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Dr. Paul specializes in dermatology.

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Editorial

Pocket MBA

Deval (Reshma) Paranjpe, MD, FACS

I recently graduated with a Master of Business Administration (MBA) degree from the University of Pittsburgh Katz Graduate School of Business Executive MBA (EMBA) Worldwide program, and I was the only physician in my class. This took a commitment of time, money, work and more time; it required intensive days of class time, and homework and group projects after my day job every other day. It forced me to re prioritize my life and create time between work and other commitments where I didn’t think time could be created. The process pushed me to the brink when family crises were added into the mix, but I survived. And I learned a lot, both about the world and myself.

Am I glad to have done it? Yes. Would I do it all over again? Absolutely. Here are some surprising – and perhaps not surprising – things I learned in business school:

1. We as physicians need to get out more.

I decided to join the EMBA Worldwide class instead of the healthcare-focused cohort in order to get a broader education that could be applied to other fields. The question my classmates asked me was: “Why did you pick the regular group and not the new healthcare group?” to which I replied: “I specifically wanted to be with all of you.” As time progressed, I did not regret that choice. The Worldwide program is an established program with 45 previous cohorts; the healthcare cohort was only in its second cohort.

I was lucky enough to be with a group of students from a diverse range of fields: Oil and Gas, Nuclear Engineering, Construction, Health Care Finance, Marketing, Consultancy, Mining, IT, Pharmaceuticals, Medical Devices, Banking and Law. I had the chance to observe master negotiators who were in charge of sourcing, as well as master salesmen and consultants and professional team leaders at their craft. I asked them how they did what they did over beers after class and lightbulbs lit up for me. I saw lightbulbs go off over each one of their heads as they learned how to apply a concept from class to their work. I learned about their industries, and how they resemble and differ from ours. The official classroom and project learnings were on one level; the learnings I derived from my classmates were priceless.

2. Businesspeople have little idea of what we actually do but are eager to learn and are interested to understand.

Uniformly, my classmates were eager to learn what being a physician was like and were surprised by things we take for granted. They were eager to learn about the healthcare industry from our perspective, as they had only known it from the patient or relative perspective. Perhaps the most curious about the humanistic side of medicine was the classmate who worked in healthcare finance and who only saw the numbers. This gave me hope for the future. It also reinforced my belief that just like police squad car ride-alongs, everyone outside the field of medicine should have to spend a week shadowing physicians – either rounding with an inpatient medicine or surgical team, or in the ER, or in a primary care practice.

3. If you have high school- or college-aged children, make sure they get a good financial education.

I honestly wish that I had done this 20 years ago, but I am so glad to have had the opportunity to do it now. If I could go back in time, I might have majored in Economics or Finance, or might at least have taken a few more courses before embarking on a career in medicine. I might have done this MBA program in between theoretical and clinical years of medical school as some programs offer. This is incredibly valuable information for life regardless of one’s ultimate career. Although they aren’t sexy, you need Accounting and Finance courses to plan and understand your financial well-being and feel more in control of your life. Teach your children early and often about the
miracle of compound interest.

4. It’s all math (and there’s a formula or program for everything).

To do this, I had to relearn Microsoft Excel (my engineering friends really helped). That was the hardest part to be honest – reviewing Statistics and learning Accounting while simultaneously catching up on the advances of the last 15 years.

Want to know how many catheters to order every month in order to maximize your profit, how much profit you would lose if you accidentally under-order, and how much you would lose in profit and inventory holding costs if you over-ordered? Want to know how to forecast demand for catheters given variables of X, Y and Z? There’s a formula (or a program) for that.

Want to know where you’d break even on any proposition? Want to know exactly how hard you have to work and what patient mix you have to see in order to achieve X in quarterly profit or nail your RVUs and a bonus? Want to know if it’s even feasible? There’s a formula (or a program) for that.

This also demystifies things like: “Why did they close the OR on Tuesday?” or “Why won’t they let me schedule that?” or “Why won’t they hire Laura? She’s such a good employee, but she just needs to be part-time!”

5. The formula approach can have a heart.

The formula approach also starts to explain things like: “Why did this clinic close and not that one, even though it looks like it ought to do so well?” There’s a formula for deciding which (plant, factory, business, hospital) to close in order to keep the whole company alive. There’s a program that tells you how many full-time and part-time employees to hire in which month and fire in which month according to demand forecasts and profit needs. Once you understand the hard logic behind these decisions, you can then start to reason and blend human factors in to make decisions that are compassionate as well as rational. We had plenty of scenarios ranging from strategy to negotiations in which surprisingly good outcomes were reached in conflict that achieved financial goals as well as humanistic ones.

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The opinion expressed in this column is that of the writer and does not necessarily reflect the opinion of the Editorial Board, the Bulletin, or the Allegheny County Medical Society.

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How often have we heard friends and neighbors tell us that they were not going to vote because they thought their vote would not make a difference? This is especially true in today's polarized political climate where there are well-documented instances of foreign (attempts of) intervention and massive campaign financing by political action committees (PACS). So, I ask, can a voice of one make a difference? Is every vote important? I say yes and have experienced it first-hand.

In 1998, I was a councilor for Pennsylvania to the American College of Radiology (ACR). While most radiology societies have predominantly academic membership, the ACR represents all of radiology – academics and private practice, and functions to establish practice standards, provide education, manage economic issues, and serves as the political arm for the profession. Among a councilor’s duties at the College’s annual meeting is to vote upon the myriad of resolutions introduced since the previous year. The procedure for managing the resolutions is akin to that used in the U.S. Congress. Once a resolution is submitted, it is then given to one of four Reference Committees, who present it to the membership for comments. The Reference Committee, in turn, and based on the comments made, will then decide to recommend one of four courses of action: adoption as written, adoption following amendment(s), defeat, or referral for further consideration to either the Council Steering Committee or to the Board of Chancellors.

In 1998, the job market for residents and fellows leaving their training programs was soft, reaching an all-time low. Although the job market fluctuated much like a sine curve, reimbursement reductions by Medicare (and the “Blues” following suit) had led many radiology groups to defer new hiring. Furthermore, the usual attrition rate due to retirement was slowed, as many senior radiologists continued to work because of drops in the stock market and hence, their retirement accounts.

It was against this background that the Residents and Fellows Section (RFS) of the ACR proposed a resolution asking that the College use its influence and “good offices” to reduce the number of residency slots available, and thus reduce the competition for the few jobs that would be available when they finished their training. Historically, resolutions introduced by the RFS were adopted and became College policy. Furthermore, opposition to resolutions proposed by the RFS was viewed by the membership as akin to spitting on the flag. And so, this resolution was presented to the appropriate Reference Committee, who, hearing no objections, recommended that it be adopted. I was attending another Reference Committee hearing and was unable to raise any objections to the resolution.

