The Bulletin

FOR MEMBERS OF THE MEDICAL SOCIETY, COUNTIES OF ERIE AND CHAUTAUQUA **WINTER 2017**

Medical Society of the County of Erie and
The Medical Society County of Chautauqua
1317 Harlem Rd.
Buffalo, NY 14206

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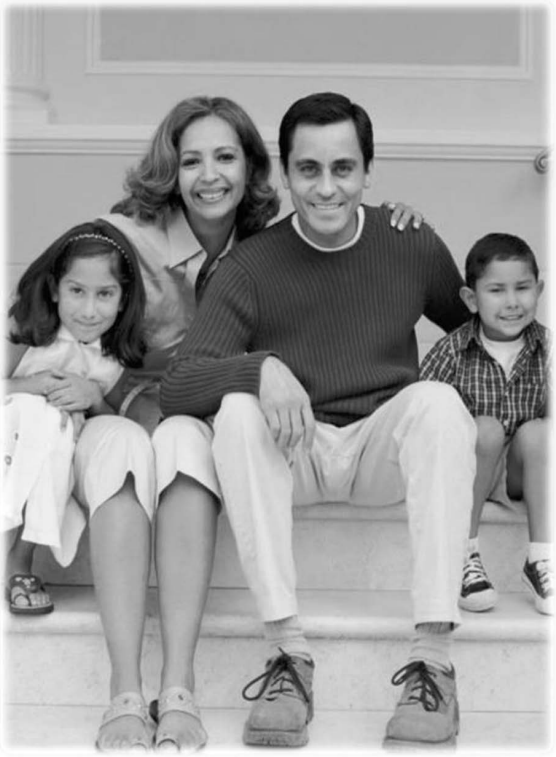

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The New Physician Practice Committee
(Irene Danziger, M.D., Chair)
of the
ERIE COUNTY MEDICAL SOCIETY
invite you to join us for a

"Meet & Greet"

Thursday, January 25, 2018
6:00 p.m. – 9:00 p.m.
1317 Harlem Rd., Buffalo, NY 14206

Join us for an evening to meet your colleagues and the medical students and Residents from SUNY at Buffalo, Jacobs School of Medicine.

Pizza, wine & beer will be served.
Hosted by The Charles Sellers Company

RSVP is required by January 23, 2018

RSVP via fax: 716-852-2930
or via email: mcmullene@wnydocs.org

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Medical Society, County of Erie
"Better Health Through Advocacy"™
"If Not You...Who"™

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A Message from the President

Willie Underwood III, M.D.

ADVOCACY AND POLITICAL ACTION: ARE NOT SELF-SERVING

As many of you may know, I have been involved in organized medicine and advocating on behalf of physicians for more than 20 years. About 12 years ago during a national meeting, I asked an internationally known urologist to donate financially to the Urology Political Action Committee (UROPAC) and to donate time to advocate on behalf of physicians. His response caught me off guard. He stated that he didn't involve himself in **self-serving activities** such as those that only benefit self, instead, he spent his time in activities that benefited others and society. "I just want to take care of my patients and I don't have time to get involved in those self-serving activities."

To understand why his response troubled me, I must give a brief background of this well respected ionic urologist. For the sake of this discussion, I will call him Dr. Smith.

Dr. Smith is a urologic oncologist, renowned expert in bladder, kidney and prostate cancers. He performed more than 7,000 prostatectomies (open and robotic), built one of the top urology departments in the county, trained and developed 100's of physicians. He has served as President of the Society for Urologic Oncology, is a fellow of the American College of Surgeons and has served on numerous boards within the organization, and has been active on boards and committees within the American Urological Association, the American Society of Clinical Oncology, the Society of University of Urologists, and others. He is recognized as a leading educator and researcher in the field, and published extensively (co-authored more than 200 peer-reviewed publications). If I stated that his character is above reproach, it would be an understatement. For example, he goes to other countries to perform volunteer surgeries on his own dime and time. During one his trips to Africa, while traveling home, as usual he called to check on the people that he operated on. After hearing that one of the people was having a complication, he immediately jumped on a plane back to Africa to manage this person's care. He stayed in Africa until the person recovered.

As you can imagine his response to my request floored me. I was speechless. How could he think that it was self-serving? He is already a great advocate for physicians and his patients. Did he think that the driving purpose of organized medicine and medical political action committees are to line physician's pockets with silver, gold, platinum, diamond and rubies (you get the point)? I am sure that many physicians feel that same way. For some physicians, it is a justification to not get involved, to not provide support for the cause so to speak. "I just want to take care of my patients and I don't have time to get involved in those self-serving activities."

