101 Years of Service to the Bronx Community
Bronx County Medical Society

Held the Centennial Gala, Membership Assembly & Physicians Expo on Sunday, October 18, 2015 at the Marina del Rey Throgs Neck, New York

We Honored Immediate Past President 2014-2015
Neil D. Herbsman, MD
THE BRONX "WHAT'S IN A NAME"

It's the only borough with an article in its name— The Bronx. As we kick off a special series called "What's in a Name?" taking a look at how many neighborhoods and streets came to be, NY1's Erin Clarke starts with how the Bronx got its name.

It all started in 1639 when a Scandinavian, Jonas Bronck, settled in a Dutch colonial province in New Netherland. "When he dies in 1643 at the age of 43, the only thing that remained that was named after him through the ages was Bronck's River," says Bronx borough historian Lloyd Ultan. Like with many names that can be difficult to say or write, the 'ck' was changed to an 'x'—and the stream of water that ran next to Jonas Bronck's farm became the Bronx River.

But the present day borough went without a name for more than 200 years until New York City got the land from Westchester County. They looked right smack in the middle of a map and there is the Bronx River, so they named it after the river, the borough of the Bronx, and that's why it's always called The Bronx and not just plain Bronx," Ultan says. The borough is named after the river. That's named after the man that came from a foreign land in the 17th century. It was an era when present day Bronx County was being settled by Dutch and British farmers. "The Bronx was a very fertile piece of land," says Angel Hernandez of the Bronx County Historical Society.

So much so that in the 1660's, English settlers Edward Jessup and John Richardson, along with a group of families decided to make their home in an area WEST of Jonas Bronck's River. "Since they were west of the place they came from and since they all had farms, this they called West Farms," Ultan says. Some 20 years earlier another Englishman, John Throckmorton came to the area by way of Rhode Island. "They were situated on a neck of land. They called it Throckmorton's Neck, which became Throgmorton’s Neck which became Throgg's Neck," Ultan says. That's Throgg with two 'g's and an 'apostrophe-s,' but the name and its spelling have changed over the years.

During the American Revolution, some historians say the British even mistakenly called it Frog's Neck. And although the original name was spelled with two 'g's, Robert Moses, who made the Throgs Neck bridge, used one and dropped the apostrophe.

Like the borough name, neighborhoods names and even boundaries continue to change over time.
GOVERNOR ANDREW M. CUOMO  
State of New York | Executive Chamber  
Andrew M. Cuomo | Governor

GOVERNOR CUOMO ANNOUNCES ACCREDITATION FOR NEW MEDICAL SCHOOL AT CUNY
Governor Andrew Cuomo today announced the accreditation for the CUNY School of Medicine, located on the City College campus in Harlem. The new medical school will increase access to an academically intensive medical education and train physicians for underserved communities across the state.

“This action increases employment, research and learning opportunities for students and faculty members at CUNY School of Medicine in Harlem and will help our next generation of healthcare workers serve communities across New York State,” Governor Cuomo said. “This new school is another step toward making medical care more accessible for all New Yorkers.”

The CUNY School of Medicine will launch its inaugural class in 2016 in partnership with St. Barnabas Health System in the South Bronx.

The Liaison Committee on Medical Education, a U.S. Department of Education recognized accreditor of medical education programs leading to the MD degree, has approved the new school following an extensive review of its academic program, teaching facilities and clinical partnership.

According to the Association of American Medical Colleges, New York State and the nation face a critical shortage of doctors. By 2025, it is estimated that the demand for physicians will exceed supply by a range of 46,000 to 90,000. For primary care physicians, the shortfall is expected to be between 12,500 and 31,000 doctors. According to a 2013 Kaiser Family Foundation study, New York State is meeting only 40 percent of its primary care needs, one of the lowest rates in the country.

Chancellor James B. Milliken said, “We thank Governor Cuomo and state and city leaders for their support of CUNY’s historic commitment of access to high quality health care education for underrepresented constituencies in New York. The new medical school is a logical and necessary expansion of the college’s prestigious 40-year old biomedical program that has gained recognition as a leader in educating underrepresented minorities for medical practice. CUNY and City College will award the MD degree for the first time in its nearly 170-year history.”