The resolution was presented to the ACR Council for a final vote, with the recommendation of the Reference Committee that it be adopted. The Speaker of the Council opened the floor for discussion. I went to the microphone and said, “Mr. Speaker, I speak against the resolution.” This was followed by a large chorus of boos. After the Speaker restored order, I presented my reasoning for opposing the resolution. I asked how many of the delegates were from practices that had residency training programs. About 20% raised their hands. I then told them that I was from an academic private practice that had a total of 12 residents. Each year, prior to 1998, we received an average of 300 applications for three available resident slots. That year, we received only 10! To me, this indicated that the system was correcting itself, adjusting the numbers to reflect the job market. As I looked around, I saw most of the academicians nodding in agreement. They had similar experiences. More importantly, I also pointed out that the total number of residency positions was determined...
by the Residency Review Committee (RRC) as well as by Congress, who reimbursed training programs. I concluded that the system was correcting itself and that the ACR should not intercede.

As soon as I sat down, several other academicians from large and small programs spoke, supporting what I had said and mentioning their own experiences in a decline in residency applications. They, too, agreed that the system was correcting itself and felt the resolution should be defeated. The net result was that the Council voted the resolution down, and I truly believe we made the right decision. Had I not spoken up, the resolution would have unanimously passed and become ACR policy.

There are several lessons to be taken from my experience. In a free society, everyone is entitled to express their opinion. If they make a cogent argument for their position, reasonable people will listen and their opinions can change. A voice of one can and does make a difference. And, most importantly, everybody’s vote counts.

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The opinion expressed in this column is that of the writer and does not necessarily reflect the opinion of the Editorial Board, the Bulletin, or the Allegheny County Medical Society.
My twinges of PTSD recurred as Hurricane Dorian approached. These “twinges” intensified as the images of destruction and the associated mounting death toll were broadcast. My “hurricane” chronicle began more than 30 years ago when my parents moved to Florida. I vicariously endured each subsequent hurricane season with increased trepidation. I’m not sure who “suffered” the most – my parents secluded in their dark, boarded-up house without power, or us, unable to discern if they were safe. As they got older, the process was more daunting, and my apprehensions intensified.

I joined their “hurricane club” after I was recruited to UTMB Galveston. During my first tropical storm, I drove along the seawall and marveled as water lapped across the roadway from its customary location 17 feet below. We had a routine – park our second car in the hospital parking garage, secure my lab, and then hope we had enough time and energy left to secure our home and evacuate. It was stressful, but like my parents, we survived each scare to enjoy our idyllic life on the island. Then Hurricane Ike came. We considered ourselves “lucky” as we watched the national coverage from our summer home in Hidden Valley 1,500 miles away. Reality followed as I viewed Anderson Cooper reporting from the exact spot that I first experienced the ravages of the flood surge on the roadway. The water was higher than I had previously experienced, and landfall was still 24 hours away. Instantaneously, I acknowledged the gravity of what was about to transpire. I was inconsolable.

The repetitive reel of TV coverage depicted catastrophic destruction. We waited an additional four days to ascertain that our house was upright. That said, all the utility lines were brutally severed, the garage contents and most importantly the requisite steps to enter our house were washed into the bay by the 16-foot storm surge. We were “lucky” – no power, no water, but our roof remained intact. Our house was uninhabitable for the next four weeks. Our helpful neighbors could only be so helpful as they had comparable issues. UTMB, the large university center where I had worked and received my medical care, was essentially destroyed. The main hospital building lost the lab, blood bank and several hundred beds. It wouldn’t fully reopen for another year in a much smaller footprint. Our local Allstate office was flooded and our agent incommunicado for weeks. Ditto for our local Bank of America branch and the businesses we frequented. The county admonished those individuals with serious medical issues and/or those who were immuno-suppressed to stay away. Again, we were “lucky.” We had a comfortable place to live, albeit 1,500 miles away. Each member of a group of our neighbors (the “Isles End posse,” as we referred to ourselves) was assigned a different trade (electrician, plumber, carpenter, roofer) to contract with to repair our collective houses. This was daunting since any prior contractors also had their houses and businesses destroyed. We imported contractors from Houston, 50 miles away. Cash was the only currency accepted. The battles with our respective insurance companies would linger for the next six to 12 months. It took more than four weeks to restore our electricity and enter our house by steps instead of a two-story ladder.

The music had long stopped playing. CNN transitioned to the latest disaster coverage. The death toll had been announced, but the lingering personal toll was never recounted. We finally returned four months later. It looked like the hurricane had landed just days, not months before. I appreciated sundown so I was spared from visualizing the destruction. Every errand took extra time as there were innumerable stories to share of the death and destruction. We learned that some would have preferred to evacuate but were either stymied by the rapid onset...
of the storm and the quickly rising flood waters, or they couldn't afford the gas and hotel rooms needed for evacuation. Many had their places of employment damaged and/or their homes rendered unlivable. Despite this, most said they “did OK” if they were still alive.

You ask ... why this detailed description of something that happened 11 years ago, 1,500 miles from Pittsburgh? My PTSD is not just about hurricanes. This story is analogous to my health saga and the narratives of your patients. The music playing the daily trepitations and tales of our mundane patient experiences has long ceased. Our tacit pre-procedure anxieties are frequently ignored or discounted similar to the trepidation I encountered with each subsequent hurricane. Over time, we’re no longer “interesting” to our surgeons or expert medical diagnosticians challenged by our complex issues. There is rarely home nursing care post discharge for the average hospitalization or surgery. Reimbursement and authorization insurance “battles” are pervasive and mirror the hurricane insurance quarrels. The transition over the years from lengthy inpatient admissions to same day outpatient procedures doesn’t mean that the issues are no longer present. It just means they are no longer visualized. Occasionally, we capture a snapshot through a family member’s ordeal (as I did vicariously with my parent's hurricane experience).

No, I'm not advocating for a return to inpatient procedures and longer hospital stays. I don't like my hospital stays. But there always comes a time when I have recovered enough to technically be on my own. The PTSD invariably recurs pre- or post-procedure as I process my new daunting diagnosis and its respective limitations. Personally, I endeavor to revert to “doctor mode” and figure things out. But how many of your patients are able to do that? Even an occasional phone call from a doc or nurse would help greatly. Unfortunately, over the years, I can count those calls on one hand! Historically, we’ve gotten more follow-up from our veterinarians. A few minutes of your time might just replay the music for all of us.