Dr. Smith, our advocacy resulted in legislation by example only, in millions of poor and lower middle-class children and pregnant women receiving healthcare (SCHIP), expansion of federal medical research funding in several areas, the development of the Joint Commission and the Accreditation Council for Graduate Medical Education (ACGME). On the flip side, our lack of strong advocacy and political action has resulted, by example only, in inadequate funding for graduated medical education; health insurance companies' consolidation leading to increased profits for them, increased premiums for patients and lower reimbursement to providers; and an electronic health record system that increased costs to medical practices, frustrations to physicians and has not improved healthcare delivery as promised.

To summarize, our advocacy and political

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To the Health Care Providers and Staffs of WNY

Gary Andelora

It is with a great amount of joy (and sadness at the same time) that I announce that I will be retiring from MLMIC as of January 1, 2018. It has been a great run of 27+ years, and I am taking away so many cherished memories. I have met a number of truly special people and am honored to have developed a number of professional as well as social relationships with so many.

I am so looking forward to returning to teaching, and already have some teaching "gigs" set up for the New Year. This combined with a number of other planned activities should keep me busy well into the future.

I wanted to take this opportunity to thank each of you for the support and guidance you have shown me over my career. It has been both an honor and privilege to work with you. I will move on now and enter other circles and meet many new colleagues. However, I will never forget working with the medical community and will always consider it to be a highlight of my life.

Regards,
Gary A.

A Message from the Executive Director

Christine Ignaszak Nadolny

On Christmas Eve our family gathers and shares the oplatek, a wafer made from unleavened wheat and water. As we pass the oplatek among everyone present, it is at that time we share our wishes for each person and give thanks for all the blessings we have received. Since I will not be present at the meal which is the centerpiece of *your* holiday, I want to share my thanks through the words I offered on November 11, 2017 at the opening of the AMA's Interim meeting – consider this as my passing the oplatek to you...

After 75 combat missions, Navy jet pilot Charles Plumb was shot down by a surface to air missile. Years after his release from a communist Vietnamese prison, he was approached by a man who identified him and remarked that he was glad that Plumb had ejected safely and survived. With astonishment Plumb asked the man how he knew. The man's response was that "I packed your parachute".

As the recipient of this years Lifetime Achievement Award I realize that when I began my career, working with physicians, I was the beneficiary of a well packed parachute. In the past 41 years, my parachute has been continuously upgraded with resources, collegiality, mentorship and most importantly friendship and trust. Each of you have continuously encouraged me to initiate new relationships which will advance the medical profession, or to provide assistance to both you and your staff. Among the most successful has been our liaison with the Bar Association of Erie County, which has provided a platform for mutually beneficial educational programming and understanding of each profession.

I am humbled that the AMA has chosen me to receive this award, but realize that the success I have achieved is because I stand on the shoulders of truly good physicians and their support staff in Western New York. Among those I need to thank, are past members of the AMA's House of Delegates, including James Cosgriff and Dick Peer. I wish to thank Tim Gabryel, Nancy Nielsen and Tom Madejski for nominating me for the award. I also want to express my thanks to every one of you and your staff because without you, I would not have received this honor.

May each of you have a happy holiday season, and a healthy and prosperous New Year.

Chris

Becoming a Doctor, Again.

Julia Faller, D.O., MS, Co-Chair, Legislative Affairs Committee

Like many of us, I knew from a young child I wanted to be a doctor. I truly believed becoming a physician was my calling and I was prepared to embrace it as my life, in its entirety. I would expect the same from my husband and children should they choose to come along for the ride. I would be a doctor all of the time, not just while at work seeing patients, but all of the time. Live it, breath it, feel it, love it.

The first 10 years of my career were spent on developing and improving my skill set and soaking everything in from those who had gone before me. My mentors and my work have allowed me to grow and learn with no end in sight. As I enter the second stage of my career, I think back to the simplicity of those first ten years and marvel at my naivety.

In developing my career, I have become involved in administration, education, our local and state medical societies and international educational opportunities. My interest has broadened to include much more than my specialty and direct patient care. The healthcare delivery system is where my added interest lies and this is where I realize I potentially can have the greatest impact on the health of my patients, my community and my country.

In the interactions with my colleagues at work, during meetings I attend or while traveling internationally, I sense a common theme. Physicians seem devalued, viewed as unimportant and feel a loss of control over the care of their patients. They complain of being burdened by administrative pressures, cost cutting measures and impositions from healthcare entities. When I listen to people, speak with people and interact with my professional colleagues, I hear these same sentiments over and over.