Chancellor Milliken also expressed appreciation to City College President Lisa S. Coico, Dr. Maurizio Trevisan, MD, Provost and Dean of the Sophie Davis School of Biomedical Education, and their team for “outstanding work toward making possible establishment of the CUNY School of Medicine at City College.”

President Coico said, “Since its founding in 1847, City College has provided a high-quality, affordable education for New Yorkers who might otherwise not attend college. The new CUNY School of Medicine at City College is a natural extension of our bold founding mission that will open doors to underrepresented students and train caring physicians for underserved communities across our city and state. Our unique academic program infuses an ethos of service and social justice. Whether our graduates serve as primary care physicians, pediatricians or plastic surgeons, all are expected to have a deep commitment to serving underserved communities.”

Scott Cooper, MD, president and CEO of SBH Health System, which includes St. Barnabas Hospital, praised the partnership with CCNY, stating, “Like CUNY, we have a congruent mission to provide quality care to underserved communities. With our combined resources and commitment, those facing health disparities will have more than good reason to hope.”

The CUNY School of Medicine received “Accredited – Preliminary Status” designation from LCMD on June 10. Preliminary status accreditation is a major milestone for the new medical school and is the outgrowth of an intensive, voluntary, peer-review process of quality assurance that determines whether the program meets established standards. This process also fosters institutional and program improvement.

The first CUNY School of Medicine class of 70 students will begin in the fall 2016. A campaign is underway to raise $20 million in interest-free loans for those students.

Congressman Charles B. Rangel said, “With the establishment of the CUNY School of Medicine, residents in the immediate vicinity of the school as well as all across the city will now have increased access to primary care. For too long, communities across the city and across the state have suffered due to a critical shortage of medical professionals. Now, with the CUNY
School of Medicine, we are now able to provide desperately needed medical care in underserving communities and also work towards closing the shortage of medical professionals not only in New York but also throughout the country.”

Senator Adriano Espaillat said, “The validation of the Sophie Davis School as a fully accredited CUNY School of Medicine is a momentous occasion for some of our most ambitious students who are pursuing promising medical careers in a number of underserved communities throughout the state. This program combines a thorough academic curriculum with the hands-on experience necessary to pave the way for students to become the doctors and nurses we so desperately need to support patients across the state.”

Assemblyman Keith L.T. Wright said, "With the launch of the CUNY School of Medicine, students can continue their medical education and careers right here in our backyard. We’re helping to resolve the troubling shortage of medical professionals in New York State while improving primary care options for our communities that suffer from restricted access to the necessary care. I am elated to welcome the new CUNY School of Medicine to Harlem and look forward to a great partnership between our community and the University."

Councilmember Inez E. Dickens said “With the accreditation of the Sophie Davis School as a CUNY School of Medicine, patients in underserved communities can begin to breathe easier knowing that homegrown doctors and nurses are on the way, beginning with the class of 2016. This medical school acts not only as a beacon of hope to families in need, but gives our students an opportunity to chase their professional goals at one of the most exceptional physician training programs in the nation.”

The CUNY School of Medicine at City College builds on the strong record of achievement of the Sophie Davis School of Biomedical Education. Founded in 1973 with the generous support from college benefactors and alumni Leonard and Sophie Davis, the Sophie Davis School has placed a special focus on patient/doctor relationships so that its graduates, regardless of specialty, treat their patients with a unique patient-centered, culturally sensitive approach.

The Sophie Davis School has gained recognition as a leader in educating underrepresented minorities for medical practice. After five years of education at the Sophie Davis School, students have transferred to other, fully accredited medical schools for the last two years of clinical education. Due to increased demand for transfer slots, CUNY was faced with the decision of either closing its medical education program or developing a full program. To continue to serve the population of students at CUNY and the communities who depend on its graduates, the choice was clear. Over the past five years, about 43 percent of the students graduating from the Sophie Davis School have been black or Latino. In comparison, blacks comprise 6 percent of the nation’s medical school graduates. Latinos are 5 percent of the nation’s medical school graduates, according to the Association of American Medical Colleges.