Dr. Witlin, associate editor of the ACMS Bulletin, is a retired maternal/fetal medicine physician and researcher. She can be reached at agwmfm@gmail.com.
‘Generation A’ comes of age

ANTHONY L. KOVATCH, MD

This handsome couple – representative of the “Greatest Generation” or the “Silent Generation” – were totally unaware that “comfort was going out of business” as they embarked upon raising their children: the “Baby Boomers.” How could they, as first-generation Americans, conceive that the cargo in the baby carriage would champion a subset of “Millennials,” fondly referred to as “Generation A?”

I must stress that this “Generation A” is an unofficial term and that I take no credit for coining it. The members had already fashioned the nomenclature with their lingo and habits: Amazing, Awesome, Attached, Awakened, Athletic, Advanced Directives. I merely repudiated the erroneous perception of sociologists that Millennials as a generation are self-centered and fiercely attached to their professions and recreational pursuits. Of course, I am a pediatrician, so I am focused on the subset of Millennials who have chosen to raise families in this past decade of existential bewilderment, political cynicism and the nebulous threat of global warming and its consequences for sustainment of life on our planet.

I personally see them as a superior lot – more skillful in the day-to-day raising of their offspring than the Baby Boomers (like myself) and “Generation X” of the 1970-80s. I think that “attachment” makes this so – not brute attachment to their own goals, but a connectivity with their peers through social media. Generation A is more liberally educated, more conversant in child-rearing practices (especially in positive disciple) and more psychologically grounded than their predecessors. They have analyzed the consequences of failed marriages and other close relationships – either first-hand or vicariously – and enter into life-changing decisions like parenting with their eyes wide open. They have been trained to plan ahead – to give advanced directives to caretakers of their beloved children and elders (and even their pets). Lists and ground rules are provided to Mimi, Granny and Pap-Pap, who are eager to bond with their loving grandchildren through the timeless art of baby-sitting.

The fathers of Generation A are more invested in the day-to-day, mundane tasks of parenting and even demand sharing the experience equally with the mothers; they have shed the narrow-minded role as “breadwinner” or “corporate tool” germane to the Baby Boomers and place the joy of raising a family emotionally at the top of their bucket list of life aspirations.

Whether deemed by sociologists as positive or negative, Generation A insists on taking an affirmative hand in making decisions regarding the health and education of its offspring. If possible, breast feeding is not the main thing – it is the only thing. Family-shared and even community-shared breast feeding is accepted and promoted. Pediatricians do not determine the time of introduction of solid foods – the babies do! (“BLISS: Baby-Led Introduction of Solids”).

The necessity of medical interventions, especially oral
antimicrobials, is more often challenged. Breast milk has become the universal curative agent for conjunctivitis, otitis media, eczema, seborrhea and whatever else responds to its topical powers. What is eaten must not only produce gains on the growth charts; everything children ingest also must have a beneficial effect on their intellectual development, their physical prowess and their critical microbiome – gut and skin. Probiotics, prebiotics, polyphenol-rich foods supplying antioxidants and fermented foods and beverages (apple cider vinegar and the popular Kombucha) have become staples of the diets of these Millennials, who take proactive prevention of disease to a level never previously aspired to. Is there credence to the slogan: “We are more bacterial and fungal than human?”

Physicians advise on the pros and cons of immunizations, but parental collaboration is the ultimate determinant of when and if to initiate. Traditional brick-and-mortar education has been replaced by home-schooling and cyber-schooling, and I have witnessed a preference for alternative theories of learning fostered by the Montessori and Waldorf models. I think religious education has been replaced by “spiritual” enlightenment, and this has become more personalized. The admixture of ethnic groups, races and religions over the years in the United States has fostered a mentality of toleration never before experienced in our civilization.

The high value placed on family time (rather than corporate loyalty) will not weaken the life ambitions of the children of Generation A, whose admiration of and inclusion of their own parents has not faltered. Indeed, it was these Baby Boomers (who mastered cursive writing but struggle greatly with technology) who imposed the 24/7 scheduling on their charges, keeping them busy as kids with high pursuits. The grandparents will be sure to pass on these values to their beloved grandchildren and teach them to always “go the extra mile.” In this regard, there will be no “skipping a generation.”

I must relay a personal experience to support my thesis. Thirty years ago, I was gifted with an eye-catching blue Penn State University sweatshirt by a mother of three boys (a contemporary whose children were about the same ages as my four children) by complete surprise; a heartwarming note of gratitude was attached to the shirt. The young mother was extremely conscientious and organized – almost to a fault. She recorded all relevant (and irrelevant) details of our management for her sons’ asthma in a journal. She made such an impact on my style of practice during my formative years that she served as my “muse” when I was interviewed about parent-doctor communication for a television short.

Her boys grew up, I moved to a more prestigious practice and, gradually, my hard-driving compulsion for perfection eroded. The extreme compassion I had inculcated in medical school and residency ebbed and flowed. I became a “mature” doctor. However, Mrs. Conscientious made one small but crucial mistake – she failed to appreciate my hoarding traits, and I placed the handsome sweatshirt in a standard commercial box – a box I would be sure to deposit in a very safe place: a hope chest so safe that the contents were to be hidden from the eyes of any human for 25 years. And so, the beloved sweatshirt sat unworn, unseen and untouched as if the owner could not bear to rekindle the memory – for 25 long years – skipping a generation!

“Yes, how wonderful and mysterious the world can be!” – Hans Christian Anderson

Continued on Page 370
I still do believe in the rare miracle. This past summer, I rediscovered the old box under heaps of linens with the blue sweatshirt unscathed by time. I realized that life's considerations over 25 years of pediatric and child rearing had certainly transmogrified my earlier intentions of being the kindest, most thorough and compassionate version of myself. However, I realized that phase II of my professional and family life was still attainable if change was possible.

Several days later, my career took an unexpected detour, a fortuitous twist. Due to a shortage of manpower, I was reassigned temporarily to round on the large service of newborns at the local teaching hospital; I was overwhelmed by my inherent anticipatory anxiety, aware that I would be serving a much more complicated clientele – one of disadvantage, lower socio-economic status and higher medical complexity. Essentially, I would be physician not to the “haves,” but to the “have-nots” – many of whom had lost the coin toss when the positive and negative genes had been distributed at conception.

“Hi, I am Katie,” replied the nurse practitioner assigned to work with me when I entered the nursery for the first time. “My husband, Kevin, was your patient years ago at Health America! Do you remember him and his two older brothers and my ultra-conscientious mother-in-law?”