I hear something else though, something much more positive. They want to be doctors. They want to treat their patients, create relationships that influence care and impact the health of their practices and communities. They want to work harder delivering care, not justifying it. This is the overwhelming theme. It is ubiquitous and it comes back to why are we here. We just want to be doctors.

These times will keep changing and we need to lead the change. We need to stand up and take control of our profession and start speaking on behalf of ourselves. We need to see the writing on the wall and act before the walls come crumbling down. It is our responsibility to protect our own profession. It's our responsibility to control what we do with our future. It is our responsibility to care for our patients, our community and our country.

Live it, breath it, feel it, love it...and now, fight for it.

From Screening to Treatment: The Clinician's Role in Eliminating Hepatitis C in New York State

This free half-day program will focus on recently released New York State clinical guideline for hepatitis C (HCV) screening, diagnosis, and treatment selection. Through didactic sessions and case-based discussions, we will explore treatment selection and discuss challenges associated with HCV care and treatment.
This program is intended for providers new to HCV.

Saturday, February 10, 2018
8:00am – 12:00pm
Millennium Hotel Buffalo
2040 Walden Avenue
Buffalo, NY 14220

Seating is limited! Register today at http://rebrand.ly/HCVBuffalo

This program is restricted to New York State medical providers including physicians, physician assistants, nurses, nurse practitioners, certified nurse midwives, dentists, and pharmacists.

Questions? Contact Jessica Steinke at jessica.steinke@mountsinai.org or 212-731-3789

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Continuing Pharmacy Education
The University at Buffalo School of Pharmacy and Pharmaceutical Sciences is accredited by the Accreditation Council for Pharmacy Education as a provider of continuing pharmacy education. "From Screening to Treatment: The Clinician's Role in Eliminating Hepatitis C in New York State", a knowledge-based live activity, ACPE #0044-9999-17-051-L01-P, will award 4 contact hours or 0.4 CEUs. of pharmacy education credit. *No partial credit will be awarded.*

Continuing Nurse Education Contact Hours
The University at Albany School of Public Health is an Approved Provider of continuing nurse education by the Northeast Multi-State Division, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.
This offering is approved for 4.0 nursing contact hours.

Continuing Medical Education
The School of Public Health, University at Albany is accredited by the Medical Society of the State of New York (MSSNY) to provide continuing medical education for physicians.
The School of Public Health, University at Albany designates this live activity for a maximum of 4.0 ***AMA PRA Category 1 Credits™***. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

CALL FOR NOMINATIONS
Resident Award

The Erie County Medical Society wishes to recognize significant achievement by a Resident currently in training. Therefore, the Medical Services Committee of the Erie County Medical Society has established the following criteria for each award. Any member or non-member of the Society, faculty, hospital personnel, peers, and community members are invited to submit nominations for those residents who have demonstrated outstanding work and commitment to the practice of medicine. Self-Nominations will also be considered. We recommend any nominated candidate be a member of the Erie County Medical Society.

Resident Award Criteria:

The candidate must:

1. Be enrolled in an accredited residency program in Erie County, New York
2. Display excellence in the performance of his/her duties, including patient care, research, and teaching
3. Display leadership qualities and abilities
4. Show evidence of service to the profession of medicine
5. Submit two letters of recommendation, one of which must come from the Program Director or Department Chair.
6. A monetary award has been established.

All submissions must be received at the
Erie County Medical Society
1317 Harlem Rd., Buffalo, NY 14206
or via email: nadolnyc@wnydocs.org
by January 20, 2018.

John Stubbenbord, M.D. ~ 10/23/2017
Raymond Hudson, M.D. ~ 12/17/2017

Referring Patients to New Physicians?

Please direct patients looking for physician referrals to our website (www.eriemds.org), where they can utilize the Physician Locator service. Once they have selected a specialty and area, all physicians in our membership who are accepting new patients will be listed.

Welcome New Members!

Pratibha Bansal, M.D., Pain Medicine

Maria Brzozowski, M.D., Student

Mikhail Choubmesser, M.D., Anesthesiology

Jennifer George, M.D., Student

Asher Weiner, M.D., Opthalmology

The Bulletin

For further information regarding
article contribution and/or
advertising for the BULLETIN, please contact

Emily McMullen at (716) 852-1810 ext. 102
or mcmullene@wnydocs.org

Audit Protection Assistance: When Prescribing Controlled Substances

Leah S. Ranke Esq., Law Office of Leah S. Ranke, Esq.

As an attorney defending physicians in charting and coding audits, I have seen patient records that could and should have been better written. Today there is probably no such thing as an "audit proof chart," but providers can get a lot closer to optimization than they are.

Prescribing controlled substances, especially for pain, is an important part of treatment. But the charting requirements for pain management have greatly expanded in both number and specificity.

