WESTCHESTER PHYSICIAN

July/August 2016 **Volume 32, Issue 7**

PRESIDENT'S MESSAGE

GIVING UP PRIVATE PRACTICE AND THE CORPORATIZATION OF MEDICINE (PART 1)

After 31 years in private practice I closed my PC medical practice; and had it taken over by a corporation for one dollar. That is the first misconception of many that people have; small practices in today's world are worthless, and are not sold for profit, or to be a retirement fund. We get absorbed into a large corporation and are given a salary.

When patients return for a visit to see me, they now have to fill out all sorts of corporate forms, get asked a lot of personal financial questions, and complete forms to obtain payment. They cannot see me until it is done. It is clear to me, and them, that they are not my patients anymore; but have become the corporation's clients.

The only choices I had were either to retire, or to get a job. As I still need to support my children, and build a retirement fund; I needed to take a job. I never excepted to become rich as a doctor, but I always thought I would make enough to send my children to school, and retire at a reasonable age too. Not only is that not possible for me, but I have not been able to do for my children what my father, who was a doctor, did for me.

In my last year of practice as an Oncologist, I made just $56,000.00, even though I grossed close to $2 million dollars in my practice. The overhead, through government and insurance mandates, and requirements to continue in practice, were continuing to go up; I would have needed another $40,000.00 to update my computer systems in the next year. I realized that I could not afford to stay in private solo practice any longer.

As an employee of a corporation, payment to the corporation for the identical services I provided for my patients increased, simply because I belong to the corporation. So I have explained to my patients that I had to join a large group in order to continue to see them.

I am at Northern Westchester Hospital, a not-for-profit institution that has operated in the black for 100 years. But due to the same financial pressures that happened to me; the hospital sold itself to the Northwell Group this year. The board of directors felt the hospital could not survive and thrive on its own.

(Continued on page 8)

GINO C. BOTTINO, MD
President, WCMS

INSIDE THIS ISSUE

UPCOMING EVENTS

WCMS/WAM Annual Pool Party & Barbecue
Sunday, August 21, 2016
West Harrison, New York

WAM 7th Annual Golf Outing
Thursday, October 6, 2016
Westchester Country Club
99 Biltmore Avenue
Rye, New York

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FROM THE EDITOR…
PETER J. ACKER, MD
GOOD NIGHT, IRENE

In the days leading up to Hurricane Irene, I felt an anticipatory excitement as I followed its course and viewed its gargantuan size on the satellite images. Of course, I was mindful of the potential destruction and suffering that such a behemoth was likely to inflict, but still I could not suppress a boyish enthusiasm at this break from the mere quotidian and dull weather patterns. Part of it was that I wasn't scheduled to be on call and thus would not have to worry about wending my way through thickets of downed trees and loose electrical wires in order to see a patient in the emergency room. I made the usual preparations around the house – gathering loose objects outside and making sure that we had plenty of batteries and candles. On Saturday evening my wife and I settled in to await the storm.

My mind harkened back to the last major hurricane to directly strike New York: Hurricane Gloria in 1985. I remembered it well because that was the year that our first child was born, Karen, who is now a fourth year medical student. She was just 2 months old and as every new parent will attest, once you have a child you learn to worry in a whole new way. I was much less casual about that storm. We taped all our windows of our Queens apartment and placed our infant daughter in the hall way to avoid any possible broken glass.

I wanted to stay up and watch the storm, but alas I fell asleep and missed the brunt of the high winds that my neighbors later told me were quite fierce at about 3 – 4 in the morning. I woke to find that we had lost power, but the winds had already abated somewhat, though the rain was coming down in buckets. We ventured out around midday, and walked up our small street, encountering fallen trees and neighbors who similarly were out assessing the effect of this rare event. There is nothing like a storm to bring out neighborly bonhomie and we chatted amiably, comparing notes and generator capacities.

Memories from even further back were stirred. Hurricane Donna struck Miami in 1960 where I spent most of my boyhood (and interestingly, barreled up the East coast to hit New York dead on). The atmosphere of my street today was redolent of that in Miami with branches and debris strewn everywhere. A large tree fell into our swimming pool and I remember vividly the boyish pleasure of swimming under the water weaving my way through the branches until my father spotted me.

(Continued on page 20)

NEW YORK STATE OF OPPORTUNITY. Department of Health

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SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

July 7, 2016

TO: Healthcare Providers and Local Health Departments
FROM: New York State Department of Health (NYSDOH), Bureau of Immunization

INFORMATIONAL MESSAGE:
LIVE ATTENUATED INFLUENZA VACCINE (FLU NASAL SPRAY)
NOT RECOMMENDED FOR 2016-17 FLU SEASON
Please distribute to the Medical Director, Vaccine Coordinator, and all healthcare providers that order or administer influenza vaccines.

SUMMARY

- On June 22, 2016, the Centers for Disease Control and Prevention (CDC)'s Advisory Committee on Immunization Practices (ACIP) voted in favor of an interim recommendation that live attenuated influenza vaccine (LAIV), also known as the "nasal spray" flu vaccine, should not be used during the 2016-17 flu season.
- The ACIP recommendation must be reviewed and approved by the CDC's Director, and the final recommendations will be published in a CDC Morbidity and Mortality Weekly Report (MMWR) in late summer or early fall.
- The ACIP and NYSDOH continue to recommend annual flu vaccination, with either the inactivated influenza vaccine (IIV) or recombinant influenza vaccine (RIV) for everyone 6 months and older.
- The ACIP vote follows data showing poor or relatively lower effectiveness of LAIV from 2013 through 2016.
- Overall, IIV vaccine efficacy was 49% in the 2015-16 season, indicating that millions of people were protected against flu last season.
- The ACIP vote may have implications for vaccine providers who have already placed flu vaccine orders for the 2016-17 season.
- Based on manufacturer projections, the CDC expects that supply of IIV for the 2016-17 season should be sufficient to meet any increase in demand resulting from the ACIP recommendation.
- The NYS Vaccines for Children (VFC) Program will make every effort to fill VFC influenza vaccine orders, as supply allows. VFC providers will be notified when influenza vaccine orders open for the 2016-17 season.
- Healthcare providers who have purchased or pre-ordered private influenza vaccine should consult with the vaccine manufacturer or vaccine distributor. Providers seeking to purchase additional doses of private IIV or RIV vaccine may need to check more than one supplier or purchase a flu vaccine brand other than the one they normally select.
- The NYSDOH will share any additional information about influenza vaccines and the upcoming flu season as information becomes available. Healthcare providers can also check for updated immunization information on the NYSDOH Immunization News web page (http://www.health.ny.gov/prevention/immunization/immmunization_news.htm).

