECMH) has gained significant attention in recent years from parents, policy makers, and a wide variety of child-serving professionals.

IECMH centers on the capacity of children, birth to age six, to experience, regulate and express emotions; form close and secure relationships; and explore the environment and learn, all within the context of the caregiving environment that includes family, community and cultural expectations for young children. Developing these capacities is synonymous with healthy social and emotional development.

Our community's need for qualified, IECMH-trained professionals far exceeds what our system can offer currently. With Rochester's child poverty rate being the highest in the nation for comparably-sized cities, and many caregivers across our region experiencing depression, substance abuse and other hardships that put stress on the child-parent relationship, it is critical we equip our child and family professionals with the knowledge and tools of IECMH to better serve our families.

The Infant and Early Childhood Mental Health Workforce

The IECMH workforce includes all professionals who work with, or on behalf of, young children and their primary caregivers. The role of each discipline within this field varies depending on the needs of the child and family being served.

Adapted from the Child Health and Development Institute of Connecticut (2015)

The primary care workforce -- including pediatrics, family care and obstetrics/gynecology – is uniquely positioned to play a role in the prevention and early identification of social-emotional development concerns in young children. From birth through age five, primary care providers see children, ideally, 15 times for well-child visits. These visits give providers an opportunity to assess several important factors relevant to the child's social-emotional health during this critical period of development.

First, through regular child developmental screening, providers are able to identify potential concerns, offer guidance and make referrals to other health care and community resources when needed. The American Academy of Pediatrics (AAP) recommends that every well-child visit in the first five years of life include a family-centered psychosocial/behavioral assessment that may include child social-emotional health, caregiver depression and social determinants of health.

Second, providers are able to observe the interactions between the child and caregiver during each visit. For example, where the adult present with the child is a parent or primary caregiver, the physician can take note of the pair's relationship, including whether the child seeks comfort from the caregiver and how the caregiver responds to the child's fearfulness, crying or other behavior.

Finally, the child's health care provider (or the caregiver's primary care provider and/or ObGyn) can observe and screen for the mental health and wellbeing of the caregiver. This is especially important in the postpartum period, where caregiver depression can have lifelong consequences on the infant's social-emotional development by interfering with the caregiver-infant attachment. Beginning with prenatal visits and monitoring for signs of depression before and after birth, the pre- and post-natal provider can assess the caregiver's mental health and connect them with needed mental health services, home visiting and other supports.

Continuing through each of the child's acute and well-child visits, health care providers have an opportunity to assess wellbeing of both caregiver and child as individuals, and with regard to the relationship and interactions they have with each other.

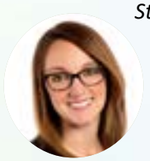
Building the IECMH Workforce in Monroe County and Beyond

Despite its importance, many pediatricians and other child and family-serving health care providers are not trained in IECMH. Fortunately, opportunities for provider training and IECMH supports for families and caregivers continue to grow across our region, state and nationwide.

Zero to Three (www.zerotothree.org), a national organization focused on infant and toddler social-emotional health, has a wealth of information available on its website and is a good place to begin learning more about IECMH. From parenting, early learning, and child development, to continuing education and advocacy opportunities, Zero to Three is a go-to resource for parents, caregivers, health care providers, and all other child- and family-serving professionals.
Locally, the Society for the Protection and Care of Children, the Children's Institute, and Mt. Hope Family Center are among several organizations that provide services, supports, and training in IECMH. The New York State Association for Infant Mental Health (www.nys-aimh.org) also provides guidance on where to find additional information and training in IECMH.

Reflections and a Call to Action

Building up our collective IECMH knowledge and putting it into practice across all child-serving disciplines has the potential to make a positive, meaningful impact for all children and families in Monroe County and throughout the region. Working together, providers can help infants, young children and their caregivers build strong, trusting, and responsive relationships from birth, and lay the foundation for healthy social-emotional development and lifelong success.



Stephanie David, JD, MPH is a Children's Health Policy Associate for Common Ground Health where she provides expertise and guidance on policy-change opportunities for advancing whole child health in Monroe County and throughout the Finger Lakes region. She is on the Board of Directors for the New York State Association for Infant Mental Health and is a member of ROC the Future's School Readiness Collaborative Action Network on Workforce Development.

References:

"The Infant Mental Health Workforce: Key to Promoting the Healthy Social and Emotional Development of Children." March 2015.https://www.chdi.org/index.php/publications/reports/impact-reports/infant-mental-health-workforce. Accessed Feb. 4, 2019.