The transformation of the Sophie Davis School into a fully accredited CUNY School of Medicine will enable CUNY to expand its efforts to serve New York’s pressing health care needs by providing a unique medical education pathway for competent, caring physicians.

In its more than 40 years of educating students for medical practice, the Sophie Davis School developed the most unique physician training program in the nation, partnering with medical schools across New York and other states.

Moreover, the majority of Sophie Davis graduates are licensed to practice medicine in New York State, many in primary care, with most serving in physician shortage areas or serving a patient base that is underserved. The CUNY School of Medicine is also expected to provide its students with earlier clinical experiences through a curriculum incorporating coursework and experiential learning alongside the medical training to become leaders in community care across the nation.

Additional news available at www.governor.ny.gov
New York State | Executive Chamber
|press.office@exec.ny.gov | 518.474.8418

Congratulations to our Friends & Colleges at SBH Health System
By: Maryam Khavandi M.D, Sanaz Sarahian M.D, Mehdi P. Vali M.D

Evidence-Based Medicine vs Guidelines in practice

INTRODUCTION — Evidence-Based Medicine (EBM) is the care of patients using the best available research evidence to guide clinical decision-making. It has become a popular movement in medicine in recent years. Clinical guidelines, on the other hand, have increasingly become a familiar part of clinical practice over the past decade. Every day, clinical decision at the bedside, rules of operation at hospitals and clinics, and health spending by governments and insurers are being influenced by guidelines.

The increasing rates of using guidelines in teaching hospitals, organization and nursing homes versus the evidence-based medicine practiced in private practices, has motivated us to do a narrative review article in order to get a better understanding of superiority of either of them.

METHODES — Systematic searches were conducted on the following electronic databases; MEDLINE, PUBMED, ELSEVIRE and UPTODATE including recent publications. In this narrative review article we have selected studies and compared/summarized on the basis of our experience, existing theories and models.

DISCUSSION —

1.1. EBM;
The basic elements of evidence-based medicine include asking clinical questions that can be answered by research, finding the best available evidence, judging whether the evidence is accurate and applicable to the patient and applying this evidence in practice. The focus is upon applying the results of research involving patients and clinical outcomes such as death, adverse symptoms, and loss of function. Other kinds of evidence, such as personal experience and laboratory studies of the pathogenesis of disease, are also useful in the care of patients but are not usually included under “evidence-based medicine”. Evidence-based medicine is meant to complement, not replace, clinical judgment tailored to individual patients.

1.2. Benefits of EBM;
EBM is not the blind application of advice gleaned from recently published literature to individual patient problems. Rather, EBM requires the use of a series of steps to gather sufficiently useful information to answer a carefully crafted question for an individual patient. Fully integrating the principles of EBM also incorporates the patient’s value system, which includes such things as costs incurred, the patient’s religious or moral beliefs, and patient autonomy.

When reliable and properly applied to an individual who belongs to that particular group (e.g., ethnicity, gender, economic standing, etc.) EBM protocols can be helpful, and sometimes necessary, to a particular patient. When used with discretion, EBM is useful as a check-sheet that makes sure that nothing vital has been overlooked. It offers the surest and most objective way to determine and consistently maintain high quality and safety standards in medical practice. It can help speed up the process of transferring clinical research findings into practice and it has the potential to reduce healthcare costs significantly.

1.3. Limitation of EBM;
The best available evidence may have come from patient populations with different characteristics from those of the patient in question, thus some judgment is required, so the data obtained is not always reliable. Also, it is not possible for a clinician to keep up with all-important new developments simply by reading a few journals. An internist reading five of the most high-yield journals (e.g. New England Journal of Medicine, Annals of Internal Medicine, Journal of the American Medical Association, Lancet, and leading subspecialty journals) would encounter only half of the most scientifically strong, clinically relevant articles in internal medicine. Additionally, patients’ wishes regarding aggressive or invasive tests and treatment must be taken into account as well as their tolerance for discomfort, risk, and uncertainty. For example, even though an EBM review may definitively show a 3-months survival advantage from an aggressive chemotherapy regimen in a certain form of cancer, patients may differ on whether they prefer to gain the extra time or avoid the extra discomfort.