(Continued on page 4)

(Continued from Page 3)

LAIV VACCINE EFFICACY

The June 2016 ACIP recommendation that LAIV not be used in the 2016-17 season was made on the basis of vaccine efficacy (VE) data. During the 2015-16 season, VE data provided by the U.S. Flu VE Network indicated that LAIV had offered no significant protection against influenza A (H1N1) virus, the predominant flu virus circulating last season, among study participants ages 2 through 17 years of age. The preliminary VE for LAIV against any influenza virus in studied children was 3% (95% CI: -49% to 37%) compared with 63% VE for IIV (95% CI: 52% to 72%). There was evidence that VE for IIV was statistically better than LAIV for influenza A (H1N1) virus but not for influenza B viruses; VE for influenza A (H3N2) viruses could not be assessed due to insufficient data.

The disappointing LAIV VE data from the 2015-16 flu season followed two previous seasons (2013-14 and 2014-15) which also showed poor and/or lower than expected VE for LAIV.

For the 2014-15 flu season, the ACIP and CDC had issued a preferential recommendation for the use of LAIV in healthy children 2 through 8 years of age. The 2014-15 recommendation had been based predominantly on data from two randomized control trials of LAIV and IIV which had measured superior efficacy of LAIV among young children during the 2002-03 and 2004-05 flu seasons. However, in February 2015, the ACIP and CDC did not renew the preferential recommendation for LAIV, on the basis of data showing poor VE of LAIV against influenza A (H1N1) in the 2013-14 and 2014-15 seasons.

The reason for the poorer overall performance of LAIV compared to IIV over the last few flu seasons is not well understood. It was initially hypothesized that the reduced effectiveness was due to reduced vaccine stability caused by a single amino acid mutation in the strain of influenza A (H1N1) that was contained in LAIV in the 2013-14 season. As a result a new H1N1 vaccine virus was used in LAIV formulations for the 2015-16 season. However, despite the change in the H1N1 virus component of the LAIV vaccine, VE data for the 2015-16 season again found that LAIV was less effective than IIV.

INFLUENZA VACCINE SUPPLY

The CDC anticipates that the supply of IIV for the 2016-17 season should be sufficient to meet any increase in demand resulting from the ACIP recommendation. Vaccine manufacturers have projected that as many as 160 million doses of IIV and RIV will be made available for the 2016-17 season. However, healthcare providers seeking to order additional doses of private IIV or RIV vaccine may need to check more than one supplier or purchase a flu vaccine brand other than the one they normally select. Healthcare providers who have purchased or preordered private influenza vaccine will need to consult with the manufacturer or vaccine distributor.

One influenza vaccine was recently FDA-approved for an expanded age indication, and a second is awaiting FDA decision later this year on an expanded age indication. In May 2016, the FDA approved an expanded age indication for quadrivalent Flucelvax (cell culture-based IIV; Seqirus, Inc.) for immunization of persons 4 years of age and older against influenza virus subtypes A and B. Flucelvax had initially been FDA approved in November 2012 for vaccination of adults ages 18 and older. The FDA is also anticipated to issue a decision in November 2016 regarding GSK's application for an expanded age indication for Flulaval (IIV; GSK) for persons 6 months of age and older. It is not yet known what impact these age indications will have on vaccine availability in the 2016-17 season.

VACCINES FOR CHILDREN PROGRAM

The NYS VFC Program will make every effort to fill VFC influenza vaccine orders this coming season, as vaccine supplies allow. Influenza vaccine is not yet available for the 2016-17 season, and it is not yet known how VFC influenza vaccine availability will be impacted by the ACIP recommendation. VFC providers will be notified when influenza vaccine orders open for the 2016-17 season, and the NYSDOH will share information regarding vaccine availability as such information becomes available.

RESOURCES

• CDC. ACIP votes down use of LAIV for the 2016-2017 flu season. www.cdc.gov/media/releases/2016/s0622-laiv-flu.html.
• FDA Vaccines, Blood & Biologics. Flucelvax. www.fda.gov/BiologicsBloodVaccines/Vaccines/ApprovedProducts/ucm328629.htm.
• Flu Supply News. List of Distributors. www.flusupplynews.com/www.flusupplynews.com/Navigation/FluSeason/ListofDistributors/List_of_Distributors.aspx.
• National Adult and Influenza Immunization Summit. Influenza Vaccine Availability Tracking System – IVATS. www.izsummitpartners.org/ivats/.
• NYSDOH. Seasonal Influenza Information for Health Care Providers. www.health.ny.gov/diseases/communicable/influenza/seasonal/providers/.
• NYSDOH. New York State Vaccines for Children Program. www.health.ny.gov/vfc.
• CDC. What You Should Know for the 2016-2017 Influenza Season. www.cdc.gov/flu/about/season/flu-season-2016-2017.htm.
• NYSDOH. Immunization News. www.health.ny.gov/prevention/immunization/immmunization_news.htm.

Westchester County Medical Society
Westchester Academy of Medicine

Annual Member Pool Party & BBQ

Sunday, August 21, 2016 1-5 PM

At the home of Drs. Kira & Robert Ciardullo
135 Osborn Road, Harrison, NY

You and your family are invited to spend an afternoon of fun and fellowship with WCMS Members, Colleagues and their families. Bring your bathing suits and towels—don't forget the sunscreen!

Food and beverages will be provided. Invite a non-member or colleague to join us.

Please RSVP to Kalli Voulgaris
email: kvoulgaris@wcms.org fax: 914-967-9232

PRESIDENT'S MESSAGE

GIVING UP PRIVATE PRACTICE AND THE CORPORATIZATION OF MEDICINE
(PART 1)
(Continued from page 1)

The difference between small practice and a large corporation, of course, is that large corporations have many monetary privileges that small businesses do not have. They have an economy of scale to buy all they need at a much reduced cost. But, what they really have is political and legal power. They have the power to force insurance companies, and government, to negotiate reasonable payment. No individual small practice or even a big, or single hospital, can do this! Northwell is now the largest employer in NY state, and one of the largest medical provider companies in the country.

Patients come into my office and complain about the large practice corporations limiting their time with their doctors. They complain that their doctors are spending a good deal of the time on a computer and not with them. I do this to an extent too; because I have to, in order to get payment and keep my job.