"Promoting Optimal Development: Screening for Behavioral and Emotional Problems." Feb. 2015. http://pediatrics.aappublications.org/content/pediatrics/135/2/384.full.pdf. Accessed Feb. 4, 2019.

"Demystifying Infant Mental Health: What the Primary Care Provider Needs to Know." 1 Jan. 2017. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4684956/. Accessed Feb. 4, 2019.

"Incorporating Recognition and Management of Perinatal Depression Into Pediatric Practice." Jan. 2019. http://pediatrics.aappublications.org/content/pediatrics/135/2/384.full.pdf. Accessed Feb. 4, 2019.

Why is My Doctor Retiring?

BY JERRY SVOBODA, MD, FACS, COL (RET)

"I just got a notice from my doctor's office that she is retiring."

"I FINALLY FOUND A DOCTOR THAT I TRUST AND NOW I FIND OUT THEY'RE RETIRING. I'M REALLY MAD!"

"My doctor can't retire! He's younger than I am!"

Sound familiar or heard about a similar story? It is not uncommon. When doctors retire, patients usually want to know: why this is happening and what should they do now?

There are good answers to both of these questions, though not necessarily what most patients would like to hear. Read on:

Unfortunately, it is true that more doctors are retiring sooner and earlier than many of them would have estimated when beginning their careers. The question of 'why' is pretty easy to figure out and generally has to do with the changes going on in American health care. The 2018 Physicians Foundation Survey of almost 9000 doctors is telling. Eighty percent are at full capacity or overextended, 78% sometimes, often, or always experience feelings of burnout, and 56% say that electronic health records have reduced their efficiency (only 29% said this in 2016). Furthermore, this survey found that 62% of physicians are pessimistic about the future of medicine, 49% would not recommend medicine as a career to their children, and 46% even plan to change their career path! You can look at these and other rather startling survey results by searching '2018 Physicians Foundation Survey' on the internet.

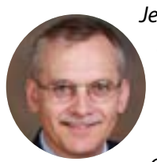
The cause of these answers is complex but much of it centers on American medicine becoming increasingly regulated since the 1980s. This has led more graduating physicians to start their careers as an employee (most often as a health system employee), rather than starting or joining a private practice. Part of this regulation has been the widespread adoption of electronic health records nationwide, a largely untested and irreversible change. This adoption has not been smooth but was easiest for younger physicians and patients. Older patients and doctors adjusted, though some missed the friendlier feel the office visit once had. Now the computer has become a part of life for doctors and patients in nearly all hospitals and offices. It is a major change in American medical culture.

How to turn around some of the negativity in American medical practices today is the topic of much discussion among physicians, medical educators, and health system planners and remains unanswered. It would take a book to get a handle on the subject and after reading it, you would still be wondering what American medicine will look like 5, 10, or 20 years from now. Things brighten up with considering the, 'What do I do now?' question that comes with the news that your doctor is retiring.

If you've been notified that your doctor is retiring, hopefully, it hasn't already happened and won't for several months. The notice, by mail or email, may come with a plan. For example, many doctors have in-office associates that begin taking care of their patients during vacations or absences, such that their patients are often acquainted with the care by, or at least the face of, the younger associate who will be the natural one to assume their care. Alternatively, a health system-based practice may provide a younger physician as an associate to a solo practitioner approaching retirement, facilitating a smooth hand-off for both the patient and the system. Often, in a planned retirement, patients receive notice 3-6 months in advance, permitting the departing physician to provide a personal introduction to his/her replacement at an interval scheduled visit. Sometimes, the announcement letter may come with a suggested practice's name, or information that your records will be transferred to a certain office unless you specify otherwise. If you decide to go along with a provider plan that's been offered to you as part of a retirement announcement, the transition will likely be effortless and as smooth as possible for you.

However, if you've been dissatisfied with the care of the retiring doctor or are uncomfortable with the one picking up the baton, a retirement announcement is an opportune time to switch to a new practice. Of course, this is something that you are really free to do at any time, at least within the confines of your insurance plan. It is most courteous to make such a change by a letter to the practice, asking for your records to be transferred to your new provider. A phone call for this purpose can work, too, but leaves no record for you of the 'statement of your wishes' and may be embarrassing for you to make. Either one of these is a better option for you, and the old practice, than simply disappearing. That would put the new practice at a disadvantage. One letter, that takes only ten minutes to write, will avoid a lot of potential problems and misinformation, making the assumption of your care easier and safer for you and the new practice. After you have made your initial appointment with the new provider, send a copy to both the outgoing and incoming practice.