Health America had long been defunct, but the memories of the family who had gifted me with the blue sweatshirt were still remarkably vivid. Because I was in public, I restrained my emotions. Only later would I disclose the legend of the sweatshirt to Katie.

The rest went according to script. Katie became my mentor in the nursery and rekindled my interest in teaching medical students my trade. Like Generation A itself, I became Awakened to the realities of family life and birth among the “have-nots.”

I reacquired some of my old values about life and love that I had buried along with the sweatshirt 25 years previously. Like William Faulkner wrote: “You don’t love because: you love despite; not for the virtues, but despite the faults.” It can take a lifetime to finally remember these kinds of truths, and maybe another lifetime to believe them enough to change our destiny.

I was lucky; the past came back to me just when I needed it the most. I learned that even our reasons for living can skip a generation. Everything occurs in cycles. As songwriter Joni Mitchell warned:

“We’re captive on the carousel of time.
We can’t return. We can only look behind from where we came.
And go round and round and round in the circle game.”

Many may disagree with my claims, but I think all will endorse this indisputable truth: The Baby Boomers and Generation A of all walks of life always have and always will love their children equally! At least, that’s one old man’s opinion.

Dr. Kovatch is a pediatrician and associate editor of the ACMS Bulletin. He can be reached at akovatch@acms.org.
The convenience of CMEs and webinars anytime, anywhere via app or desktop empowers you to…
In our hospice inpatient unit, we have taken care of the following patients:

- An elderly patient with metastatic cancer who fell while walking and suffered a traumatic lower extremity fracture, requiring inpatient hospice care to manage fairly severe pain and agitation. She was not a surgical candidate. Her medication regimen included a continuous infusion of morphine at 10 mg intravenously per hour, along with a scheduled dose of lorazepam at 2 mg every six hours. She could have as-needed doses of both medications for breakthrough pain and agitation (10 mg of intravenous morphine hourly is the approximate equivalent of 30 mg of oral morphine tablets taken every hour).

- A middle-aged man with an aggressive urologic cancer associated with poorly controlled symptoms of pain, along with a painful inguinal wound, as well as generalized anxiety, who required inpatient hospice care for more aggressive management. His medication regimen included a continuous infusion of hydromorphone at 2 mg per hour, along with scheduled doses of both intravenous haloperidol and lorazepam given on an alternating schedule every four hours around-the-clock (2 mg of intravenous hydromorphone hourly is the approximate equivalent of 40 mg of oral morphine tablets taken every hour).

- A fairly young patient with an end-stage metastatic gynecologic cancer with symptoms of poorly controlled pain, both nociceptive and neuropathic, along with agitation and anxiety and worsening dysphagia, who required aggressive inpatient hospice care. Her medication regimen included a continuous infusion of hydromorphone at 10 mg intravenously per hour, along with a continuous infusion of midazolam at 1 mg hourly. She could have as-needed doses of these medications for breakthrough symptoms (10 mg of intravenous hydromorphone hourly is the approximate equivalent of 200 mg of oral morphine tablets taken every hour).

Please consider the following multiple-choice statements about these patients:

A) They are comatose with varying levels of apnea and hypotension.
B) They are unconscious, bedbound and unable to respond to questions with normal vital signs.
C) They are generally comfortable and each of them is able to meaningfully interact with their caregivers and loved ones, answer questions and tolerate small amounts of oral nutrition.
D) One of the patients is (A), one of the patients is (B) and one of the patients is (C).

And the answer is: (C).

Yes (C) … in case you thought (C) might be a typo … it is not a typo. Most clinicians who do not regularly practice hospice and palliative care would find this very surprising indeed, and probably chose (D).

But the correct answer is (C).

I chose to highlight these three inpatient hospice cases to illustrate a very important principle in end-of-life hospice care – high to very high doses of opiate and benzodiazepine medications do not actually cause the deaths of people WHEN USED AND TITRATED APPROPRIATELY by knowledgeable clinicians in the field of hospice and palliative care. While the high doses of morphine, hydromorphone, lorazepam and midazolam listed are atypical for most patients on hospice, if the patient is started on low doses of these medications, and then titrated upward slowly but appropriately, then symptoms of pain, agitation and shortness of breath can be successfully managed.

November is National Hospice and Palliative Care Month
managed while the patient continues to be able to interact with their surrounding environment, loved ones and caregivers, even as their decline continues and the doses escalate (sometimes dramatically).

(It is important to remember that almost every medication, IF USED INAPPROPRIATELY, can be deadly. Too much heparin ... too much insulin ... too much Tylenol, even ... all can cause significant harm. In addition, the use of the opiate and benzodiazepines illustrated here apply to only the very end-of-life symptom management done by hospice and palliative care clinicians.)

Make no mistake here; these highlighted patients are very seriously ill, with prognoses for each of them in the neighborhood of only a few weeks. They do spend most of the day in bed and the nutrition that they are able to take would be considered fairly small. However, these patients illustrate that it is not the use of these medications themselves, even in extremely high doses, that results in the death of the patient. Rather, it is the slow steady progression of the diseases that ultimately lead to the deaths of the patients, and the medications, even at very high doses, allow for the underlying symptoms to be controlled, so that the patient’s last days of life can be as meaningful and as interactive as possible to all involved.

Even if only for a few days, this is a very rewarding result.

Dr. Miller, associate editor of the ACMS Bulletin, is clinical associate professor of medicine in the section of Supportive and Palliative Care at UPMC. He also serves as full-time medical director of the inpatient hospice facilities for Family Hospice. He can be reached at smiller@familyhospicepa.org or (412) 572-8800.

The opinion expressed in this column is that of the writer and does not necessarily reflect the opinion of the Editorial Board, the Bulletin, or the Allegheny County Medical Society.
As we enter November, it is always a pleasure to provide reflections during National Hospice Month. In healthcare, when we reference hospice, we are typically referring to “human hospice.” This field has continued to evolve and flourish over the last 30-40 years. Nearly half of Medicare beneficiaries are dying with at least some hospice care in the United States.1

Another growing area of hospice care in our country is occurring with our companion pets. This has significant relevance, considering more than two-thirds of American households own a pet, with nearly 40% of households choosing a dog as their preferred pet.2 I recently had my first “pet hospice” experience with the loss of my beloved canine and “best friend” Pluto, a standard poodle of almost 13 years. Before exploring that state of end-of-life care for pets, please allow me to share some reflections on Pluto and the effect he had on our family.