Unfortunately, the corporate ethos of money being the bottom line, has changed everything about medicine and the way we practice. Gone is the humanism of "one-on-one" medicine. Gone is caring about the patient first, and the money later. Gone is taking the time to really care for and about the patient.

Now the notes on the computers have to justify the payment; not the satisfaction of the person being cared for. What my patient's do not know is that under the new system of "pay for performance," if the doctors don't check off all the right boxes (like did we ask if there are guns in the house), we could be docked up to 9% of what is owed us from government, for lack of performance!

Doctors have become the hired help (and what they do is more and more controlled by corporate interests).

When my practice was my own practice, anyone that walked in the door was cared for. Now the staff (which I am just a part of and not the boss), has to check eligibility before they can see me. My hours used to be open, and any time patients were ill, they knew they could just walk in. No longer. In the "old days", I would tell the nurses what to do and they would. We would figure out the money later. Even at the hospital this was the way. Now the staff tells me what I can and cannot do. There are progressive roadblocks for the patients to access care.

Doctors have lost autonomy, and patients have lost more access to care.

My patients still think I am the boss. It is a rude reality for them that I am not. They have become more and more mistrustful of the system, for all good reasons. They are no longer what is important, or the center of attention; no matter what lip service they hear from those that control: they know the truth.

5 and 10 years ago I would order what tests and medications I felt would be best for my patients. Now I look up on a computer screen that has their drug plan loaded in it, to see what I can give them. Now I have to look on "treatment guidelines" for what testing I can even order.

Even with this, I will routinely get denied; and have the choice to fight for the patient. No one pays us to take the time and fight. It is a well-known fact that with each road block the insurance companies and government put up, fewer and fewer doctors will fight it; and they know it will cost them less.

It has always been hard to fight city hall. And then, if I decide to fight and pick up the phone to get permission (why should I have to get permission to take care of my patient from another large corporation or government office?), I end up talking to a low level non-qualified person looking on a computer screen telling me what corporate policy is. To fight further I have to ask to have a qualified doctor call me to discuss my patient's case. If they do not agree, I have to ask for an independent review that can take days or weeks to happen. My patients are not stupid. They see what is going on and they hate it. More roadblocks for my patients to get care.

Doctors have lost authority in this system, to do what we feel is right for our patients.

Then, if I get to order something what happens? More and more my patients tell me that what I ordered is not covered (or at a cost that they cannot afford). The companies and government cut what seem to be little things that do not matter when reading the contract (or you just get sent a new updated contract); until they do matter.

(Continued on page 15)

STATLAW® New York

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Late breaking news on medical-legal development affecting physicians and health care professionals

CMS Warns of Possible Delay of MACRA Implementation. On July 13, CMS Acting Administrator Andy Slavitt and senators showed that they have heard and understand the calls to slow down plans for implementing the Medicare Access and CHIP Reauthorization Act (MACRA). Slavitt said he knows small physician practices might not have enough time to prepare for the important changes in Medicare payments if they go into effect on Jan. 1 as planned, particularly since the CMS Final Rule on new payment models is not expected to be announced until November. The Senate Finance Committee expressed concerns over the short period between the Final Rule announcement and the planned implementation date. In response to repeated questions concerning this issue, Slavitt advised that the CMS is open to alternatives that include postponing implementation and establishing shorter reporting periods. Additionally, Slavitt also suggested that the CMS was considering modifying reporting requirements to ease the burden on physicians. For instance, CMS could obtain data through an automated database such as a registry. Also, in instances where a practice demonstrates strength in a particular area of care, that practice might not have to report such data. Similarly, if physicians do not see a high volume of Medicare patients, they might not be required to report data. Unfortunately, there is still much uncertainty surrounding MACRA that may not be resolved until the Final Rule comes out in November.

CMS Report Notes High Deductible Plans Will Curb Physician Spending. Healthcare spending is expected to grow 5.8% annually, outpacing the overall gross domestic product by 1.3 percentage points between 2015 and 2025. According to a new CMS report, however, spending on physician services during the next decade is likely to be significantly slower and limited in part by the continuing rise of high-deductible health plans. Actuaries at the CMS found that currently one in four employer health plans had high deductibles in 2015, up from one in five in 2014. Sean P. Keehan of the CMS' Office of the Actuary said "research has found that moving into high-deductible health plans or being subject to other increases in cost sharing tends to have a disproportionate impact on the use of physician and clinical services, such as preventive care." The Office of the Actuary found that 2015 was the first year of an expected 4-year trend of accelerating out-of-pocket spending resulting from both fading coverage gains under the Affordable Care Act and more people being moved to high-deductible plans or coverage that requires other forms of increased cost sharing. Plans that emphasize cost-sharing have been criticized widely in the healthcare community as they both reduce patients' use of both necessary and unnecessary care. The CMS report also found that physicians will likely be affected in 2016 by private health plans' continued expansion of "narrow networks" of providers, designed as a way to "prevent sharp increases in health prices." For a copy of the CMS report, please see: http://content.healthaffairs.org/content/early/2016/07/12/hlthaff.2016.0459.full.

New Law Limits Initial Prescriptions for Opioids for Acute Pain to Seven Day Supply. The New York State Legislature recently passed legislation mandating that a licensed practitioner may not prescribe more than a 7 day supply for any schedule II, III, or IV opioid to any ultimate user upon the initial consultation or treatment for "acute pain." The bill was signed into law by Governor Cuomo on June 22, 2016 and by its terms becomes effective 30 days thereafter, on July 22, 2016. The law defines "acute pain" as ". . . pain, whether resulting from disease, accidental or intentional trauma, or other cause, that practitioner reasonably believes to last only a short period of time. Such term shall not include chronic pain, pain treated as part of cancer care, hospice or other end-of-life care, or pain treated as part of palliative care practices." The bill further provides that, upon any subsequent consultations for the same pain, a practitioner may issue up to a 30 day supply, any appropriate renewal, refill, or new prescription for the opioid or any other drug. The legislation amends various provisions of the Insurance Law to provide that every insurance policy which provides coverage for prescription drugs subject to a copayment shall charge a copayment for a limited initial prescription of an opioid drug that is either (i) proportional between the copayment for a 30 day supply and the amount that the patient was prescribed; or (ii) equivalent to the copayment for a full 30 day supply of the opioid drug provided that no additional copayments may be charged for any additional prescriptions for the remainder of the 30 day supply.

For more information on the above items, contact Kern Augustine, P.C. at 1-800-445-0954 or via email at info@DrLaw.com.

CYBER THREATS, CYBER INSURANCE

By Kate Sellers, JD, CLU®, Asst. V.P., Charles J. Sellers & Co., Inc.