Finally, here are some suggestions for finding a new doctor if you don't wish to accept the hand-off plan of the retiring physician or if one isn't offered. The two time-tested methods are: 'word of mouth', and calling the county medical society, which most often maintains a list of physicians accepting new patients. Locally, that would be www.mcms.org/FindaPhysician. The third method, of course, is to look online for physicians in your area and check their reviews. Unfortunately, some online reviews can be misleading. 'Word of mouth' seems to be the most satisfactory route. A friend who is happy with their doctor usually wants to share the good news. You may be pleasantly surprised with the response you get from your best friend about their great doctor when you tell them you're losing yours. Even doctors have doctors. An older doctor is generally happiest with a personal physician who is younger than they are... you can be, too!



Jerry Svoboda, MD was born in Cleveland in 1951 and started working in a hospital in high school. He graduated from Hahnemann Medical School (now Drexel) in Philadelphia, PA in 1977. He interned in Denver, CO, completed his surgical residency in Sayre, PA, and his vascular fellowship in Englewood, NJ. Dr. Svoboda and his wife Adelaide, have been married 42 years. They moved to Rochester in 1984, and currently reside in Brighton. They have two grown children and two grandsons.

Medical Scribes: Exam room intrusion or physician attention expander?

BY J. CHAD TEETERS, MD

We all know the cliché. A patient goes to their physician visit to discuss a problem or for their annual physical and the physician spends most of the visit with their back to the patient, documenting on a computer, which de-personalizes the doctor-patient relationship and harms the value of the encounter for the patient and the physician. As a busy Cardiologist, I myself had made a conscious effort to minimize my use of the computer in the exam room, so as not to introduce that experience for my patients; however, I was always struck by how much time my patients perceived I spent on the computer during my interview/exam with them. Likewise, in many specialties, such as Primary Care, it is almost essential that the physician utilize the computer during the patient encounter to be able to accurately document what occurred, generate the necessary prescriptions/referrals/orders, and to avoid long hours at the end of the day catching up on documentation. Unfortunately, a recent study from The John Hopkins University School of Medicine showed that internal medicine residents spent just 12 percent of their time with patients and 40 percent of their time on computer-related or administrative tasks. Documentation and interaction with electronic health records are a leading cause of physician burnout and in many cases is driving physicians from clinical practice. For patients, these documentation requirements leave them feeling less connected with their physician and lead patients to report spending less time with their doctor or having a harder time finding a doctor because of the lack of appointment availability.

In my own clinical practice, I experienced all of these issues – more time spent on non-patient care, less satisfied patients, longer hours to complete documentation and less time spent with my family and my own health. I knew something had to change, and thus I opted to utilize a medical scribe. Medical scribes are often medical technicians, nurses or in some cases students interested in getting into medical school, who are looking to gain experience working in a medical environment. They do not provide care, but rather, accompany a physician into their office visit with a patient and capture the pertinent details, generate notes and sometimes orders, for the physician to review and sign off on at the conclusion of the visit. The ultimate goal is more face-time between physicians and patients and less time performing data entry into the computer for the doctors, but with equal or greater accuracy collecting the details of the visit. There is no cost to the patient for the scribe accompanying the physician, and in many cases, the scribe will not speak at all during the patient encounter. However, as a physician who prided himself on having close relationships with my patients, I worried how the dynamic of my patient visits may change with the scribe in the room.

Would patients see this additional person as intrusive?

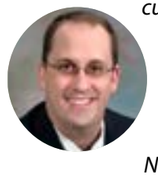
Would I change my conversation to ensure the scribe captured all the pertinent details?

Would my notes no longer be as thorough or useful to myself or other physicians who read them?

As I would come to learn over the last 3 years working with scribes, not only were my fears unjustified, but I found my patients to be appreciative that I was trying to improve my communication with them. I also learned that my patient interaction was different, but actually far improved, as I did not have the stress of trying to capture details in the computer and rather I was able to be more present with the patient in the exam room. I was shocked at how patients would leave comment cards indicating how much they appreciated how the scribe improved our visit by allowing me to be more engaged, and even how my notes became more comprehensive and reflected the full scope and details of our conversation. While occasionally patients would ask if the scribe could step out for a part of the discussion, or even if I would come in for the visit without the scribe, this was by far the exception rather than the rule. Certainly, for any exam or procedure that required the patient to be undressed, I would ask the scribe to step out or ask the patient's permission for them to remain, if beneficial. Scribes are only allowed in the room with the patient consent. I have been surprised at how many times patients reported wishing there was more use of scribes so that the physician could be more engaged. If my scribe was unavailable due to illness or time off, I found it interesting that patients began to ask why my scribe wasn't accompanying me far more frequently than asking if the scribe could step out.

