ONC is pleased to announce the selection of 28 practicing providers & office staff from 18 states to serve as the inaugural class of Health IT Fellows. These Fellows are clinicians, office staff and administrative office champions who have taken meaningful use and leveraged it to become more efficient and innovative in their practices. Health IT Fellows will hinge on past experiences to promote patient-oriented care. With the Health IT Fellows program, we hope to help other providers overcome challenges faster and more efficiently by sharing key lessons learned. If these lessons are specific and actionable, we can help both providers and patients become more informed – and empowered. The Health IT Fellows will help promote and focus attention on stories, tools, and technical assistance that can be used in providers’ offices nationwide – and to help make these tools better with the goal of keeping the patient at the center of care.

How were the Health IT Fellows chosen? The Health IT Fellows are practicing health care professionals who have turned their attention toward innovation and improvement in patient care by using and leveraging new technologies in their practices. The Fellows were nominated due to their stature as recognized health IT leaders in their communities, and ONC based their selection on a variety of factors, including: Experience in leveraging Meaningful Use: How that experience can help other clinicians and office staffs replicate solutions to common problems-Diversity of experience brings unique viewpoints to the Health IT Fellows team. The Health IT Fellows represent a variety of unique viewpoints, as they come from a variety of settings, such as: clinical backgrounds, specialty backgrounds, locations, practice roles…In addition, many of the Health IT Fellows are already lending their insight to ongoing national conversations—for instance, in areas such as patient safety and implementation of the Million Hearts initiative. We are honored to have such a dedicated group of champions, and we look forward to moving forward together through our Health IT Vanguards program. We encourage you—providers, office staff, and administrators everywhere—to join in this conversation by telling your story and emailing us at HealthITVanguard@hhs.gov.

Front Row (left to right): Christopher Tashjian, Bethany Sanders, Felix Carpio, Frank Maselli, Dr. Sumir Sahgal, Bambi McQuade-Jones, Lisa Lyon, Annick Hebou
Back Row (left to right): John Berneike, Dennis Saver, Gustin Ho, Drew Jackson, Frank Sonnenberg, Angela Murphy, Paulo Pinho, Farzad Mostashari, Raj Desai, Douglas Ashinsky, Eugene Heslin, Jen Brull, Emily Krohn, Emily Milton, Lisa-Nicole Danehy, Angie Walker
Not pictured: Alan Barton, Robyn Chatman, Tiffany Nelson, Karen Smith, Steve Stark, Brian Yeaman

Make Your Reservations Now!
Annual Membership Meeting – Wednesday, October 16, 2013
Visit Our New Website: www.bronxdocs.org -For all Society Updates, News, Events & Photographs
**United HealthCare's (UHC) Network Optimization**

MSSNY has been informed by UHC staff that UHC will be ending their Medicare Advantage contracts with approximately 2100 physicians in the NY downstate region, as part of their 'Network Optimization' program. This activity will impact approximately 8,000 Medicare beneficiaries. UHC will be sending letters to the impacted physicians and patients starting in October 2013. The physicians impacted will be those medical practices with an average panel size of 4 patients or less. These letters will indicate that their UHC Medicare Advantage participation will end, effective January 1, 2014. All United Medicare Advantage benefit plans will be removed from the physician's contracts. The physician's participation in Commercial or Medicaid benefit plans will not be terminated through this process.

The UHC Medicare Advantage patients will be instructed to select another UHC Medicare Advantage network physician for services rendered on or after January 1, 2014.

MSSNY has asked to receive copies of the sample letters in advance of UHC's mailing. However, we have not received them as of this writing.

In consideration of existing patient/physician relationships, we would hope that the UHC letter to the Medicare Advantage patients inform them that Medicare’s Open Enrollment period is October 15 - December 7, 2013. During the Medicare Open Enrollment Period, ALL people with Medicare can change their Medicare health plan and prescription drug coverage for 2014. Information on 2014 plans will be available beginning in October. People with Medicare can call 1-800-MEDICARE or visit [www.medicare.gov](http://www.medicare.gov) for plan information. These patients also have the ability to change their Medicare coverage back to the traditional fee-for-service Medicare plan, if they so choose.