The thought of bringing another “son” into our chaotic household seemed ludicrous when it was first suggested by my wife in winter 2007. We were overwhelmed and attempting to stay afloat one day at a time, but I trusted the family consensus to proceed. I still remember the day clearly when my wife and I drove to Donora, Pa., to pick out a puppy from the fresh litter of apricot-colored poodles. There truly was nothing more gratifying than plucking him out of the puppy crate and bringing him back home to share with our three young boys. My oldest son declared his name should be Pluto, and it stuck. According to American Kennel Club records, his full name was “Planet Nine Pluto,” but forever known to us as Pluto or “Plutie.”

It very quickly became clear that adding a dog to our family unit was truly one of the best decisions we ever made. Pluto helped even out all of the things our family couldn’t seem to figure out – stress, anger, boredom, hostility, laziness and even sadness. He distracted us and brought us simple joy and entertainment, which easily gets lost in the shuffle of life.

I’m confident that many of the fondest memories of our pet are not necessarily unique to our family, which is why companion pets remain so wildly popular throughout the world. We chose to include Pluto in everything we did, even when it may have violated certain rules and norms. He came to the kids’ baseball games, jogged with my wife, mountain biked with me and usually traveled on our family vacations. We could never envision him in a kennel and always chose personalized dog-watching services when it wasn’t feasible to travel with him. His demeanor or around other animals and humans was unique and did not go unnoticed by anyone.

As Pluto’s lifespan extended beyond a decade and he began to experience the expected effects of aging and decline, we remained focused on his quality and comfort of life. His arthritis and spinal stenosis became severe enough to affect his gait and ability to get into our cars and beds. We used stepping stools and often lifted him to minimize the frequent falls. The veterinarian prescribed anti-inflammatory drugs and neuropathic pain meds to further alleviate his pain. The medications and treatment approaches were quite similar to the approach of medical care for elderly patients and loved ones as they age in place, which made sense.

When Pluto had more abrupt decline last month, and his mobility and appetite became greatly limited, we were faced with the difficult decision of seeking semi-emergent veterinary evaluation versus increased palliative efforts. We had many meetings and discussions with friends and family and began exploring pet hospice. In effect, we defined Pluto’s “Goals of Care.” We learned that most available pet hospice services focus on home euthanasia, obviously quite different than home hospice for humans.

Our local veterinarian confirmed
our suspicions, that Pluto was indeed nearing the end with little quality of life. He offered the prospect of immediate euthanasia to Pluto as an option to my wife in the office to end his suffering. Although the in-office cost for this service was minimal, it still felt abrupt, and the exam room felt sterile and far from comforting. She opted to carefully lift him back into our car and take him home. We contacted a local, well-respected Veterinary Hospice company and scheduled a home veterinarian visit for the following day. Even the person who answered my call provided so much comfort to us and essentially immediate grief support, sharing personal stories about our pets.

My wife and I both took a personal day from work and our teenage son stayed home from school so that we could all be with Pluto during the home visit by the hospice vet. We FaceTimed our older sons who were both away at college to allow them to say their final good-byes to Pluto. All of our boys initially questioned our decision and wanted to make sure this was the right time. In the end, we all agreed that this absolutely made the most sense for Pluto, who had stopped eating and had significant pain with any movement.

The home visit by the hospice veterinarian was somewhat surreal. She arrived and immediately provided a calm and comforting demeanor in our home. She took her time to assess Pluto and explain everything she was doing. She made sure to provide relief and comfort to each of us during this process, which was equally important. She then provided an injection to Pluto to provide pain relief and sedation and allowed us to say our final goodbyes. This part was not easy; there were lots of tears, prayers and human touch. We captured Pluto’s paw print in a small cast and clipped a few strands of his soft curly hair.

The next step was to administer the pentobarbital, which is the most common medication to euthanize animals, and just like that, an end of a family legacy and era was over. We wrapped him in blankets, placed him in a dog stretcher and all carried him out to the car together. Emotionally drained but satisfied, we watched the vet leave our driveway with our beloved Pluto. This process allowed necessary closure and the important piece of knowing we allowed him to pass comfortably in our home at peace on his favorite pillow.

What I find interesting is the trajectory of medical care to pets has evolved similarly to humans. Increased aggressive care and treatments, whether it be complex medications (including chemotherapy for cancer) and surgeries have been chosen by pet owners in recent decades for their pets. These often come at high costs paid out of pocket. Just like human healthcare has shifted the pendulum to include more palliative and hospice options at the end of life, so has veterinary medicine. This includes mirroring the human desire to die at home.

In regards to the history of pet hospice, the earliest organized efforts occurred in 1996 with the formation of the Nikki Hospice Foundation for Pets (NHFP) in California and eventual development of the first guidelines for animal hospice care in 1999. By 2001, the American Veterinary Medical Association (AVMA) developed their own hospice care guidelines for pets. The most recent guidelines have come from the American Animal Hospital Association (AAHA) and the International Association of Animal Hospice and Palliative Care (IAAHPC) in 2016.

In regard to veterinary medicine educational efforts, the Colorado State University School of Veterinary Medicine started a formal pet hospice program in 2003. Their goals were to provide not only a training program for its students, but also a philosophy from which community pet owners and veterinarians could benefit. Interestingly, the early founders of this program utilized expertise from local human hospice to guide their principles. Out of 28 veterinary colleges, this remains the only one with a pet hospice education program.

Continued on Page 376
hospice program in current operation, although it has been estimated that 80% of veterinary students have some exposure to end-of-life topics. 

There are other noteworthy relationships between hospice and pets. The therapeutic physical and emotional benefits of pets and chronically ill patients can be traced back to the mid-1800s by the nursing pioneer Florence Nightingale. The early days of hospice in the 1970s recognized the importance of embracing these therapeutic benefits of pets in the terminally ill. To this day, most hospices have some form of a pet therapy program, as a mainstay to the disciplinary approach to patients.

Although certified therapy dogs remain the most common choice by hospices, other animals including pigs, birds and horses are utilized as well.

In summary, the next time you encounter a pet companion, whether it be in your own home or elsewhere, keep in mind the role they can play in healing, as well as the expanding palliative and hospice options available as they arrive at the end of their own lives.

Dr. Lagnese is chief medical officer at Family Hospice & Palliative Care. He can be reached at klagnese@family-hospicepa.org.