It seems like just about every week, we hear about another major corporation that has had its systems compromised by a hacker, breaching the privacy of its customers. But it's not just major corporations that are experiencing privacy breaches – small businesses, including medical practices, are targets too. And hacking incidents aren't the only cyber risk facing businesses today.

What's the Risk?

Medical practices are at high risk of a privacy breach because their systems hold both financial and medical information. This information is valuable on the black market. In fact, medical records can sell for as much as 20 times the price of stolen credit card information. ("90% of Healthcare Firms Hit by Cyber Risk: Ponemon," *Insurance Journal*, May 7, 2015). The increased digitization and sharing of medical records also puts medical practices at increased risk of a breach. (Experian 2016 Data Breach Industry Forecast).

Hackers aren't the only cause of privacy breaches. Employees can make mistakes that cause a breach, such as losing a backup tape or accidentally e-mailing private information to the wrong recipient. And, while most of the focus is on the security of electronic systems, paper breaches still occur.

An annual study sponsored by IBM, the Ponemon Institute Study, estimates the costs of a data breach, including notification, lost business, and other costs. The 2015 study estimated the average cost of a data breach in the U.S. at $217 per breached record. In a heavily regulated industry, such as healthcare, however, the average cost is higher – an estimated $398 per record.

> Contributing to these costs in the healthcare sector are the requirements under the HIPAA Breach Notification Rule (45 CFR §§ 164.400-414). A covered entity must notify individuals within sixty days after discovery that unsecured information of patients has been or is reasonably believed to have been breached. Affected individuals must be notified by mail or by e-mail if they have agreed to this in advance. The entity must also notify the media if more than 500 residents of a single state are affected, as well as notifying the Secretary of Health & Human Services "without delay." If the breach affects 500 or more individuals, information about the breach is added to the "Wall of Shame" on the Health & Human Services Website, a list of the data breaches affecting 500 or more individuals, including the entity's name, the number of individuals affected, and a brief description of the breach. This list is available at: https://ocrportal.hhs.gov/ocr/breach/breach_report.jsf.

Another risk with a data breach is that your practice may be sued by a patient who claims to have been harmed by the breach. While a private citizen generally can't sue under HIPAA, a creative plaintiff's lawyer may be able to find a claim to bring under state tort law. Some medical practices also feel that they are protected from this kind of lawsuit because they have contracted with an EMR vendor who has assured the security of the medical records. While this type of agreement does offer the practice some protection, the risk is not eliminated. If one of the practice's employees mistakenly causes a data breach, for example, your vendor will not be responsible for any harm that results.

And there are other cyber risks to be concerned about as well. One form of cybercrime that's quickly on the rise is ransomware attacks. Ransomware is malicious software designed to block access to a computer system until a ransom is paid. The ransom is typically demanded in Bitcoin, a digital currency that isn't regulated by any government, and is therefore harder to trace. In 2015, the

(Continued on page 14)

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The following risk management tip was published in the spring 2016 issue of Dateline. *For a more detailed analysis of the subject of treating friends and family, including two pertinent case studies, please visit MLMIC.com to review the summer 2016 issue of* Case Review.

Risk Management Tip #19 – Treating Patients with Whom You Have a Close Relationship

The Risk:

Physicians are often asked by close friends, relatives, or colleagues for medical advice, treatment, or prescriptions both inside and outside of the office. At times, these individuals may be seen at no charge as a courtesy. Although the American Medical Association advises physicians not to treat immediate family members except in cases of emergency, or when no one else is available, this practice continues to exist.

Unfortunately, over the years, we have seen a number of lawsuits filed against physicians by close friends, colleagues, and even their own family members because of care provided by our insureds. The defense of these suits is frequently hampered by the fact that there are often sparse or entirely non-existent medical records for the patient. The failure to maintain a medical record for every patient is defined as professional medical misconduct in Education Law § 6530(32). Providing care under these circumstances may pose unique risks. Here are some suggestions on how to handle these situations:

Recommendations:

- Always create a medical record for friends, relatives, and colleagues for whom you provide care of any kind.
- All patient encounters must be documented in the medical record, including those that occur outside the medical office.
- A thorough medication history should be obtained to avoid potential drug interactions and identify any contraindications.
- Take a complete history when seeing friends, relatives, or colleagues as patients. If indicated, this should include issues that may be uncomfortable to discuss such as the use of psychotropic medications and sexual history.
- Perform a thorough physical examination. Sensitive portions of a physical examination should not be deferred when pertinent to the patient's complaints. These may include a breast, pelvic, or rectal examination. A chaperone may be necessary for those portions of the exam.
- Do not write prescriptions for individuals with whom you do not have an established professional relationship and always document the reasons for prescribing the medication and dose. If narcotics are prescribed, the Prescription Monitoring Program (I-STOP) must be checked.
- If a surgical procedure is to be performed, a signed informed consent must be present in the record, with accompanying documentation that the requisite risks, benefits, and alternatives to the treatment have been discussed with the patient.

CYBER THREATS, CYBER INSURANCE

By Kate Sellers, JD, CLU®, Asst. V.P., Charles J. Sellers & Co., Inc.

(Continued from Page 11)

FBI received 1,838 complaints of ransomware, and estimates that victims lost more than $23.7 million. ("Under Pressure to Digitize Data, Hospitals are Hackers' New Target," *Washington Post,* April 1, 2016). At our agency, we've heard from many medical practices of all sizes that they've experienced one or more ransomware attacks in the last six months or so.

Insurance to Protect Your Practice

Your technological safeguards and the proper training of employees are critical to defend your practice. But because even the best preventative measures can fail, insurance is available. Your practice's general property and liability insurance policy generally will not cover most potential cyber losses. You need additional insurance coverage, which is available as an endorsement to some Business Owners Policies. Separate, stand-alone policies are also available, which tend to offer higher limits and broader coverage.

Most policies offer coverage for many of the costs your practice would incur to manage a breach event. These include breach investigation costs (such as computer forensics experts and legal consultations), breach notification costs, and public relations costs. One of the most significant benefits of this insurance coverage is that the insurance companies have already vetted experts on breach management and negotiated fees with them that, as an individual business, you would not have the bargaining power to obtain. Getting the right assistance quickly after a breach can help contain the overall cost of the event.