**New Member – elected 9/24/2013**

Ryan Rogers, MD
Basil Kurdali, MD
Susan DiStasio, DO
Paul Levin, MD
Manisha Kulshreshtha, MD
2 Resident Members
45 Einstein Medical Students

**What Are Patients Looking for?**

Patients generally can't tell whether doctors are making the right diagnosis or prescribing the right treatment, but patients do make judgments on the quality of care they receive. Their perceptions are affected by their interactions with the practice on the telephone, the ease of finding parking, and their interactions with staff and healthcare providers. Based on my experiences as a physician, I started an online patient satisfaction survey service, [www.DrScore.com](http://www.DrScore.com),[1] where patients can rate their doctors and look up doctor ratings. We've analyzed the survey results to determine what patients think is important to an excellent medical experience.[2] Quality of diagnosis and treatment plays a role, but more importantly, patients value access and communication with their doctor; a doctor who is supportive, caring, and compassionate; follow-up on test results; quality facilities; and a friendly office staff.

Sometimes we doctors are so caring, so well trained, and so efficient that we can quickly identify a problem and know exactly what to prescribe. When we do that, though, the patient may feel that we were uncaring and that we didn't take the time to do a proper examination or consider the best course of treatment.[3] It's not enough to just be caring and technically expert; the doctor also has to make the effort to communicate that care and empathy to their patient and to provide a uniformly excellent medical experience. When doctors do that, patients are more satisfied. They are also more trusting and adherent to medication -- they actually do better clinically -- not to mention being less likely to sue![4,5] By measuring their patients' satisfaction, doctors gain the information they need to assure patients the best possible medical care experience.

That's my opinion. I'm Dr. Steven Feldman.
MSSNY Council Meeting Highlights  September 12, 2013

Dr. Unterricht opened the Council meeting with a presentation of the Albion Bernstein Award to Anthony Szema, MD. Dr. Szema is an assistant professor of medicine and surgery at Stony Brook University School of Medicine and is Chief of the Allergy Section at the Veterans Affairs Medical Center in Northport. He was the first to describe new-onset asthma among previously healthy soldiers from Long Island who had been deployed to Iraq and Afghanistan. The Albion O. Bernstein, MD Award is given to a physician, surgeon or scientist who has made a recent and widely beneficial scientific discovery in medicine, surgery or the prevention of disease.

Michael T. Goldstein, MD, JD, discussed Physician Cooperatives, Guilds and Unions, based on his ABA article entitled, American Medical Cooperatives Using the Agricultural Model: Legal and Structural Analysis. “Private practice and small group practice were once the major method of healthcare delivery in the U.S.,” Dr. Goldstein told the Council. “Today only 39% of physicians practice independently and that number is declining at a rate of 2% per year.” Instead of inventing new entities for physicians who want to practice independently, Dr. Goldstein proposes the adoption of an existing business model, the agricultural cooperative. “Coops restore balance and can increase competition.” Following the presentation by Dr. Goldstein, MSSNY’s Legal Counsel Don Moy said that “in order to form a cooperative, a group of physicians must be willing to invest both time and capital.” Dr. Unterricht recommended the formation of a workgroup to discuss this concept further.

Executive Vice President Phil Schuh reported that the MSSNY Council Executive Committee agreed unanimously this summer not to participate in the AMA Partnership for Growth (PFG) agreement for the 2014 dues year. The AMA had changed the agreement as it relates to state usage of AMA data. (MSSNY would have been required to destroy all nonmember records in our files that originally came to our attention through the AMA, if the agreement were ever terminated). The terms also stated that the AMA could terminate the agreement at any time for any reason, thereby forcing the issue. MSSNY had been one of only 17 states, and the last large state, to continue with this arrangement. The major immediate change resulting from this change is that MSSNY will no longer bill membership dues on behalf of the AMA.

9/11 First Responders, Survivors Must Register for VCF Economic Compensation by Oct. 3

Oct. 3 is the deadline for most 9/11 first responders, recovery workers, and survivors to register for economic compensation through the Victim Compensation Fund (VCF). Anyone who was injured or made ill by the toxins released that day should take the time to find out about the VCF and if they should register for it by the Oct. 3 deadline. In early July the VCF had over 20,000 registrations submitted, but as a result of the amount of outreach that has been done, they now have over 27,000 registrations submitted. The financial compensation available through the VCF applies to injured and ill 9/11 first-responders and survivors. Those who believe they are eligible for compensation can register by visiting the VCF’s website at www.vcf.gov. The VCF website has a significant amount of information regarding eligibility and the registration process, but injured and ill 9/11 first responders and survivors should be aware of several facts:

Most must register by the Oct. 3 deadline, or they will not be able to file a claim.
You MUST register with the VCF – even if you are enrolled in the World Trade Center Health Program and are receiving its health benefits.