For more information on pet hospice, please utilize the following websites:
- International Association for Animal Hospice and Palliative Care (IAAHPC): www.iaahpc.org
- Lap of Love (provides pet palliative and hospice services nationally (32 states): www.lapoflove.com

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To learn more, contact Terri Dowd at 412-321-5030 or email terri@acms.org.
A case for diversity in the Pittsburgh workforce

William Simmons, MD

Our country is undeniably becoming the home to an ever-increasing number of individuals from distinct racial and ethnic backgrounds. According to the U.S. Census Bureau, Statistical Abstract of the United States 2001, between 1980 and 2000, while the country’s white population grew by 9%, the African American population increased by 28%, the Native American population increased by 55%, the Hispanic population by 122% and the Asian population grew by more than 190%. The abstract goes on to state that Asians and Native Americans already account for more than half of California’s population. Forty-five percent of Texans self-identify as members of minority groups, as do one in three residents of New York, New Jersey and Florida.

Analyzing the 2010 Census, more than half of the growth in the total U.S. population between 2000 and 2010 was because of a 43% increase in both the Hispanic and the Asian population. This made Hispanics, 16%, the undisputed largest minority population in the United States, eclipsing Blacks/African Americans at 13%. The group that self-identifies as non-Hispanic whites grew at an even slower 1%. The total proportion of U.S. whites declined from 69% to 64% and is expected to decline even further during the upcoming 2020 Census.

After a lifetime of trying to describe the American experience as a melting pot of assimilation, today’s workplace is repeatedly being described as a salad bowl, where individuals retain their differences and value their uniqueness. America has come from a place where equal employment laws and residual affirmative action mandates represented the bare minimum when it came to compliance, because the new push for “Diversity and Inclusion” goes well beyond what is legally required and tries to create a culture of acceptance and promoting differences, while shining a disapproving light on instances of discrimination, harassment and retaliation.

Has Pittsburgh evolved beyond the need for such concerns as diversity? Is the playing field in 2019 level? On Tuesday, Sept. 17, 2019, Mayor Bill Peduto’s office and the city’s Gender Equality Commission released a white paper entitled “Pittsburgh’s Inequality Across Gender and Race,” written by five PhD researchers from the University of Pittsburgh (Howell, J, Goodkind, S, Jacobs, L, Branson, D & Miller, L). The essence of the report is that if you’re white, your health, education and employment experience is about average to what you could expect if you lived in any comparable city in the United States. However, if you’re black, your health, education and employment prospects are worse than just about any comparable U.S. city.

Dale Shoemaker, in an online PublicSource article, quotes co-author Junia Howell, “… if Black residents got up today and left and moved to … any other (comparable) city in the U.S., automatically by just moving, their life expectancy would go up, their income would go up, their educational opportunities for their children would go up as well as their employment opportunities.” The researcher compared Pittsburgh to approximately 90 other cities with similar large black and white populations.

Some highlights from the white paper include the fact that infant mortality for blacks is six times higher than whites in Pittsburgh, which is worse than most similar cities: 13 deaths per 1,000 births compared to two deaths per 1,000 births. In Pittsburgh, blacks and other non-white females make 54 to 59 cents for every dollar a white male makes. In Pittsburgh, the black adult mortality rate is higher than 98% of similar cities. Pittsburgh police referral is high for all students but disproportionately affects black students. Black women and children are more likely to live in poverty in Pittsburgh than comparable cities. Pittsburgh has an extremely high occupational segregation. Black men
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**Emil J. Fernando, MD**
Breast Surgical Oncology

Dr. Fernando specializes in caring for women with breast cancer and other benign breast conditions. His surgical expertise includes breast and lymph node biopsy, lumpectomy, oncoplastic surgery, and nipple-sparing mastectomy.

After earning his degree at Loyola University Chicago Stritch School of Medicine, Dr. Fernando completed his residency at the Cleveland Clinic. He also had a fellowship in breast surgical oncology at Northwestern University Feinberg School of Medicine.

Certified by the American Board of Surgery, Dr. Fernando sees patients at **AHN Breast Surgery** in Pittsburgh and Wexford.

**Yousuf Qureshi, MD**
Dermatology

Dr. Qureshi provides specialized care for conditions affecting the skin, hair, and nails.

He earned his degree at Harvard University School of Medicine in Boston and completed his residency at the University of Texas Southwestern Medical Center in Dallas. He is certified by the American Board of Dermatology.

Dr. Qureshi sees patients at **AHN Dermatology** in Natrona Heights and Pittsburgh.

**Warren C. Swegal, MD**
Otolaryngology

Dr. Swegal specializes in the surgical treatment of head and neck cancers.

He attended Cleveland Clinic Lerner College of Medicine at Case Western Reserve University in Cleveland and completed his residency at Henry Ford Hospital in Detroit.

Dr. Swegal gained additional experience during his fellowship in clinical head and neck surgery at the Johns Hopkins Hospital in Baltimore.

Certified by the American Board of Otolaryngology, Dr. Swegal offers same-day appointments at **AHN Otolaryngology**. He has two offices in Pittsburgh.

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work maintenance/janitorial jobs, while white men work construction.

How do we affect change? Laws are on the books aimed at preventing and correcting discrimination, harassment and retaliation in the workplace. Title VII of the Civil Rights Acts of 1964 even has an entire federal agency, the Equal Employment Opportunity Commission (EEOC), charged with providing equal opportunities, and they function here in Pittsburgh as well. Yet, intolerable inequities still exist. We tried Executive Order 11246 “Affirmative Action” laws, which reached out to previously disadvantaged groups to eliminate barriers to hiring and advancement. That backfired with fierce resentment on both sides, and an endless parade of legal challenges whittled away any altruistic benefits that it may have attained.

Unlike affirmative action, diversity is a voluntary, broader and more inclusive concept of valuing people of different races, religions, national origins, gender, sexual orientation, economic status and other differentiators in the workplace. It hinges on the premise that organizations and companies are most effective when they leverage and include the views and abilities of employees of all backgrounds. The goal of diversity is to foster a culture of mutual respect, leading to a more productive workplace.

The benefits of having a diverse workplace include (accumulated from multiple sources):

1. Increases the ability to service and establish a rapport with a variety of customers of different cultures, religions, races and languages.
2. Higher productivity because employee differences and backgrounds are valued, and they are encouraged to work to their strength.
3. Building and improving the company’s brand by improving the public image.
4. A positive and healthy work environment by leading to an atmosphere of respect, mutual understanding, tolerance and enhanced teamwork.
5. Creativity, innovation and new ideas.
6. Opportunity for employees to learn to grow and develop when challenged with new ideas and perspectives. Diversity may lead to increased adaptability and flexibility in changing demographics.
7. Greater employee retention because they feel valued and respected.
8. A more civil workplace that promotes fairness, decreases conflicts and reduces the number of complaints.
10. Attracting the best talent by drawing from the widest pool of potential employees.
11. Improving the employees’ and workplace morale.