Cyber insurance policies vary, but most will cover breaches caused by employee errors or hacking. Paper breaches, as well as electronic ones, are covered by most policies. These policies can provide liability coverage for suits brought against the practice by a patient alleging harm from a breach. Some policies will cover suits brought by an employee who claims to have been harmed by a privacy breach as well. This type of coverage covers defense costs (including attorney fees) as well as providing indemnity for a settlement or judgment, up to the limit of liability purchased.

A breach event can bring with it a regulatory investigation at the state or federal level, which would cost your practice time and money. Some policies offer coverage for regulatory investigation costs, including attorneys' fees and employee overtime. While some policies offer coverage for regulatory fines and penalties, these are not likely to be deemed insurable in New York State.

Other items that can be covered by cyber insurance include:

- The costs to repair damage to your computer systems and data from a breach or other cybercrime;
- Business Interruption coverage to help replace income that your practice may lose if normal operations are disrupted due to a cyber event;
- Losses from cybercrime such as unauthorized electronic funds transfer;
- Cyber threats and extortion losses, where a hacker threatens to harm your network or release confidential information; and
- Losses from phishing scams.

There are side benefits to applying for and obtaining cyber liability or data breach insurance coverage. As with other types of insurance, the application is designed to measure the risk your business presents to the insurance company. As such, the application process is a good review of your IT safeguards, such as password protection, firewalls, antivirus software, criminal background checks on employees, restricted access to data, and encryption of mobile devices. And, because it is in the best interest of the insurance company as well as in the best interest of the insured customer to prevent a breach, the insurance companies provide their customers with helpful breach prevention resources, such as risk assessment tools and online employee training.

The premium for this coverage varies, depending on, among other things, the size of the practice and the types and limits of coverage selected. An insurance agent experienced in cyber insurance for medical practices can help you review the available options so that you can choose coverage with the cost/benefit balance that works for you. Many experts say that it is a matter of when, not if, a business will experience a cyber or data breach event. For this reason, it is important for all businesses to consider this insurance coverage.

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PRESIDENT'S MESSAGE

GIVING UP PRIVATE PRACTICE AND THE CORPORATIZATION OF MEDICINE
(PART 1)
(Continued from page 8)

Weekly patients tell me that after years of blood products being covered by insurance, with changes made by converting to an "improved plan", that suddenly bills of thousands of dollars in patient-responsible payments start showing up. It took many calls to find out the coverage for blood products had been dropped. And this is with a premium increase too!

Daily patients will come back from the pharmacy and tell me that they cannot afford the medicine I prescribed, and ask for a cheaper medicine (even when it is not as effective).

This "cost shifting," which is so prevalent now by insurance companies, was started by government. What is happening is that when the government does something to cut its costs, because it is running out of money; the insurance companies copy that, and do it to increase profits. And, because the government did it first, the government Insurance regulators cannot say anything to the insurance companies for doing the same thing! Insurance more and more is becoming very limited in what it will do for the average patient in an average year. What is worse is that even with this cost shifting, premiums are skyrocketing. What else is skyrocketing is the salaries of the insurance corporate heads and their buildings.

Doctors are extremely aware and concerned about the ever increasing cost of medical care, that leads to limited care for our patients.

We doctors tend to blame the lawyers for most of the high cost of medicine, but it is not just them. It has become the whole system in the US, that is clearly broken. On the other hand, the cost of litigation against hospitals and doctors is a major contributor to the ever increasing cost of medical care. Doctors have been successful in some states to get tort reform, which has resulted in a significant drop in costs. In NYS, we have the highest insurance costs in the US, and **twice** the second costliest state that is Pennsylvania! We desperately need tort reform; and it should be national reform, not just state by state.

Patients may be aware that the medical liability system is adding to the cost of their care, but not nearly to the extent that it impacts them directly.

Many of my older patients, and a significant amount of younger ones on the new "Affordable Care Act" plans, are losing their primary care doctors, and have to find new ones. They are bewildered by this. Simply put, these large corporate practices limit Medicare and Medicaid enrolments. Especially on new Medicare and Medicaid plans that lose money. Elderly people get sucked into these plans being told that their medical visits and drugs will be covered. What they don't see is all the fine print about what is not covered. In my opinion this is no better than the multiple scams the elderly are subjected to, in the mail and on the web, to get them to sign up for services that they either do not need, or short change them. This is just more corporate greed at work. And, as for government plans allowing you to keep your doctors, what a joke that is! Every week I see a new patient because their doctor no longer takes their insurance; and I lose a patient for the same reason. Is that a system that makes sense?

Doctors are very concerned about the lack of continuity of patient care; and the lack of choice.

All of this has a great effect on people's doctors. We have lost professional authority and autonomy in our care of patients. We are subjected to countless mandated reviews, and intrusions on our practice of medicine. We are forced to spend hours documenting on computers to prove our worth and defend our payments. And, we are forced to work in a production mode instead of a caring mode. The cornerstone of a medical practice is the doctor-patient relationship; which is being attacked on every front, every day. The practice of medicine is being destroyed. You may say, as government and the insurance industry people do, that all this is to protect patients and to ensure quality in the care provided (i.e. cut costs), but the cost of medicine just keeps going through the roof. The number of law suits continues to grow, medical accidents are on the raise, while our patients are more dissatisfied than ever.

(Continued on page 16)