There is a new climate for prescribing pain medication. You might even say it is a whole new planetary atmosphere from where we were even just five years ago, and charting requirements now reflect those changes. We have mandatory consulting of the I-STOP/PMP Internet System for Tracking Over-Prescribing - Prescription Monitoring Program, which went into effect in New York in 2013. Prescribers were required to eliminate most paper scripts, move to mandatory electronic prescribing, register with the New York State Department of Narcotic Enforcement, and the U.S. Department of Justice Drug Enforcement Administration Office of Diversion Control, which had been working on the opioid issue in particular, in stages of implementation since 2006. In 2016, AMA and the CDC issued new pain medication prescribing guidelines, as did the New York State Department of Health. The Surgeon General was spearheading a national information campaign directed at physicians who prescribe pain drugs. Insurance companies had new prescribing and coverage policies in place, and New York adopted the first of two sets of new restrictive laws about the amounts and timing of prescribing and dispensing of prescription pain medications. This year, new State rules for acute pain prescriptions went into effect, directing the dosing and limiting the duration. Major health insurance prescription utilization and management entities like Express Scripts and CVS/Aetna, have now issued policies with lower limits on their coverage of the cost of these drugs. Malpractice carriers have reacted accordingly. I am asked what a provider should do to comply with it all. After we discuss it, I am then asked, how can I eliminate long-term pain medication prescribing from my practice?

Today, the documentation that must exist in an outpatient medical chart to prescribe a controlled substance of any legal type, is very specific. Excepting cancer patients and hospice/palliative care patients, the list of charting requirements for maintaining a patient on long-term outpatient prescription pain management is lengthy, and options are shrinking.

First, the basics in New York; administration, dispensing and prescribing any controlled substance must all be fully documented in the patient's written chart. But what constitutes "fully" is now a much longer list than ever before. The chart must justify both the diagnosis, and that the prescription is warranted. Pursuant to New York State Public Health Law Title 10 Volume A-1a Subchapter K Part 80, §80.62, practitioners may, in the course of their professional practice, dispense, administer or prescribe controlled substances only when it is:

(1) in the course of their professional practice. This means your patients. You cannot write this script for a friend, relative, colleague, or yourself.

(2) for a legitimate medical purpose. The diagnosis must be made and proven, such as a recent MRI proving the patient has a bulging disc, and documentation proving other methods of treating the pain have been exhausted.

(3) in regulated dosage, and

(4) in amounts no greater than is sufficient. Tailoring and tapering is required. The minimum effective dose of the slowest acting, shortest duration drug must be constantly reassessed, and documented.

At a minimum, this means the chart must include the patient identification data; chief complaint; present illness; physical examination as indicated; diagnosis; other data which support the diagnosis or treatment; and the regimen including the amount, strength, and directions for use of the controlled substance.

If the reason for the prescription is short term acute pain, such as for a kidney stone, a broken limb, or post-operative pain (any operation) New York law now states it can be for no longer than a 7-day supply. A second script, for 30 days, and a third beyond that can be written, but not before the prescriber sees the patient in person and completely justifies the need in the patient's record. Beyond 60-90 days is now considered long-term pain management.

Now, the details. Based on available laws and guidelines now in effect, long term pain management charting requirements for prescribers in any area of medicine today are quite lengthy. There are different requirements for the chart from many sources like those listed above, and at three basic stages of treatment: before long-term prescription pain is implemented, during the course of maintaining a patient on long-term prescription pain medications, especially opioids, and when treatment is stopped for any reason. These rules apply to physicians in any medical discipline, mostly affecting neurology,

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Audit Protection Assistance…

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internal medicine, family practice, primary care, orthopedics, rheumatology, and pain management. Going above and beyond the following items listed is recommended for anyone prescribing these drugs. Using the following charting requirements lists should get you started.

Charting requirements at the start of long-term prescription pain management.

In addition to all the other office visit evaluation and management charting requirements, including a complete physical exam and PFSH, at the start of long-term prescription pain management the chart documentation should include:

a. justifying diagnosis recently proven by imaging studies, nerve conduction studies, past ED or surgical records. It is not recommended that you take the patient's, or any other prescriber's word for it. Confirm the need yourself, based on recent proof. That four-year old MRI is not good enough,

b. objective and subjective assessment of the patient's baseline pain and function. Use pain charts, qualitative and quantitative assessment tools, both for the patient to complete, and for you,