The transitional period to a diverse workplace can have challenges and barriers:

1. Language and cultural barriers can inhibit effective communication initially.
2. Initial resistance to change because of unconscious bias.
3. Increased conflict in the workplace and tensions based on employee’s differences.
4. Stereotypes based on preconceived judgments.
5. Prejudices based on unfair and unfounded opinions.
6. Discrimination and harassment based on stereotypes and prejudices.
7. Perceived preferential treatment of one group at the expense of another.
8. Concern about the cost from training and initial accommodations.

Risk to employers who choose not to be diverse:

1. Employers who are not diverse may be faced with lawsuits for discrimination and harassment due to poor treatment of the few underrepresented employees they do have.
2. Employers may lose customers who gravitate to businesses who employ people that they can better relate to.
3. Tensions in the workplace leading to conflicts and low productivity of employees who are stressed by an unfriendly or unaccepting environment.
4. Lose out on the richness of collaboration and debate from individuals with unique points of view forged by their life’s struggles.

Diversity is a solution, not a source for anxiety or concern:

1. It can help employers with gender issues by encouraging equal opportunity, eliminating improper language, avoiding stereotypes and encouraging supervisory and management roles for women.
2. Diversity is the solution to race issues by recognizing that racial discrimination can exist between employees of the same or different races, the same or different groups, complexion differences (light/dark skin color) and among blacks from Africa vs. American descendants of slaves.
3. Diversity can provide employees with reasonable accommodations based on religious practices, allowing employees to display religious imagery in their workplace cubicles or offices and taking
The city of Pittsburgh is growing and rising fast to a tech and industrial hub, but not all boats are rising. The gentrification of parts of our city leaves beautiful gleaming high-rises for the new inhabitants, but physically evicts and displaces the former. An entire industry has successfully grown around attracting new highly educated young people to Pittsburgh. What about investing in the ones we already have? Our Journey to Medicine Academic Mentorship Program, over the past 11 years, has shown that with education and proper mentoring, boys who could have easily dropped out of school or ended up in Shuman Center can have the trajectory of their life changed and they can become among the best students in their classes. Let's choose to develop educational strategies in our departments, offices, workplaces, schools and in our city that will forever erase the false legacy of “separate but equal” and make Pittsburgh one.

Dr. Simmons is associate professor, University of Pittsburgh School of Medicine, Department of Anesthesiology, UPMC Presbyterian Shadyside Hospital, immediate past president, Gateway Medical Society, Inc., and chair, Journey to Medicine Academic Mentorship Program. He can be reached at bulletin@acms.org.

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Perspective

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Society News

Pittsburgh Ophthalmology Society meeting set for Dec. 5

On Thursday, Dec. 5, the Pittsburgh Ophthalmology Society (POS) will welcome Collin M. McClelland, MD, assistant professor, Department of Ophthalmology and Visual Neurosciences, University of Minnesota, Minneapolis, Minn. Dr. McClelland specializes in neuro-ophthalmology, pediatric and strabismus. Thank you to Pamela Rath, MD, for inviting Dr. McClelland.

Please visit www.pghoph.org to register or for more information.

Geriatrics Teacher of the Year Award: Call for nominations open

The Pennsylvania Geriatrics Society – Western Division (PAGS-WD) is seeking nominations for the Geriatrics Teacher of the Year Award. The award will be presented to two outstanding teachers for their dedication and commitment to geriatrics education.

The annual award will recognize and honor both a physician and a professional from another healthcare discipline, including nursing, advanced practice, physical therapy, pharmacy, occupational therapy, dentistry, audiology, speech-language, pathology and social work, who have made significant contributions to the education and training of learners in geriatrics and to the progress of geriatrics education across the health professions. Members and non-members of the Pennsylvania Geriatrics Society will be considered.

Eligible nominees will have demonstrated leadership and inspired learners to better the care of older adults and will have contributed to the growth

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of geriatrics in their professions. Teaching expertise and/or education program development are valued in the selection of the recipient for this honor.

Award eligibility and criteria, along with the nomination form, is available on the Society's website at www.pagswd.org. Nominations must be received on or before Jan. 25, 2020. Questions regarding the awards or nomination process can be directed to Nadine Popovich, administrator, at npopovich@acms.org or (412) 321-5030.

Awardees will be recognized at the 28th Annual Clinical Update in Geriatric Medicine conference, scheduled for March 5-7, 2020, at the Pittsburgh Marriott City Center. The ceremony will take place Thursday, March 5, 2020, where recipients will be honored with a plaque and receive complimentary membership in the society for one year.

ACMS member named 2019 Laureate Awardee by PA-ACP

ACMS member Judith Black, MD, MHA, FACP, secretary/treasurer of the Pennsylvania Geriatrics Society – Western Division (PAGS-WD), has been named a 2019 Laureate Awardee (Western Region) from the American College of Physicians – Pennsylvania Chapter (PA-ACP).

The Laureate Award honors those Fellows or Masters of the College who have demonstrated by their example and conduct an abiding commitment to excellence in medical care, education, or research, and in service to their community, their Chapter and the American College of Physicians.

The awardees shall be senior physicians who are Fellows or Masters of long standing, with acknowledged excellence and peer approval in the field of internal medicine. In addition, the awardees should have served the Chapter with distinction. Exceptional circumstances may modify these requirements.

Dr. Black was honored along with other awardees at the PA-ACP Annual Awards Dinner following the Annual Scientific Meeting Nov. 16 in Harrisburg.
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Long-time Allegheny County Medical Society member Lawrence John, MD, became the 170th President of the Pennsylvania Medical Society (PAMED) on Oct. 26, 2019. Below is a portion of his inaugural speech:

I still recall the awestruck wonder from my first visit to Fallingwater, a house designed by the iconic architect Frank Lloyd Wright on the side of a mountain in Western Pennsylvania. The year was 1964, and I was 14 years old.

Fallingwater reflects breathtaking balance, as this intriguing design actually becomes part of the mountain and the stream over which it is built. Fallingwater’s captivating presence has always created a yearning in me to find balance in my own life.

However, what I did not realize as a young person was that life’s balance requires incredible support. I have been fortunate over the years to receive the continuous support that has enriched my life and has helped me find the balance that keeps me going today.

I feel extremely fortunate and blessed to have had such wonderful relationships over the years. It strikes me now, as I focus on physician burnout and wellness in this next year, with the support of PAMED, how vital these relationships have been to my personal and professional wellness.