2.1. Guidelines;
Best practice guidelines are being used to an increasing degree, not only by physicians to improve the level of care, but also by bureaucrats to constrain reimbursement and guide the pathways of care. Physicians recognize that most guidelines simply reflect the provisional opinions of so-called experts about care under modal circumstances, and they know that all are subject to change in accordance with the constant flow of new information.

2.2 Benefits of guidelines;
The principal benefit of guidelines is to improve the quality of care received by patients. It has been shown in rigorous evaluations that clinical practice guidelines can improve the quality of care. Also, Guidelines can improve the consistency of care; studies around the world show that the frequency with which procedures are performed varies dramatically among doctors, specialties, and geographical regions,
even after case mix is controlled. Furthermore, Some clinical guidelines follow “if, then” rules (e.g. if a patient is febrile and neutropenic, then institute broad-spectrum antibiotics). More complex, multistep rules may be formalized as algorithms. Guidelines and algorithms are generally straightforward and easy to use and apply.

2.3. Limitation of guidelines;
Guidelines are expressions of the optimal pathway for the average patient, but, of course, most patients are not average. An example of how the doctrinaire application of guidelines to all patients can be harmful was provided in a recent study, which showed that the inflexible use of the most widely accepted hypertension guidelines would lead to inferior outcomes. Moreover, bureaucratic inflexible application can be an impediment to both reducing expenditures and raising quality, and the pervasive expansion of their use by regulators should be greeted with deep alarm.

CONCLUSION — Although there may be many explanations for variation in care, studies show that differences in physicians’ beliefs in treatment effects are the most important reason for variation in clinical practice. This means that when the confidence in the underlying effects of health care interventions is high, it may be possible to achieve uniformity in clinical care by adhering to practice guidelines. However, this is possible, or even desirable, only when we have high quality of evidence. Under these circumstances, evidence may indeed serve as the neutral arbiter when conflicting opinions exist related to a particular recommendation.

In some cases, failure to practice according to the best current evidence is out of ignorance. But knowledge alone rarely changes behavior. Usually, no single influence is strong enough to make important changes; combinations are necessary. In general, changing clinical behavior requires not just information, but also time set aside for rethinking practice habits. Although guidelines have been important adjuncts to clinical decision-making, they have also been used in regulatory processes, including the Patient Protection and Affordable Care Act (ACA), in ways that stretch them well beyond their intended use. Guidelines are not standards. They are guides. They are provisional. Their application as standards in the regulatory framework is cause for concern. Guidelines do not take into account the degree of uncertainty inherent in test results, the likelihood of treatment success, and the relative risks and benefits of each course of action. To incorporate uncertainty and the value of outcomes into clinical decision-making, clinicians must often apply the principles of quantitative or analytical medical decision-making.

As we know, most doctors spend a considerable amount of time reading, reviewing, assessing, updating or writing clinical practice guidelines. As a result, we are aware of the current philosophy of making these guidelines ‘evidence based’. In so doing, we are attempting to improve the general practice of the science of medicine. We are aware that a number of classification schemes have been developed to aid in this process, although in this attempt, there are still some limitations such as;

1- Scarce independent level A evidence on which to base clinical practice guidelines since most of the published controlled clinical trials (level A evidence) are directly supported by the pharmaceutical industry.
2- another difficulty concerns evaluating older recommendations, many of which were originally based on case reports or limited clinical studies.
3- Recommendations based only on expert opinion can be difficult to evaluate. In these instances, there is usually little or no systematically gathered evidence on which to base the needed recommendation.

Overall, Both EBM and Guidelines are carriers for the same content, and have the same destination; patient’s health. What makes this journey helpful is the content delivered at the destination. So citing the levels of evidence will enhance the scientific basis for the practice of medicine and utilizing non-profit resources would set us loose from bureaucratic chains and pharmaceutical manipulations.