c. detailed explanation of all applicable non-prescription medication therapeutic alternatives that were tried and optimized if not exhausted, including: exercise, physical therapy, orthotic devices, meditation, acupuncture, chiropractic, non-opioids, electronic stimulation devices, behavioral treatment, weight loss, non-prescription pain medications, and/or massage. Prove it with records, either your own or, if the patient is new to you, then by requisitioning past records. You should not take the patient's word for it. If this list has not been exhausted, it is not recommended that a patient be on long-term controlled substance treatment for pain,

d. any therapeutic alternatives that in your opinion the patient cannot tolerate or are contraindicated and should not be tried, such as nsaids for a patient on anticoagulation therapy, or PT for a patient with advanced lung disease,

e. detailed patient education and care counseling performed, including the risks of addiction, abuse, overdose, tolerance, increased pain experience, and oversedation,

f. thorough evaluation of the patient's risk factors of harm or misuse, such as obtaining a urinalysis toxicology screen, past overdose history, patient requesting a specific drug by name and dose, past expulsion from another provider's practice, past illicit drug use or treatment, depression or other mental illness,

g. the setting of advanced criteria for stopping the drug, transferring the care of the patient to another provider, and/or discharging the patient from your practice,

h. patient's signature on a well-written pain medication contract, agreeing on the rules. A good contract is one page, its phrases are short and clear, e.g., "No lost or stolen prescriptions will be replaced."

i. realistic treatment goals for pain control and function you set for the patient,

j. choice of drug and regulated dose specifically explained, with the goals of the slowest acting, shortest duration, minimum effective dose,

k. discussion of safety and risk/benefit analysis of drug choice in light of patient's overall health including other prescriptions medications the patient is taking, and

l. of course, check I-STOP to make sure the patient is not doctor-hopping.

Obviously, establishing all of the above takes time. Referring the patient for diagnostic studies, trying non-narcotic alternatives, and getting copies of old records, are not always fast or easy. The time all this takes is a large part of the purpose of these rules, to make controlled substance prescribing a last recourse, especially opioids.

In New York, patients can be dispensed only 30 days of opioids at a time, no refills. The patient must be seen again by the prescriber before another opioid script is written. It is recommended that every prescriber planning to maintain a patient for any reason on a controlled substance for pain longer than 60-90 days make a referral of the patient to a pain management specialist. If the patient has already been there and is stable on a regimen, you should take it over only if you are willing to completely reassess and monitor that regimen as if you initiated it.

Charting requirements at every visit during long-term prescription pain management therapy.

Every physician treating a patient on long-term opioid therapy should know about it, and make a point to chart the following details about their observations and opinions or risks and efficacy. For the prescribing physician especially, at each and every return visit, the chart for a long-term pain management patient on controlled prescription medication, particularly opioids, should include documentation of all of the following:

a. proof that the patient was seen face to face in the office by the prescriber,

b. reassessment of subjective and objective pain and function, and comparison to baseline,

c. detailed proof of clinically meaningful improvement in pain and function without significant risks of harm,

d. observation for signs of over-sedation, overdose risk, diversion,

e. continued effort at optimizing non-prescription therapies, by prescribing alternative therapies, and repeating patient education on weight loss, exercise, behavioral therapies, etc.,

f. continued assessment of safety in light of patient's other conditions and prescriptions,

g. continued patient education on risks and benefits,

h. reassessment of patient's risk of harm or misuse,

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Updates from the American Medical Association Chapter at the Jacob's School of Medicine and Biomedical Sciences

This past semester at the Jacobs School of Medicine and Biomedical Sciences has been very successful for our local student AMA chapter. In August, we welcomed the class of 2021 during orientation week. We were able to recruit over 60% of the first-year class, making it the second consecutive year that we have been able to achieve such high student involvement. Thanks to our members, we continue to maintain our status as the largest chapter in New York State.

In October, our chapter took part in "National Medical Student Advocacy Week." The topic this year was "Combating the Opioid Epidemic." We held a talk titled "The Buffalo Community's Response to the Opioid Epidemic." Dr. Nancy Nielsen, a past AMA president and our current advisor, moderated the talk. We had four additional speakers, including Dr. Gale Burstein, the Erie County Health Commissioner, Dr. Paul Updike, Dr. Joshua Lynch, and Emma Fabian, director of Substance User Health Policy at Evergreen Health. With over 70 students in attendance, we were able to learn about the various efforts that are being led by the Buffalo community to combat the opioid epidemic. Dr. Gale Burstein informed us of the actions that Erie County has taken to battle this issue. We learned about Dr. Joshua Lynch's effort to connect opioid users with addiction treatment from the emergency room. Dr. Updike discussed his work at the methadone clinic and advised doctors and medical students on the treatment of those struggling with opioid addiction. Emma Fabian gave us a non-medical perspective while discussing her work with Evergreen Health,the only needle exchange program located in Buffalo. Dr. Nancy Nielsen concluded the talk with her work as the Chair of University at Buffalo's Addiction Initiative.