AMA News Ceases Publication

The American Medical Association recently ceased publication of American Medical News, which ran the final edition of the paper on September 9. The publication was launched in 1958 and written for the practicing office and hospital-based medical community. In lieu of a print publication, the AMA plans to enhance online communication channels for physicians.
Employers Required to Provide Employees with Notice of Exchange Availability by October 1, 2013

The Federal Department of Labor has posted a notice on its website (http://www.dol.gov/ebsa/newsroom/tr13-02.html) reminding employers with over $500,000 in annual volume of business of their obligation under PPACA to notify new and current employees of the availability of health insurance Exchanges in their respective states and their possible eligibility for tax credits to subsidize the purchase of this coverage. The notice is required to be provided to existing employees before October 1, 2013 and to new employees after October 1, 2013. However, according to an FAQ on the DoL website (http://www.dol.gov/ebsa/faqs/faq-noticeofcoverageoptions.html), “there is no fine or penalty under the law for failing to provide the notice”.

The Department of Labor notice also contains a link to templates that employers may use to provide this required notice to employees: This is the DoL form for employers who provide health insurance to their employees (http://www.dol.gov/ebsa/pdf/FLSAwithplans.pdf) and This is the DoL form for employers who do not provide health insurance to their employees (http://www.dol.gov/ebsa/pdf/FLSAwithoutplans.pdf)

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NY State of Health will expand its hours and begin enrolling New Yorkers in health plans starting on October 1, 2013, but you can call us now to learn more or you can visit our website at nystateofhealth.ny.gov.

Thank you for your interest in NY State of Health. We'll send you more updates soon.

Resource for Caring for Patients with Addictions

How has the stigma of addiction affected the lives of your patients and their families? How has it affected your screening and treatment of patients? These are the types of questions that the National Institute on Drug Abuse (NIDA), part of the National Institutes of Health, explores in the Addiction Performance Project Addiction Performance Project—a new online learning module about caring for patients with addiction. The online APP was adapted from a series of 16 live events that featured actresses Blythe Danner and Debra Winger and panelists such as Congressman Patrick Kennedy and Dr. Nora Volkow, Director of NIDA. This unique learning experience includes professional actors reading from Eugene O’Neill’s Long Day’s Journey into Night—a play about one family’s struggle with alcohol abuse and morphine addiction. The module combines the play reading with reactions from expert panelists—including family medicine physicians and other specialists—to challenge physicians to think about barriers to treating patients with substance use disorders.

The module also contains guidelines for engaging patients in a discussion about their drug use and tips for talking with patients about entering formal treatment when necessary. The APP is part of NIDAMED—an initiative to provide free, science-based resources to clinicians to help address drug abuse and addiction and improve clinical outcomes. For more information about the APP or any of the other NIDAMED resources, contact nidacoeteam@jbsinternational.com

MSSNY Hassle Factor Form

The Medical Society of the State of New York’s Hassle Factor Form may be completed online to report insurance administrative and claims processing concerns including settlement disputes that you may have filed. The information provided will be used to assist MSSNY in identifying trends and facilitating public and private sector advocacy related to health plans. MSSNY’s Ombudsman office can be reached at (800) 523-4405, ext. 318.
REGISTRATION FORM
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Annual Membership Inaugural Meeting
Wednesday, October 16, 2013
MARIO’S RESTAURANT – 6:30 PM
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All physicians are welcome. There is no charge to attend, but space is limited. You must pre-register on or before October 12, 2013

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Diane P. Miller, Executive Director
3560 Netherland Avenue, Suite 2F
Bronx, NY 10463-1601

Deadline: October 12, 2013
Preventative Planning Not Just for Health
Jennifer Kirschenbaum, Esq

Every so often I am reminded that many (too many) of our professional clients who preach preventative care do not take the most basic steps to protect themselves and their family. I had one such reminder recently, when a client received a very unfortunate diagnosis requiring her immediate retirement due to disability from medicine. This provider would have automatically qualified for a disability benefit had this provider had a policy in place. She did not. She will not be receiving any benefits. So, I am prompted to send a quick reminder—a checklist for you to review for both yourself and your family.