References available upon request.
Future of Residency Training in the United States
Shervin Mortazavi, MD & Dr. Soheila Nourabadi, Essen Medical Associates, PC, Bronx, NY

The United States is a racially and ethnically diverse nation. Producing a physician workforce that reflects the diversity of the American population has been a goal of medical schools, teaching hospitals, policy makers, and the health care professions. The importance of these efforts is highlighted by strong evidence that racial, ethnic, and linguistic diversity among health care providers is directly correlated with better access to and quality of care especially for underserved populations.

IMGs play an important role in US healthcare system providing much-needed diversity in GME which can lead to a richer training environment and increasing access to health care, and better health care outcomes.

Although cultural competence is increasingly recognized as a core competency for health providers the gap among physician trainees diversity compared with the overall population is in fact widening. In addition, residents report that they feel ill-prepared to provide culturally competent care to diverse populations.

The United States population will swell up by 15.2 percent by 2025, to serve the expanded populace new physicians will be required. In the past few years and as an effort to prevent anticipated shortage of physicians in coming years, new US medical schools were setup and increased their enrollment. The number of enrollments increased consistently since 2010 forward and are expected to reach 26,709 per year by 2016-2017. The rapidly increasing number of US medical school graduates which is expected to surpass the number of positions in residency programs coupled with the trend of preference by US Residency Programs given to US Seniors, will make nearly impossible for IMGs to get into US GME Programs in future Residency Matches.

In 2015 though the number of offered positions increased by 615 from 2014, the number of IMGs who Matched decrease by 55 from 2014. Based on NRMP, match rate for non-US citizen IMGs who had participated in MATCH 2015 was 49.4% which is 21% of all participants in Main Residency Match.

GME programs are increasingly producing a highly specialized workforce. Different studies show this expansion in training capacity is undertaken without any coordinated planning in respect of local, regional, and national needs for a balance of primary care practitioners and sub-specialists. Workforce planning involves gauging not only the numbers of needed personnel but also whether those with the right training are available “to deliver the right services to the right people at the right time” (Birch et al., 2009, p. S-56). Thus, to assess the output of the GME system, one should consider the capacity of the system to produce the types of physicians that will meet the health needs of a growing, aging, and diversifying population.

The United States will need approximately 52,000 new primary-care doctors by 2025 as the population grows and ages. Keeping in view the new law of Affordable Care Act and non-willingness of US Seniors to go into primary care it will become more difficult for such programs to fill all of their spots for PGY-1 spots.

On the other hand the percentage of matched IMGs who obtained Internal Medicine positions has grown every year since 2011, from 37.5% to 43.9% in 2015. IMGs filled 56% of Family Medicine, 51% of Internal Medicine, and 29% of Pediatric residency positions. It seems GME programs are able to prevent “brain waste” and solve lack of diversity and primary care physician shortage in healthcare providers by understanding particular challenges faced by IMGs and strengthening support for them during their vulnerable transition period. This is a meaningful investment to reverse widening gap and increase the accessibility and outcomes of the healthcare system.

There are still questions remain to be answered such as; is there any way to motivate US graduate physicians to train in specialties and locate in areas where they are most needed and whether IMGs choose their specialties because of personal interest or be pushed to do that, and how it would affect the quality of care in long term.
New Prescribing Mandate for Controlled Substances Coming Soon

IMPORTANT UPDATE: On March 13, 2015, Governor Cuomo signed a one-year extension of the e-prescribing mandate that will require all prescriptions to be submitted electronically. The mandate will now go into effect on March 27, 2016.