Our semester ended with the AMA interim meeting that took place in Honolulu, Hawaii from November 9th-11th. Eight students from the chapter attended the conference, and five students presented research at the research symposium. One of our chapter members, Moudi Hubeishy, ran a strong campaign for Board of Trustees against the incumbent, Karthik Sharma. Although Mr. Hubeishy was not selected as a trustee, the chapter is very proud of how he carried himself and the University at Buffalo's name throughout the campaign. The chapter also submitted a resolution to be discussed at the conference titled "Addressing the Rise of Medical Tuition." We received a great deal of support for the resolution. We hope to continue to bring awareness to this issue and to address this issue within the AMA. This semester has been quite eventful and exciting for our chapter, and we look forward to the coming semester. We always welcome any doctors who are looking to be involved with our chapter. If you would like to contact us, our email address is sunybuffaloama@gmail.com.

The current AMA executive board with Dr. Nancy Nielsen, the chapter advisor

Chapter members attending the Interim Meeting in Hawaii

AMA Honors Executive Director Christine Ignaszak Nadolny

The American Medical Association (AMA) honored Christine Ignaszak-Nadolny, Executive Director of the Erie County Medical Society, with the Medical Executive Lifetime Achievement Award during the 2017 AMA Interim Meeting in Honolulu, Hawaii on November 12th.

Christine has worked tirelessly to support physicians and identify, recruit and engage members," said AMA President David O. Barbe, M.D. "A sustaining force for the organization, she is respected and admired by members of MSCE for her widespread service to the county, district, and other medical and community organizations." Recognized for her leadership and talent for bringing people together in her 22 years of service at MSCE,she has developed strong relationships with local and state officials, helping advance legislative initiatives and respond to evolving regulatory challenges.

Congratulations Chris!

Peter J. Walsh and Lisa J. Walsh
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Converting Savings to Retirement Income

During your working years, you've probably set aside funds in retirement accounts such as IRAs, 401(k)s, or other workplace savings plans, as well as in taxable accounts. Your challenge during retirement is to convert those savings into an ongoing income stream that will provide adequate income throughout your retirement years.

Setting a withdrawal rate

The retirement lifestyle you can afford will depend not only on your assets and investment choices, but also on how quickly you draw down your retirement portfolio. The annual percentage that you take out of your portfolio, whether from returns or both returns and principal, is known as your withdrawal rate. Figuring out an appropriate initial withdrawal rate is a key issue in retirement planning and presents many challenges. Why? Take out too much too soon, and you might run out of money in your later years. Take out too little, and you might not enjoy your retirement years as much as you could. Your withdrawal rate is especially important in the early years of your retirement, as it will have a lasting impact on how long your savings last.

One widely used rule of thumb on withdrawal rates for tax-deferred retirement accounts states that withdrawing slightly more than 4% annually from a balanced portfolio of large-cap equities and bonds would provide inflation-adjusted income for at least 30 years. However, some experts contend that a higher withdrawal rate (closer to 5%) may be possible in the early, active retirement years if later withdrawals grow more slowly than inflation. Others contend that portfolios can last longer by adding asset classes and freezing the withdrawal amount during years of poor performance. By doing so, they argue, "safe" initial withdrawal rates above 5% might be possible. (Sources: William P. Bengen, "Determining Withdrawal Rates Using Historical Data," *Journal of Financial Planning,* October 1994; Jonathan Guyton, "Decision Rules and Portfolio Management for Retirees: Is the 'Safe' Initial Withdrawal Rate Too Safe?," *Journal of Financial Planning,* October 2004.)

Don't forget that these hypotheses were based on historical data about various types of investments, and past results don't guarantee future performance. There is no standard rule of thumb that works for everyone--your particular withdrawal rate needs to take into account many factors, including, but not limited to, your asset allocation and projected rate of return, annual income targets (accounting for inflation as desired), and investment horizon.

Which assets should you draw from first?

You may have assets in accounts that are taxable (e.g., CDs, mutual funds), tax deferred (e.g., traditional IRAs), and tax free (e.g., Roth IRAs). Given a choice, which type of account should you withdraw from first? The answer is--it depends.

For retirees who don't care about leaving an estate to beneficiaries, the answer is simple in theory: withdraw money from taxable accounts first, then tax-deferred accounts, and lastly, tax-free accounts. By using your tax-favored accounts last, and avoiding taxes as long as possible, you'll keep more of your retirement dollars working for you.