Do you have:
- Disability Insurance
- Life Insurance
- Will/Trust/Estate Planning
- Appointed Guardian for your children (often handled in a Will but worth a separate mention)
- Healthcare Proxy
- Living Will
- Power of Attorney

The above list might seem like an optional list of items you can eventually get around to, or better yet, not bother with at all. Wrong. It is mandatory for anyone who does not want his or her loved ones to suffer from lack of planning, protection or direction. Insurance should be self-explanatory, but I will touch upon it briefly regardless. If you become disabled and cannot work many of you would not be able to earn a living, which may cause some difficulty. Same thing with your life. You can insure against these risks. Please do so.

**Living without a Will** means you are okay dying without a Will. This also means you are satisfied with our government and legal system and that you are willing to trust the dissolution of your remaining assets and minor children and/or dependents to the government once you are gone. Don’t wait, call for a consult to discuss. A Will is a standard document modified to fit your personal needs. You should not be using legal zoom for this document, however having a Will drafted (even with a Trust and certain planning) is not a major expense, and one that can potentially save your loved ones an emotional and financial expense.

I’m always surprised how few healthcare practitioners have a healthcare proxy, living will and/or power of attorney. Why are you risking having your end of life care in someone else's hands when you know the cost?

**To discuss Wills, Trusts, planning, proxies and power of attorney,** call Jennifer at (516) 747-6700 x. 302 or email Jennifer at Jennifer@Kirschenbaumesq.com. Our firm's Trust and Estate attorneys have agreed to extend our Medical/Dental/Chiropractic Society discounts and to expeditiously assist in getting your needed planning documents in place.

For a referral for Disability and Life insurance, and for assistance planning for retirement (preferably age 65 not 85), email Jennifer for a referral to a trusted adviser.
Telemedicine in today’s Healthcare

Leila Mahdavian MD, Shervin Mortazavi, MD

Introduction:

Telemedicine is a diverse and comprehensive concept that incorporates transfer and exchange of medical information using telecommunication technologies, beyond the main concept of single patient/practitioner interface. Craig and Patterson (2006) outlined natural extensions that could include electronic link between multi-center care facilities either locally, nationally or internationally. Telecommunication technologies can be used to facilitate the delivery of health care to patients living in remote areas and enable information exchange between healthcare professionals.

Logan (1998) defined telemedicine as a "Simply a tool that permitted more equitable distribution of comprehensive specialty and subspecialty health care services to remote populations. Telecommunication technologies can be used to facilitate the delivery of health care to patients living in remote areas and enable information exchange between health care professionals (Maheu et al, 2001).

Levels and types of telemedicine:

Craig and Patterson (2006) said all telemedicine interventions are based on patients or professionals obtaining an opinion on treatment or care from someone who is more experienced or an expert in a particular field. According to Maheu et al, such intervention could be categorized into four levels:

Level 1 - using emails or faxes to transfer medical data over telephone lines

Level 2 - transmitting still images or “store and forward” information such as electrocardiogram strips, pathology slides and/or X-rays;

Level 3 - transmitting synchronous, interactive, audio-visual communications. This requires satellite, telephone and microwave or internet technology;

Level 4 – started as a research project at the US Department of Defense. The technology was designed for remote palpation and guided robotic surgery.

Examples of telemedicine applications:

Patient care: Radiology consults, post-surgical monitoring, triage of ER patients

Professional education: CME programs, education resources, individual mentoring and instructions

Patient education: online help services for patients with long-term conditions and their families

Research: Aggregation of data; conducting and coordinating research at multiple sites

Public Health: Access to care for disadvantaged groups; poison control centers; reporting statistics

Healthcare administration: Video conferences for managers of integrated health systems; quality monitoring

Benefits of telemedicine:

Telemedicine can be used to monitor patients’ health from a distance, offer advice and manage healthcare needs effectively.

Hui et al conducted a pilot study on the feasibility of telemedicine in providing geriatric services and whether this method of care delivery might increase productivity and cost savings. Two hundred residents were recruited from a local nursing home. Teleconferencing was used to replace face-to-face outreach services over one year. The feasibility of telemedicine was evaluated by participating specialists (medical staff, nurses, psychologists, physiotherapists and occupational therapists), who tested productivity gains, use of hospital services and user satisfaction.