We have reached an era where appropriate documentation is important for physicians and patients so that patients can use the notes for their own records, referrals and procedures are adequately justified and covered by insurance, and physicians have the capacity to accept new patients or see patients when they are most ill. It is estimated that within the next decade there will be a shortage of up to 120,000 physicians in the United States. Thus, optimizing use of a physician's time will only become more essential. I myself found that I was able to increase my number of patients seen by 14% after using medical scribes. This translates into an additional 2-3 patients per workday for someone seeing 20 patients a day.

Therefore, for patients and physicians alike, embrace the opportunity that medical scribes can provide! It may just improve the doctor-patient relationship for you both!



Dr. Teeters is an Associate Professor of Clinical Medicine at the University of Rochester Medical Center. He currently serves as the Executive Medical Director for Accountable Health Partners, an IPA affiliated with the University of Rochester Medical Center. He also is the Chief of Cardiology at Highland Hospital where he has been on faculty since 2009. Dr. Teeters completed his residency, chief residency, and fellowship at the University of Rochester Medical Center after completing his MD and undergraduate studies at the University of North Carolina at Chapel Hill. Dr. Teeters is married to Dr. Jennifer Campbell, a practicing primary care physician in the Rochester community and together they have two daughters.

ROCOVERY FITNESS

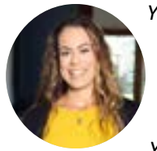
BY YANA KHASHPER

I did not grow up aspiring to become addicted to drugs and alcohol. Addiction is an overpowering, debilitating disease that does not discriminate and knows no bounds. I certainly did not think I would be able to crawl out of the darkness and create a life beyond my wildest dreams. Recovery is a gift. It is readily available to all who struggle.

You see, addiction is not a moral failing; we are not fundamentally flawed. We have a chronic health condition, the symptoms of which include a complete disconnection from reality which forces us to no longer be the people that we once were and act on the morals and values we once had. I once heard someone say that in active addiction, the need to use drugs and/or alcohol is stronger than the desire to breathe. Try holding your breath underwater and see how long that lasts before you come up gasping and desperate for air. I bet you would bulldoze anyone and anything that stood in your way of that breath. You get the point.

Recovery is possible! It is beautiful and magical and can be so much fun. Don't get me wrong, it is not easy but it is definitely worth every second. When I first got out of treatment, I did not have sober friends or healthy coping skills. I did not have hobbies or outlets. I needed help from people that were just like me – those who have been through this journey and have found a better way. The power of community is unshakeable and the recovery community is no different. I was lifted up and carried until I could stand on my own two feet. The greatest gift of all is that I started having fun and I found purpose.

Early on in my recovery, I was introduced to the wonderful work of fitness and the great outdoors. I fell in love. Here was my outlet, my way of coping with the stressors and building confidence, self-esteem and self-worth. I am no longer a drug addict or alcoholic. I AM a runner, a cyclist, a weight-lifter, a friend, and a daughter. I HAVE Substance Use Disorder. I not only work and pay taxes, together with my partner, we started our very own nonprofit based around community, health and wellness. ROCovery Fitness. It is a place of healing and recovery, a safe place that is nurturing and supportive of all. Together we bike, and hike, climb mountains, lift weights, plow through our PRs (personal records), celebrate holidays, offer support and live life free from substance. ROCovery is a free program, open to anyone with a minimum of 48-hours of continuous sobriety Family and friends are greatly encouraged to attend. You see, we are all in recovery from something and we are all in this together. We do not differentiate, do not shame or scold. We grow and prosper together. ROCovery is a place without stigma, a place that is full of love and camaraderie. Come in for a tour, see the magic for yourself and experience the beauty of recovery. You have nothing to lose and everything to gain. Now let's get busy living – sober. For more information visit our website (www.rocoveryfitness.org) and check us out on social media.



Yana is a Certified Personal Trainer through NASM and a Certified Peer Recovery Advocate (provisional). She is from New York City and has resided in Western N.Y. since 2012. Yana is a Licensed Clinical Social Worker with extensive experience in trauma, addictions, and mental health. She graduated Magna Cum Laude from New York University and went on to work with The New York City Fire Department Counseling Unit where her focus was to provide services to firefighters and emergency personnel of the FDNY impacted by the WTC tragedy and other disasters. Yana's addiction took hold of her life during this time leading to complete incapacitation. She struggled for years before finding recovery. It was not until she found physical activity and exercise that she felt a sense of freedom and purpose in her life. She found that being outdoors has significantly strengthened her spirituality and given her added tools she needed to live sober and free. She wants to share this gift with others who are on similar journeys of their own. Get busy living!

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