A new state regulation goes into effect on March 27, 2015, requiring all medication prescriptions to be electronically prescribed. This requirement affects all medication prescribers, including physicians and dentists. Here is some additional information on this new regulation, published in MSSNY’s e-newsletter:

Prescribing Mandate of Controlled Substances Effective On March 27, 2015

E-prescribing will be required for all New York State prescriptions, including controlled substances, on March 27, 2015. While the E-prescribing mandate goes into effect on March 27, 2015, physicians who comply with these regulations may now begin to electronically prescribe controlled substances (EPCS), as long as their EPCS systems are DEA certified. Physicians must register their EPCS software with NYS Bureau of Narcotic Enforcement (BNE). Transmission of a prescription of a controlled substance using software that is not DEA certified will fail. The prescription will not be filled. A waiver process from the E-prescribing mandate has been established under regulations. A waiver is only good for one year, and physicians will need to apply directly to the Commissioner of Health. BNE officials have indicated that they are not currently taking any waiver applications as the law is not yet fully in effect.

The Department of Health “Practitioner EPCS The E-prescribing of controlled substances was required under the passage of the I-STOP law in 2012.

Helpful to any physician or his STAFF_ICD10

The following website should be helpful to any physician or his/her office practice staff that is concerned about the transition from ICD-9 to ICD-10 diagnosis coding: http://www.aapc.com/icd-10/codes/

If you haven’t done so already before October 1, 2015 either you or your staff should “crosswalk” 10, 20 or 100 of your most common diagnosis codes that you use in your practice, today. Please be sure that if the ICD-10-CM diagnosis code contains the word left or right in its description, you should still include the LT and/or the RT modifier(s) when submitting your claim(s). In addition, please be sure that your medical documentation contains the data to support the ICD-10-CM diagnosis/specificity selected.

Regina McNally, VP, Division of Socio-Medical Economics
Medical Society of the State of New York
865 Merrick Avenue, Westbury, NY 11590
516-488-6100, ext. 332 Fax: 516-352-4093

Evaluating and understanding new payment model commercial payer contracts:
What physicians need to know

Commercial payers are increasingly pursuing contracts with physicians based on new payment models, such as pay-for-performance and bundled or episode-based payment. These alternative payment models can rely on both cost and quality metrics to determine payment rates for physicians. Navigating the assortment of new payer contracts can be made easier by gaining an understanding of payer agreements and the portions of those agreements that should be prioritized and can be negotiated.

The American Medical Association, in continuing its work to help physicians adapt to and succeed in the new world of alternative payment models, has developed two new resources that explain key issues physicians should consider when evaluating bundled or episode-based and pay-for-performance agreements. Each of these documents outlines important considerations, including:

• Summary of payment model
• Contractual issues, including model language
• Guidelines for evaluating risk and success

These documents are part of a continuum of resources the AMA is developing to ensure physicians are well equipped to succeed in our evolving health care environment. We hope you find these resources add value to your own efforts, and encourage you to promote their use.

Terri Marchiori, Director, Federation Relations
330 N Wabash, Chicago, IL 60611
P: (312) 464-5271
terri.marchiori@ama-assn.org

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Report from Diane P. Miller, Executive Director

Our Annual Inaugural Meeting was held on September 9th at Portofino's, City Island. Our president, Dr. Shervin Mortazavi outlined his goals and promoted membership in our society. We welcomed our new officers and new members. After a brief executive session we presented a two part education program which as very well received.

**PART 1 EDUCATIONAL PROGRAM**

Title: "Diabetes: Most effective and efficient regimens"

Speaker: Dr. Jason Nehmad, Board Certified Internist, Meridian Health - Ocean Park Medical Associates

**PART 2 EDUCATIONAL PROGRAM**

Title: "New Oral Non Biologic for Drug Psoriasis and Psoriatic Arthritis"

Richard H. Haddad, MD, Rheumatologist
Clinical Assistant Professor of Medicine Rutgers - Robert Wood Johnson Medical School New Brunswick, NJ

Sponsors for this evening Educational program were
- Central NJ Rheumatology Society
- Horizon Pharma
- Celgene - Committed to Improving the Lives of Patients Worldwide

Special Thanks to Dr. Richard Haddad & Dr. Adolph Meyer who introduced him to our society.

Sunday, October 18, 2015 we held our Annual Membership Assembly/Expo, Auction & Gala at the Marina del Rey in the Throgs Neck Section of the Bronx. As you know, the Marina is on the waterfront overlooking the East River, between the Whitestone & Throgs Neck Bridges. We honored of our immediate past President Neil Herbsman, MD. 2015 marks our 101st year of service to the Bronx Community.