The findings suggested telemedicine was an adequate means of service delivery in up to 99% of cases, in that follow-up intervals were reduced, follow-up care via teleconferencing was cheaper than face-to-face outreach or clinic activities and, importantly, patients accepted telemedicine as a valid form of continuity with healthcare professionals. A 9% reduction in A&E visits and 11% fewer admissions to acute hospital wards demonstrates more tangible economic savings.

Hui et al concluded that telemedicine is a feasible means of delivering multidisciplinary care to frail nursing home residents and may result in increased productivity and significant savings.

Pain et al conducted a randomized controlled trial in three centers over two years to evaluate the effectiveness of using internet-based video link technology. The study was for patients in the first six months post-discharge from spinal rehabilitation centers. Standardized assessments took place before allocating participants to intervention or control groups. Both groups received standard post-discharge support, but the intervention group also had regular videoconferencing sessions. Participants also underwent assessment at two months and six months post-discharge. The results (from 77 participants) revealed significant differences between the two groups when quality of life intra-subject score differences between discharge and month six were compared (p=0.025). Other findings indicated that the video link was accepted by the intervention group.

Pain et al suggested regular expert consultation after discharge via video-link technology benefited participants’ quality of life. Participants suggested that tele-rehabilitation
should be targeted at people assessed as having continuing healthcare or rehabilitation needs. This supports earlier points on the efficacy of telemedicine as a malleable tool for acute care and follow-up and preventative healthcare. Other benefits include educational opportunities for healthcare professionals. Similar considerations of ease of access, travel constraints and costs, applicable to patient care, also apply here.

Telemedicine is also playing a major role in home care collaboration and partnership working between primary and acute care professionals. The driving forces for this are patients being discharged earlier from hospital with some additional care needs at home; treating patients at home is cheaper than in hospital and many prefer to stay in their own homes rather than moving to nursing homes or hospices.

Advocates of telemedicine argue it offers effective advice and enhanced communication between healthcare professionals and relatives. Guest et al examined its use in helping neurologically impaired children at home. One family was recruited as a pilot study to assess the feasibility of telemedicine. The findings suggested the family did not feel isolated from expert help and advice since the technology was simple to use and they found tele-consultations as reassuring as face to face consultations. The child was able to spend more time with family in a familiar setting instead of hospital. The family indicated significantly improved independence.

Soopramanien et al examined telemedicine in providing post-discharge support for patients with spinal cord injury (SCI), with a sample of 12 patients recruited from a spinal center in the UK. Preliminary results indicated telemedicine enabled healthcare professionals to gain better understanding of family interactions, facilitating more effective care. The study concluded that telemedicine offers an additional means of support for outpatients with SCI.

The role of telemedicine:

Healthcare related technology is evolving rapidly, and telemedicine is part of this quickly changing field. Critical elements of care from store and forward dermatology consultations to emergency stroke management are being provided as telemedicine services. Medical education, training, and conferences are routinely augmented by telecommunications technologies. Telemedicine provides specialty services both acute and chronic care settings such as psychiatry, perinatology and emergency stroke management to the vulnerable populations where inadequate public transportation, payment systems, and access to care is limited. There are many successful telemedicine programs at AHDs across the United States. Implanting and operating and enterprise level telemedicine program at the University of California, San Diego (UCSD) Medical Center has been very successful contracting with more than 40 remote locations, offering services in Psychiatry, General Neurology, HIV Neurology specialty care, pain medicine, Hepatology, Internal Medicine, Endocrinology, Neonatology, and Oncology. There are 15-20 other specialties at various stages of development.

Investigators at the university of California San Diego Health System [ED Manag 2013 Aug; 25 (8): 93] performed a study to see if Telemedicine can ease crowding and the long wait times in ED. Although there are administrative hurdles on the way but the study shows this strategy could offer big savings in terms of time and efficiency. Remote physicians can evaluate patients in multiple ED sites while the on-site nurses facilitate telemedicine encounters utilizing the technology. Investigators say the approach could produce significant gains in efficiency, including the possibility that a single on-call physician could remotely treat patients from multiple ED sites.