For retirees who intend to leave assets to beneficiaries, the analysis is more complicated. You need to coordinate your retirement planning with your estate plan. For example, if you have appreciated or rapidly appreciating assets, it may be more advantageous for you to withdraw from tax-deferred and tax-free accounts first. This is because these accounts will not receive a step-up in basis at your death, as many of your other assets will.

However, this may not always be the best strategy. For example, if you intend to leave your entire estate to your spouse, it may make sense to withdraw from taxable accounts first. This is because spouses are given preferential tax treatment with regard to retirement plans. A surviving spouse can roll over retirement plan funds to his or her own IRA or retirement plan, or, in some cases, may continue the

**Guarantees are subject to the claims-paying ability and financial strength of the issuing insurance company.*

complicated one. A financial professional can help you determine the best course based on your individual circumstances.

Certain distributions are required

In practice, your choice of which assets to draw first may, to some extent, be directed by tax rules. You can't keep your money in tax-deferred retirement accounts forever. The law requires you to start taking distributions--called "required minimum distributions" or RMDs--from traditional IRAs by April 1 of the year following the year you turn age 70½, whether you need the money or not. For employer plans, RMDs must begin by April 1 of the year following the year you turn 70½ or, if later, the year you retire. Roth IRAs aren't subject to the lifetime RMD rules. (Beneficiaries of either type of IRA are required to take RMDs after the IRA owner's death.)

If you have more than one IRA, a required distribution is calculated separately for each IRA. These amounts are then added together to determine your RMD for the year. You can withdraw your RMD from any one or more of your IRAs. (Your traditional IRA trustee or custodian must tell you how much you're required to take out each year, or offer to calculate it for you.) For employer retirement plans, your plan will calculate the RMD, and distribute it to you. (If you participate in more than one employer plan, your RMD will be determined separately for each plan.)

It's important to take RMDs into account when contemplating how you'll withdraw money from your savings. Why? If you withdraw less than your RMD, you will pay a penalty tax equal to 50% of the amount you failed to withdraw. The good news: you can always withdraw more than your RMD amount.

Annuity distributions

If you've used an annuity for part of your retirement savings, at some point you'll need to consider your options for converting the annuity into income. You can choose to simply withdraw earnings (or earnings and principal) from the annuity. There are several ways of doing this. You can withdraw all of the money in the annuity (both the principal and earnings) in one lump sum. You can also withdraw the money over a earnings from the annuity, there is no guarantee that the funds in the annuity will last for your entire lifetime, unless you have separately purchased a rider that provides guaranteed minimum income payments for life (without annuitization).

In general, your withdrawals will be subject to income tax--on an "income-first" basis--to the extent your cash surrender value exceeds your investment in the contract. The taxable portion of your withdrawal may also be subject to a 10% early distribution penalty if you haven't reached age 59½, unless an exception applies.

A second distribution option is called the guaranteed* income (or annuitization) option. If you select this option, your annuity will be "annuitized," which means that the current value of your annuity is converted into a stream of payments. This allows you to receive a guaranteed* income stream from the annuity. The annuity issuer promises to pay you an amount of money on a periodic basis (e.g., monthly, yearly, etc).

If you elect to annuitize, the periodic payments you receive are called annuity payouts. You can elect to receive either a fixed amount for each payment period or a variable amount for each period. You can receive the income stream for your entire lifetime (no matter how long you live), or you can receive the income stream for a specific time period (ten years, for example). You can also elect to receive annuity payouts over your lifetime and the lifetime of another person (called a "joint and survivor annuity"). The amount you receive for each payment period will depend on the cash value of the annuity, how earnings are credited to your account (whether fixed or variable), and the age at which you begin receiving annuity payments. The length of the distribution period will also affect how much you receive. For example, if you are 65 years old and elect to receive annuity payments over your entire lifetime, the amount of each payment you'll receive will be less than if you had elected to receive annuity payouts over five years.

Each annuity payment is part nontaxable return of your investment in the contract and part payment of taxable accumulated earnings (until the investment in the contract is exhausted).

Audit Protection Assistance…

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i. random pill counts, and repeat urinalysis toxicology report, looking for no illicit substance use, and the presence of the requisite amount of the prescribed medication to prove the patient is not engaged in diversion,

j. documentation of warning signs such as requesting early refills, or threatening behaviors,

k. reason for any drug or dose changes, such as due to health insurance coverage limitations, formulary changes, or adverse effects,

l. repeat analysis of whether to continue, adjust, taper, or stop the prescription. Refilling of opioids should never appear in the chart to have been automatic.