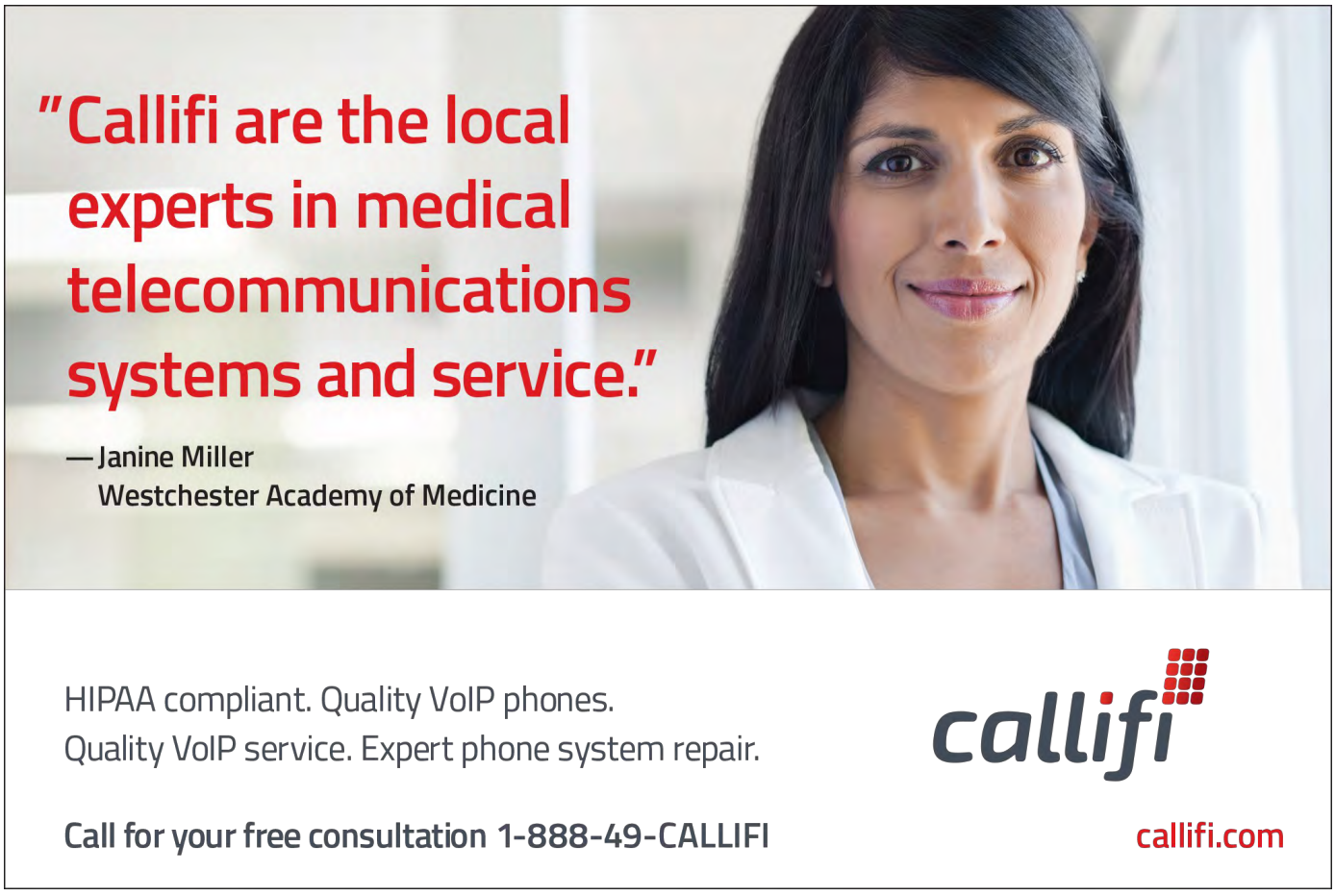
PRESIDENT'S MESSAGE

GIVING UP PRIVATE PRACTICE AND THE CORPORATIZATION OF MEDICINE
(PART 1)
(Continued from page 15)

The strain on society in general is progressive, and harming everyone. Insurance companies and government want to control us, because we spend "their" money on our patients. But nothing they have done has worked, and none of what they want to accomplish has come to pass; just the opposite in fact. Why? Because they are not the doctors, and they can never be doctors.

The profession of medicine is being destroyed to increase profit for corporations and limit expenses for government. Not only do doctors lose in this situation, but eventually our patients and society at large are the big losers.

Instead of controlling doctors and beating us down, they need to work with us to find answers. The only way that will happen is if we as physicians, together with our patients, stand as one to make it happen.



Healthcare news Boomers & Beyond HOSPITAL NEWSPAPER

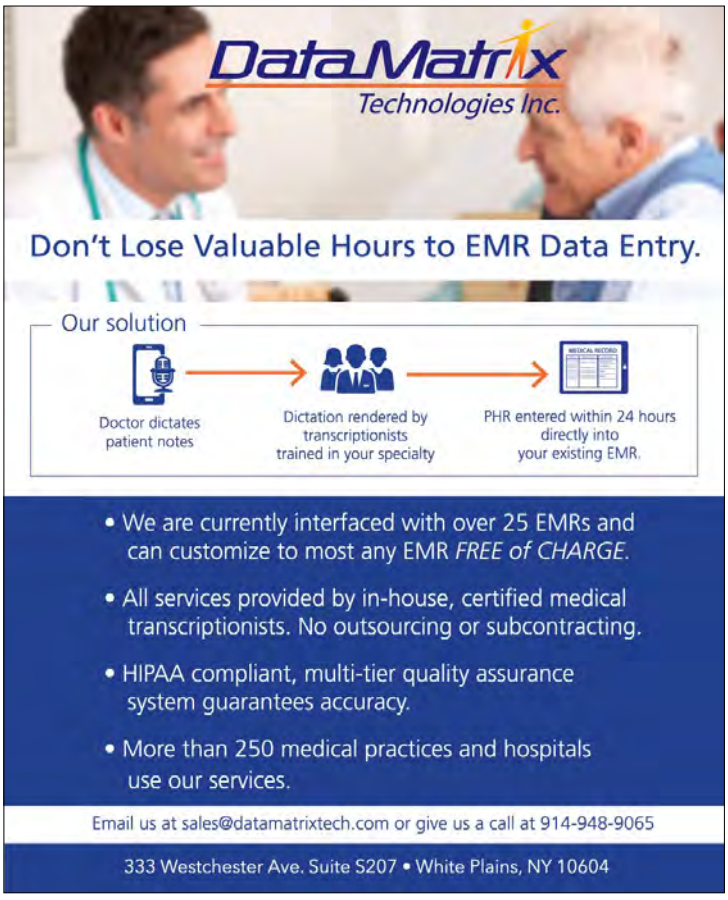
Special offer for all WCMS members! Special Discounted Advertising Rates in the *Westchester Healthcare News*, *Boomer's & Beyond* and *Hospital Newspaper.*

The Westchester County Medical Society has formed a special partnership with *Healthcare News* that allows all physician members and their medical practices to receive a substantial discount of 30% on any marketing plans in the publications by *Healthcare News.*

Healthcare News is a respected monthly publication which focuses on health, wellness and other important trends in healthcare and the medical field. Started in 2006, *Healthcare News* has a circulation of nearly 100,000 with editions in Westchester, NY and nearby Fairfield County, CT. The target audiences are residents who seek the best health options, along with a diverse array of physicians aiming to promote their services in the community. Inserted into each edition of *Healthcare News* is *Boomer's & Beyond* publication for the ever growing 55 and over demographic.

In addition *Healthcare News* has a companion bi-monthly publication called *Hospital Newspaper* for which the advertisng discount also applies. *Hospital Newspaper* has been a top source of news and information for medical professioanls in the hospital industry since 2001.