The quality of care delivered to critically ill children receiving telemedicine in rural emergency departments was evaluated in retrospective charts review at the UC, Sacramento.[critical care Med 2013 Aug 5] Quality of care was independently rated by two pediatric emergency medicine physicians applying a previously validated 7-point implicit quality review tool to the medical records. Quality was compared using multivariable linear regression adjusting for age, severity of illness, and temporal trend. Referring physicians and parents were surveyed to evaluate consultation-related changes and parents satisfaction. In the multivariable analysis, with the no consultation cohort as the reference, overall quality was highest among patient who received telemedicine consultations [n=63; b=0.12 (95%CI, -0.14 to 0.39)], and lowest among patients receiving no consultation. Referring emergency department physicians reported changing their diagnosis (47.8% vs 13.3% p<0.01) and therapeutic interventions (55.2% vs 7.1% p<0.01) more frequently when consultations were provided using telemedicine than telephone. Parent satisfaction were significantly higher when telemedicine was used, compared with telephone, for six of seven measures. Overall, according to this study Telemedicine was associated with more frequent changes in diagnostic and therapeutic interventions, higher parent satisfaction and physician-rated quality of care.

A study done at the department of Veterans Affairs Pacific Islands Healthcare System [telemed J E Health. 2013 Aug 9] provided evidence that delivery of psychotherapy via clinical video-teleconferencing (CVT) to the veteran with the posttraumatic stress disorder (PTSD) was a cost-reducing mode of service delivery. Several cost outcomes were calculated in order to investigate the clinical and cost outcomes associated with CVT delivery modality relative to in person delivery. Telemedicine (CVT) enables veterans who would not normally receive services to empirically based treatments at a much lower cost.

Telemedicine has been impacting triage of patients which reduces the need to transfer patients to subspecialty care.
and enables them to stay in community hospital for their treatments. University of California, San Francisco Division of Pediatric Care has investigated the role of Telemedicine consultation between pediatric intensivists and community hospital physicians combined with a pediatric hospitalist program at the community hospital (Telemed J E Health 2013 Aug 12 ).153 charts were analyzed: 41 from prior to hospitalist and telemedicine implementation( cohort 1)153 charts were analyzed: 41 from prior to hospitalist and telemedicine implementation( cohort 1), 56 from post-implementation of telemedicine but pre hospitalist program (cohort 2), and 56 after implementation of both the telemedicine and hospitalist programs (cohort 3). Baseline data did not differ among cohorts. Transfer rate after intensivist consultation were lower after implementation of telemedicine consultation(100%, 85.7%, and 87.5% in cohorts 1-3 respectively). p=0.04). The proportion of transferred patients who were diverted to the tertiary ward decreased over time (19.5%, 14.5% and 6.1% in cohorts 1-3, respectively; p=0.003). This retrospective charts review showed potential improvements in lesser referrals to subspecialty and thus less costs and more convenience.

A retrospective study on Telemedicine carried out by the Department of Oral and Maxillofacial Surgery, University College Hospital in London has confirmed that telemedicine provides adequate information to make clinical decisions in children with facial lacerations.[Pediatr Emerg Care 2013 Aug ] Of the 2524 telemedicine referral, 27% were pediatric referrals. 145 of these were children with facial laceration, with average age of 4.85 and male-to-female ratio was 2:1. Laceration to the lips (42%) were the most common site of injury, and 42% of cases were due to mechanical fall. Among the telemedicine group, 86% had surgery, whereas in the non-telemedicine group it was 82%. On average, 2 to 3 photographs accompanied the referrals, and none of the patients who were treated conservatively by the referring center following telemedicine referral and discussion with Queen Victoria Hospital required a referral.

So far the literature indicates that telemedicine can reduce healthcare costs by providing appropriate care to patients at home, reducing the need to travel to specialist centers. In addition, unnecessary duplication of test results and other information can be reduced.

However, there is a need for large-scale trials to examine the cost-effectiveness of telemedicine applications in healthcare services as there is little quantitative information about potential savings.

References

1) Meyer, Brett, M.D.; Clark, Christopher A.; Troke, Tana M. MBA; Friedman, Lawrence S. MD. Essential Telemedicine Elements (Tele_Ments) for Connecting the Academic Health Center and Remote Community Providers to Enhance Patient Care. Academic Medicine, volume 87(8), August 2012, p 1032-1040


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