Charting requirements when long-term prescription pain management treatment is stopped for any reason. Every effort should be made to have the patient back in the office for a face to face appointment to explain the reasons for the practice determining not to continue to maintain the patient on a long-term controlled substance. Perhaps the practice has decided it cannot dedicate the necessary resources to all of the above, or that the risks or costs to the patient and practice are too great. Perhaps the patient broke their prescription pain contract. For whatever reason the controlled substance prescriptions are ending, the patient chart should include:

a. list of any signs of misuse or harm detected, such as the toxicology report, or detection of drug seeking behaviors,

b. proof that the dose is tapered safely toward cessation or stoppage as medically appropriate,

c. documentation that the patient was counseled in person about your findings, and if applicable, of substance abuse dangers, and referred for drug abuse treatment, if applicable,

d. proof that you gave the patient as much written and verbal advance notice of the decision as is safe and possible, optimally, 60 days to effectuate proper notice, transition, and referrals to other providers, especially when it was not due to any fault on their part.

e. reports from any another treating providers about their findings of harm or drug misuse, which is generally not a HIPAA violation if the providers are all engaged in treating the patient. Remember, PTO: "treatment, payment, and healthcare operations" are excepted from HIPAA consent requirements.

f. any threatening or abusive behavior by the patient toward anyone in the medical office,

g. patient's care continuity and coordination are safely maintained by assisting the patient and their insurer with the appropriate time and transitional care, referrals, and chart transfer free of charge.

h. signed patient statement acknowledging all of the above.

The patient may not heed your medical advice and directives, but your chart should prove that you provided everything in the name of patient safety, gave adequate time, notice, assistance, referrals, care coordination, and made every effort to maintain the patient's continuity of care.

These requirements are not the last we will see. The point of them is to make the decision to prescribe controlled substances for long term pain management, particularly opioids, a last resort.

CALL FOR NOMINATIONS
Fellow Award

The Erie County Medical Society wishes to recognize significant achievement by a Fellow currently in training. Therefore, the Medical Services Committee of the Erie County Medical Society has established the following criteria for each award. Any member or non-member of the Society, faculty, hospital personnel, peers, and community members are invited to submit nominations for those fellows who have demonstrated outstanding work and commitment to the practice of medicine. Self-Nominations will also be considered. We recommend any nominated candidate be a member of the Erie County Medical Society.

Fellow Award Criteria:

The candidate must:

1. Be enrolled in an accredited fellowship program in Erie County, New York
2. Display excellence in the performance of his/her duties, including patient care, research, and teaching
3. Display leadership qualities and abilities
4. Show evidence of service to the profession of medicine
5. Submit two letters of recommendation, one of which must come from the Program Director or Department Chair.
6. A monetary award in the amount has been established.

All submissions must be received at the Erie County Medical Society, 1317 Harlem Rd., Buffalo, NY 14206
or via email: nadolnyc@wnydocs.org **by January 20, 2018.**

A Message from the President

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action, in my opinion has increased and improved our ability to provide healthcare, and do our jobs, to do what we were trained to do and what we swore an oath to do. Because over the years physicians have become less involved and provide less support for political action efforts, our ability to influence healthcare delivery has resulted in a negative impact on our ability to do what Dr. Smith stated that he wanted to do "I just want to take care of my patients". Dear Dr. Smith, if you wanted to take care of your patients, then make time to get involved because it helps you, help your patients. If that is self-serving, then call me selfish. To be honest, I don't remember exactly what I told Dr. Smith that day, but he did financially support UROPAC, got involved himself and provided opportunities for his residents, fellows and staff to get involved. I hope you will do the same, if you are not already doing so.

CALL FOR NOMINATIONS

Medical Student Award

The Erie County Medical Society wishes to recognize significant achievement by a Medical Student currently in training. Therefore, the Medical Services Committee of the Erie County Medical Society has established the following criteria for each award. Any member or non-member of the Society, faculty, hospital personnel, peers, and community members are invited to submit nominations for those medical students who have demonstrated outstanding work and commitment to the practice of medicine. Self-Nominations will also be considered. We recommend any nominated candidate be a member of the Erie County Medical Society.

Medical Student Award Criteria:

The candidate must:

1. Display leadership qualities and abilities in his or her class
2. Be active in community service
3. Show evidence of service to the profession of medicine
4. Display academic excellence
5. Submit two letters of recommendation, one of which must come from the student's direct supervisor in the community service setting.
6. A monetary award has been established

All submissions must be received at the
Erie County Medical Society
1317 Harlem Rd., Buffalo, NY 14206
or
via email: nadolnyc@wnydocs.org
by January 20, 2018.

The Medical Society would like to wish the following members a *Happy Birthday!*

Erie

December - February

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