Digital copies can be found at www.healthcarenewspaper.com or www.hospitalnewspaper.com. To take advantage or learn more about this special membership discount telephone Jim Stankiewicz, General Manager, at 845-202-4737 (work) or 845-568-7687 or e-mail him at Jim@healthcarenewspaper.com



Mark Your Calendars!
Upcoming WCMS Board Meetings:

All Board meetings are held on Thursdays beginning at 6:00pm in the WCMS Headquarters located at 333 Westchester Avenue, Suite LN01 in White Plains, NY. If you are interested in attending a meeting, please call or email our office.

September 8
October 13
November 10
December 8
January 12
February 9
March 9
April 13
May 11
June 8

(914) 967-9100—jmiller@wcms.org

Westchester Academy of Medicine
2016 Golf Outing & Fundraiser

Thursday, October 6, 2016
Westchester Country Club
99 Biltmore Avenue
Rye, NY 10580

Registration, Driving Range & Halfway House Lunch—11:00 AM
Shotgun Start at 12:30 PM
Golf Format: Scramble
6:00 PM—Cocktails
6:45 PM—Buffet Dinner/Awards/Raffles

If you are unable to attend, please consider making a tax-deductible donation. Contact Kalli Voulgaris kvoulgaris@wcms.org or 914-967-9100 for more details.

Individual—$400 ◊ Individual plus Hole Sponsorship—$525
Paid Foursome—$1,400 ◊ Paid Foursome plus Hole Sponsorship—$1,525
Hole Sponsor $275

Additional Sponsorship Opportunities Available
Cocktails/Dinner Only—$150 per person/$250 per couple

All proceeds will benefit the Westchester Academy of Medicine
For more information and other sponsorship opportunities, contact Janine Miller at 914-967-9100 or jmiller@wcms.org

Please RSVP Today!

Westchester Academy of Medicine
2014 Golf Outing & Fundraiser
Thursday, October 6, 2016
Westchester Country Club

*** * *Please Fax to 914-967-9232* * ***

Name_____Phone_____ e mail_____

Address_____ City_____ State_____ Zip_____

Golfers_____ x $400 = $_____ Name_____

Golfer + Hole Sponsorship $575 _____ Name to appear on sign:_____

☐ **$1,400 Foursome:**

Name_____ _____Name_____

Name_____ Name_____

☐ **$1,525 Foursome + Hole Sponsorship**

Name to appear on sign: _____

☐ **$275 Hole Sponsorship**

Name to appear on sign: _____

☐ **Cocktails & Dinner Only**: #_____ Name(s):_____

$150 per person/$250 per couple; Amount Enclosed: _____

Please make checks payable to: Westchester Academy of Medicine, 333 Westchester Ave., White Plains, NY 10604 – 914-967-9100

Or fill out the information below to pay by credit card

Please charge: ☐ **Visa** ☐ **MasterCard** ☐ **American Express** ☐ **Discover** **AMOUNT $**_____

Card # _____**V Code**_____ **Billing Zip Code**_____ **Expiration Date**_____

Name on Card _____ **Signature**_____

SEVEN DAY INITIAL OPIOID PRESCRIBING LIMITATION EFFECTIVE ON FRIDAY, JULY 22ND

Friday, July 22, 2016 prescribing limitations will go into effect for prescribers under a new law signed as part of New York State's efforts to curb opioid abuse. The measure limits to seven days the prescription of Schedule II, III, or IV opioid upon initial consultation or treatment of **acute pain.**

- Under the NYS Public Health law "acute pain" is defined to mean pain, whether resulting from disease, accidental or intentional trauma or other cause that the practitioner reasonably expects to last only a short period of time. Such term **SHALL NOT**include chronic pain, pain being treated as part of cancer care, hospice or other end-of-life- care or pain being treated as part of palliative care practices.
- The new limitation applies to the initial prescription ONLY. The measure gives flexibility to the prescriber to, upon any subsequent consultations for the same pain, issue any appropriate renewal, refill or new prescription for the opioid or any other drug consistent with existing 30-day or 90-day statutory limits for Schedule II, III and IV medications.
- The measure also limits application of co-pays for the limited initial prescription of an opioid to either (i) proportionate amount between the co-payment for a thirty day supply and the amount of drugs the patient was prescribed or the equivalent to the copay for the full thirty-day supply provided that no additional copays may be charged for any additional prescriptions for the remainder of the thirty-day supply.

The New York State Department of Health has put into place temporary procedure for billing for the Medicaid Fee for Service Program. The department's letter can be found HERE**.**

- The letter does stipulate that pharmacists are NOT required to verify with the prescriber whether an opioid prescription writer for greater than a seven-day period.

Additional information on opioids and this law may be obtained by contacting the NYS Department of Health's Bureau of Narcotic Enforcement at 1-866-811-7957 or click HERE.

- For billing questions please contact CSC at **1-800-343-9000.**

Questions specific to Medicaid FFS policy can be directed to ppno@health.ny.gov or call **518-486-3209.**

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FROM THE EDITOR…
PETER J. ACKER, MD
EVOLUTIONARY PEDIATRICS

(Continued from page 2)

As the winds receded, so did the excitement and it was replaced with the more sobering practicality of living without power. Many, I'm sure, had an initial feeling of "that wasn't so bad" until over the next days news trickled in of the awful destruction in the Catskills, Vermont and Northern New Jersey. And then, worse, the loss of life. In particular I was moved by the death of a local psychiatrist, Dr. Peter Engel who drowned while rafting on the Croton River. He was by all accounts a beloved and admired physician and a highly skilled whitewater rafter. It stirred yet another memory – of me body surfing in the Pacific coast of El Salvador last January (at the end of a medical mission there). Similarly, I am an experienced body surfer (in my early 20's, I spent 4 weeks camping out on Pie de La Cuesta, a small Mexican village north of Acapulco and riding monster waves day after day). Also, I was a champion competitive swimmer. Yet one wave caught me and I was powerless to change my tumbling trajectory which ended with me being slammed head first into the sand. My shoulder took the brunt of the impact and left me with an AC separation which took 2 months to heal. As I thought back on the experience, I felt a chill as I thought about how the slightest shift could have resulted in a fatal cervical fracture. I felt a sense of chagrin about my casual attitude toward the coming of the storm. In the words of Dante, "And as he, who with laboring breath has escaped from the deep to the shore, turns to the perilous waters and gazes."