**NYS Senator Jeffrey Klein** was in attendance. He has been a long time friend of Bronx County Medical Society. He was introduced MSSNY President Joseph Maldonado as well as many of our guests of honor.

We published our annual Souvenir Journal in recognition of our past president and SBH Health System, which was a Platinum Sponsor for this event. At the dinner we acknowledge Jacobi Medical Center who is celebrating it's 60th Anniversary. Certificates of Appreciation were awarded to Medical Liability Mutual Insurance Company (MLMIC) for it's continued sponsorship of our society. Dr. Kira Geraci, Member of the MLMIC Board of Directors, and Speaker of the MSSNY House of Delegates, accepted the award.

Our Preferred Insurance Company, Charles J. Sellers & Co., Inc. & SBH Health System was also awarded Certificates. By far this was the most impressive event. The food & service was outstanding and a good time was had by all.

Annual Jacobi Medical Staff Meeting was held on Monday, October 19

BCMS Board Member, Michelle Stern, MD is the President of the Medical Staff and helped orchestrate the facility and Speakers. Invited guests included: Dr Luis Marcos Chief Executive Officer of PAGNY; Senator Jeffrey Klein who spoke on the dangers of Synthetic Marijuana; David Jakubowicz, MD, President-Elect of the Bronx County Medical Society, who updated members on current legislative issues facing the Medical Community; David Hoffman Chief Compliance Officer PAGNY, H.C.A.H.P.S., covered other acronyms that rule our lives. The meeting was well attended and opened the door to future conversations on membership in the medical society.

Saturday, October 24, 2015 the Medical Society of the County of Queens, Inc., and the Academy of Medicine of Queens County, Inc., held its 209th Annual Past Presidents’ Masked Ball & Physician Expo at Terrace On The Park, in Flushing, New York. They Honored their past president Deborah S. Blenner, MD, for her outstanding dedication and service.

Dr. Tabarroki, Dr. Mortazavi, Dr. Rodriguez & Dr. Diaz Represented the Bronx County Medical Society

Respectfully Submitted
Annual Italian-American Heritage Celebration
Thanks to our Borough President, Ruben Diaz, Jr. for hosting this amazing event. I was honored to be in attendance

Bronx Borough President Ruben Diaz Jr. hosted his annual celebration of Italian-American Heritage & Culture Month, “Mese della Cultura Italiana,” at the Schiff Family Great Hall on the grounds of the Bronx Zoo, on Thursday, October 8, 2015. Honorees included WFAN 660 AM radio host Mike Francesa, Sal Abbatielo, Owner of Fever Records; Donna Cirolia, Vice President for Regional Public Affairs and Communications, Northeast for Coca-Cola; and Peter Vallone, former speaker of the New York City Council. The event was sponsored by Coca-Cola, the Wildlife Conservation Society, the Belmont Business Improvement District and Artuso’s Pastry.

Bronx Economy Grows, Unemployment Falls
Bronx Unemployment Drops to 6.6%

Nearly 100K More Bronxites Working Today Than In May 2009

Bronx job statistics continued to improve this month, according to the latest numbers from the New York State Department of Labor.

The unemployment rate in The Bronx fell to 6.6 percent in September 2015, down from 7.3 percent in August 2015 and 8.7 percent in September 2014. Those same statistics show that the total number of Bronxites who are employed is 565.7 thousand, up from 468.8 thousand in May 2009 when Bronx Borough President Ruben Diaz Jr. first took office, meaning that nearly 100,000 more borough residents have jobs today than did roughly six years ago.

“Our borough is in the midst of a tremendous revival, and these numbers bear that out,” said Borough President Diaz. “More Bronxites are employed today than at any point since they began keeping such statistics. We are bringing new businesses to our borough, helping our existing businesses expand, and fostering the right climate for growth and development. Those efforts are having a positive effect on our borough and its population, as is clear from these job numbers.”