♦

2016
WESTCHESTER COUNTY
DOCTORS of DISTINCTION

A UNIQUE AWARDS PROGRAM CELEBRATES THE ACCOMPLISHMENTS OF PHYSICIANS IN WESTCHESTER COUNTY JUDGED BY A PANEL TO BE THE MOST EXEMPLARY IN THE PROGRAM'S CATEGORIES. THIS PRESTIGIOUS FOURTH ANNUAL EVENT IS CO-FOUNDED BY ACCOUNTING AND CONSULTING FIRM CITRIN COOPERMAN, THE WESTCHESTER COUNTY BUSINESS JOURNAL AND WESTCHESTER COUNTY MEDICAL SOCIETY.

Open to nominations from the public, this is an opportunity to recognize those physicians who make an impact each and every day on people's lives.

NOMINATION DEADLINE: SEPTEMBER 14

NOMINATE A DOCTOR
IN THE FOLLOWING CATEGORIES

- **ALL IN THE FAMILY:** In recognition of husbands and wives, parents and children or siblings who work together in a practice or separately, dedicating their lives to make other lives better.
- **NO LAND TOO FAR:** In recognition of a doctor who donates his or her time and expertise to countries where medical care is either nonexistent or at barest minimum.
- **CUTTING EDGE:** In recognition of a doctor who spends endless hours working on research and clinical trials to save lives.
- **CARING FOR ALL:** In recognition of a doctor who turns no patient away, but rather devotes time and effort to philanthropic cases.
- **FEMALE TRAILBLAZER:** In recognition of a female doctor who has made great strides in empowering other women to advocate for themselves and be aware of their specific medical needs.
- **PROMISE FOR THE FUTURE:** In recognition of a medical student who excels in his or her studies and will bring compassionate care and a fresh perspective to the medical profession.
- **LIFETIME ACHIEVEMENT AWARD:** In recognition of a physician respected for a lifetime career in the medical profession.

To nominate, visit westfaironline.com/doctors or call Danielle Brody at 914-358-0757.

AWARDS PRESENTATION OCT. 27 5:30 P.M.

at the

NEW YORK MEDICAL COLLEGE
A MEMBER OF THE TOURO COLLEGE AND UNIVERSITY SYSTEM

7 Dana Road, Valhalla | HOST AND CO-SPONSOR

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YOU CAN PLAN ON IT

Webster's definition of "planning" is simple: *the act or process of making a plan to achieve or do something."* However, when it comes to financial planning for doctors, things can quickly evolve from simple to more complex. You can plan on it: from medical school through residency to single or group practice, physicians' lives, finances, and goals are continually evolving. As complexity builds, working with a knowledgeable and experienced financial planner can both help you realize your life goals and also avoid missteps that can easily derail the best-laid plans.

"Do I really need a financial planner?" is a logical question that in our experience many medical professionals have asked themselves. Some things to keep in mind as you answer the question:

- *As my practice, professional obligations and family all grow, do I have the time to devote to keeping a financial plan on track and making adjustments when appropriate?*
- *Do I have the time and energy to keep pace with financial market and other developments that can have a critical impact on my personal and family finances?*
- *Can I properly assess all the risks that can arise as my career progresses – business and legal risk, estate planning, and adequate protection of my earning power?*

Of course, physicians have the ability to make important financial decisions. We provide guidance and input on key areas such as retirement planning, investments, family needs, income protection, and philanthropic goals. The client uses our process to validate their decision making and to realize their overall vision. He or she makes the final determinations on the broad direction and content of the plan.

Below are a few points a good financial planner might raise with you in an introductory conversation:

- ***How did you get started in your current practice or position?*** *This is more than a polite conversation starter. Your answer provides insight into what is important to you, your aspirations, and other priorities and interests.*
- ***What is the legal structure of your practice?*** *Whether you practice as part of a team or as an individual, the specific legal structure impacts the risk profile of the practice.*
- ***Do you have a specific retirement plan in place?*** *Many medical practitioners are so deeply engaged with the practice or other responsibilities that they do not take time to craft a specific retirement plan with appropriate funding, asset allocation, etc. A good retirement plan is a reflection of your post-retirement goals and desired life style.*
- ***Do you have appropriate asset protection?*** *Creating a solid asset protection plan is critical in an environment where malpractice suits are common, and tax planning is imperative.*

As a financial planning team, we recognize the importance of utilizing other professional resources, too, such as attorneys and CPAs who can function like a board of directors to assure that a plan is comprehensive and that all bases are covered.

BARNUM
FINANCIAL GROUP

By: Ron Pac and Eric Gerhard
565 Taxter Road, Suite 625
Elmsford, NY 10523
PH: 914-372-2864
Rpac@BarnumFG.com
www.GerhardPac.com

Physician Wellness: Mindfulness and stress management for the busy doctor.

Beginning Monday, October 17th

This course will run 8 weeks (no class on 10/31).

8:00pm – 9:00pm (Online course)

Please contact jmiller@wcms.org to register

Presented by Mark Bertin, MD

Together with the Westchester County Medical Society, Dr. Mark Bertin will present his class, *Physician Wellness: Mindfulness and stress management for the busy doctor.* This eight week course is designed to reduce the risk of chronic stress and burnout that is on the rise. This program will be offered online to cut down on logistics. While live and interactive, anyone can log in from any internet-connected device. If you need to miss a class, recordings are available to watch at any time. We hope you'll be able to join us for this exciting trial program.

If you're a practicing physician, you don't need anyone else to tell you that the risk for chronic stress and burn out has been rising. A recent Mayo clinic survey found more than half of physicians today have at least one symptom of burn out. Excessive stress of this kind doesn't affect only your own wellbeing, but often affects communication and patient care.

Mindfulness-based stress reduction programs have been shown through hundreds of studies to decrease stress and anxiety, along with many other specific benefits. Smaller studies report improvements in how health-care providers feel, and suggest gains in patients' perceptions of provider empathy, as well as other measures. The evidence behind mindfulness has become so strong that is now considered 'mainstream' medicine instead of 'alternative' for the purpose of funding grants.

Most importantly, mindfulness is meant to be practical and accessible to anyone. It isn't specifically a meditation technique, nor does it aim for bliss, perfection, or the elimination of stress – none of which is possible. It also doesn't take a lot of time, and can be integrated into anyone's busy life.

What mindfulness really shows is that we can intentionally develop traits that help manage the stress and uncertainty of life. When we regularly train ourselves to be more focused, less reactive, and to settle ourselves throughout the day before stress takes over, our lives get easier. The best analogy is exercise. Work out, your physical health improves. Practice mindfulness, your mental health does.

Registration pricing

Register before August 31 and receive a discount - $375.00 for the full 8-week course

After August 31 - $450.00

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