“Our borough is in the midst of a tremendous revival, and these numbers bear that out,” said Borough President Diaz. “More Bronxites are employed today than at any point since they began keeping such statistics. We are bringing new businesses to our borough, helping our existing businesses expand, and fostering the right climate for growth and development. Those efforts are having a positive effect on our borough and its population, as is clear from these job numbers.”

“Bronx residents are a talented and committed work force that just needed the opportunity to work. The Bronx businesses that have expanded recently and those that have moved into the borough in the past few years are contributing mightily to this collective effort. I am gratified by this news,” said Marlene Cintron, President of the Bronx Overall Economic Development Corporation.

Since Borough President Diaz took office in 2009, The Bronx has seen more than $7 billion in total development, which has led to the creation of over 15,000 new jobs. In addition, a new partnership announced by Governor Andrew Cuomo announced in August between the New York State Department of Labor and the Bronx Overall Economic Development Corporation, as part of the “NY Works,” program is placing Bronx residents in these jobs, helping to ensure that new development here benefits everyone, especially Bronxites.
Featured "Physicians"
The Bronx County Medical Society "Featured Physicians" is designed to highlight outstanding new community Doctors that have join the Bronx County Medical Society. In an effort to introduce them to their fellow colleagues and to help them expand their private practices & network, I introduce the following physicians

**Uel J. Alexis, MD, FIPP**, has an ardent passion to help people. He serves as an anesthesiologist and a specialist in pain management at the Spine & Pain Institute of New York. In addition to the certifications he holds in both fields by The American Board of Anesthesiology, he has attained an international certification in Interventional Pain Medicine by The World Institute of Pain. Dr. Alexis’ distinct bedside manner is based in empathy and compassion. He proves that the best way to cure a disease is to care for the patient. In essence, if a patient suffers from pain, he can mitigate it. Dr. Alexis also has a proven track record in administrative medicine and leadership. He served as the American Medical Association’s Vice Chair of the Global Health and Policy Committee, the Texas Medical Association’s liaison for the University of Texas Health Science Center to the TEX-PAC, and the Member-At-Large in the American Society of Anesthesiologists. During his fellowship in Pain Management at The Mount Sinai Hospital, he was the Chief Administrative Fellow.

**Uel J. Alexis, MD, FIPP**
Board Certified Anesthesiologist
Specializing in Pain Management
560 Prospect Avenue
Bronx, NY 10455
Office - 718-667-3577
uelalexis@gmail.com

My personal Cell for Physician's only 917 -545-4670

Accepting new patients - We wish to welcome BCMS Board Member, Uel J. Alexis, MD, FIPP...best of luck in your newest practice location here in the Bronx - We have offices conveniently located in Manhattan, Staten Island, Brooklyn, Long Island, and the Bronx. To find out all our locations along with contact details, please visit: http://spinepainny.com/mobile-page/directions/

**Stephanie Salas, MD, MHSE**, Board Certified Internal Medicine

Accepting new patients - We wish to welcome BCMS Board Member, Stephanie Salas, MD MHSE Internal Medicine...best of luck in your new practice on Waters Place...
**SPECIAL PRICING FOR PHYSICIANS 50% OFF**

Date: ___________________________
PO: ____________________________
CSR: ____________________________

**BILL TO:** ____________________________
MAILING ADDRESS: ____________________________

PHONE: ____________________________

**SHIP TO:** ____________________________
SHIPPING ADDRESS: ____________________________

PHONE: ____________________________

**METHOD OF PAYMENT**
- Check or Money Order # ____________________________
- Credit Card # ____________________________

Expiry Date: ____________________________
Security Code: ____________________________

**UNITs**

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<th>Item #</th>
<th>HEALTHMATE</th>
<th>Black</th>
<th>White</th>
<th>Sand</th>
<th>Mid. Blue</th>
<th>Price Ea.</th>
<th>S/H Ea</th>
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Model #: ____________________________
Serial #: ____________________________
DOM: ____________________________
Color: ____________________________

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**ORDER TOTAL:** ____________________________

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