I owe so much gratitude to my partners, my office staff, and medical colleagues and administrators from Pittsburgh who have supported me. I am sincerely grateful. Special thanks to all my personal friends and long-term patients and families. I am so appreciative to have my family, my children and my wife at my side. To my wife, Martha, your partnership in life and in sharing a career in medicine has been such an extraordinary blessing to me and to our family.

This image of an extensive and integrated family and community has anchored and balanced me over the years.

Recognizing the need for balance in life and knowing that physicians require support and resources to achieve a level of holistic wellness in life and work are the driving forces behind my presidential goal at PAMED.

During this time in medicine when so many unnatural forces threaten physician wellness, PAMED will focus on heightening awareness, cultivating the right conversations, and researching new solutions that enhance physician wellness and resilience.
We will spearhead this effort, so all of our colleagues may be able to find a true and meaningful balance, one that helps bring the best out of our physicians and benefits the communities they serve.

Many of us can easily acknowledge indicators of physician burnout, such as emotional exhaustion, a sense of feeling removed from relationships and a low sense of personal accomplishment due to all the demands of modern medicine. The cost of burnout is significant not only on a personal level but also on a monetary level with early retirement, declining productivity and decreased reimbursement due to decreased quality care.

While tackling burnout will be my presidential goal, PAMED as an organization is also committed to making progress on many other issues which face modern medicine, such as eliminating prior authorizations, ensuring that the maintenance of certification process is fair for all physicians, promoting common-sense solutions to the opioid crisis and promoting vaccines as a safe and effective way to protect our world – just to mention a few.

Jane Goodall has said that we cannot get through a single day without having an impact on the world around us. And she reminds us that each of us makes a difference in everything we do.

As physicians, we are called to make a difference for our patients – and that is what we are trying to do each day.

From left are ACMS Board member David L. Blinn, MD; Dr. John; and ACMS Board Chair Robert C. Cicco, MD.

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Bictegravir/emtricitabine/tenofovir alafenamide (Biktarvy®)

Kevin Wissman, PharmD
Erica Wilson, PharmD, BCPS

Background

An estimated 36.9 million people were infected with human immunodeficiency virus (HIV) and 940,000 were estimated to have died of an HIV-related illness in 2017. Prevalence of HIV has continued to increase, but incidence of HIV has plateaued since 2005. The Centers for Disease Control and Prevention (CDC) currently recommends screening all adults aged 15-65 years old, patients with risk factors and all pregnant women.

Antiretroviral therapies (ART) have advanced throughout history to reduce side effects, improve tolerability and simplify daily medication regimens. ART is recommended for all patients with a positive HIV infection. The U.S. Department of Health and Human Services (HHS) HIV guidelines recommend a first-line treatment regimen consisting of two nucleoside transcriptase inhibitors (NRTI) and an integrase strand transfer inhibitor (INSTI). Research and development have provided patients the opportunity to take a once-daily, three-in-one tablet containing two NRTIs and one INSTI.

Biktarvy is a branded three-in-one medication containing bictegravir 50 mg (INSTI), emtricitabine 200 mg (NRTI) and tenofovir alafenamide 25 mg (NRTI). It is the first three-in-one antiretroviral to include tenofovir alafenamide, providing an improved safety profile with less renal and bone adverse events. Bictegravir/emtricitabine/tenofovir alafenamide is FDA approved for treatment of naïve patients infected with HIV and for treatment-experienced patients desiring to switch ART regimens.

Safety

Bictegravir/emtricitabine/tenofovir alafenamide did not present an increased risk of serious adverse reactions compared to other ART regimens in clinical trials. Cases of new onset or worsening renal impairment have been reported with tenofovir products in trials. It is recommended to closely monitor patients' renal function when initiating bictegravir/emtricitabine/tenofovir alafenamide, two to eight weeks after initiation, and every three to six months indefinitely. Less than 1% of bictegravir/emtricitabine/tenofovir alafenamide clinical trial participants experienced serious renal adverse events. Bictegravir/emtricitabine/tenofovir alafenamide is contraindicated with co-administration of rifampin due to decreased plasma concentrations of bictegravir/emtricitabine/tenofovir alafenamide. It is contraindicated with co-administration of ofdofetilide (Tikosyn) due to increased dofetilide plasma concentrations. Additionally, bictegravir/emtricitabine/tenofovir alafenamide is contraindicated with co-administration of rifampin due to decreased plasma concentrations of bictegravir/emtricitabine/tenofovir alafenamide.

Similar to other ART regimens, bictegravir/emtricitabine/tenofovir alafenamide has a boxed warning that worsening of hepatitis B infection may occur after discontinuation of bictegravir/emtricitabine/tenofovir alafenamide treatment in patients infected with HIV-1 and hepatitis B. In patients with HIV and hepatitis B co-infection, it is recommended to monitor hepatic function closely for nine months after discontinuation of bictegravir/emtricitabine/tenofovir alafenamide. If appropriate, anti-hepatitis B therapy may be warranted.

Tolerability

The most common adverse reactions of bictegravir/emtricitabine/tenofovir alafenamide in clinical trials include diarrhea (6%), nausea (5%) and headache (5%). Clinical trials followed patients for 48 weeks. Ongoing
studies are currently following patients for up to 144 weeks. Bictegravir/emtricitabine/tenofovir alafenamide has shown a reduction in metabolic disturbances and nausea-related side effects compared to other ART regimens. It is unknown if bictegravir/emtricitabine/tenofovir alafenamide provides a reduction in neuropsychiatric events, sleep disturbances, or cardiovascular events compared to other ART regimens. Eighty-seven percent of adverse reactions were of mild grade. Less than 2% of participants in all clinical trials withdrew from the studies due to adverse events.3

Efficacy

Bictegravir/emtricitabine/tenofovir alafenamide has been studied by four phase 3 clinical trials. Two trials focused on treatment-naïve patients. The primary outcome of these trials was maintaining a virologic response of HIV-1 RNA < 50 copies/mL at 48 weeks. Bictegravir/emtricitabine/tenofovir alafenamide was non-inferior to abacavir/dolutegravir/lamivudine and dolutegravir/emtricitabine/tenofovir alafenamide in both phase 3 “switch” trials.3-7 Although data is limited, clinical trials have shown a low risk of HIV drug resistance with bictegravir/emtricitabine/tenofovir alafenamide.2

The primary outcome of these trials was maintaining a virologic response of HIV-1 RNA < 50 copies/mL at 48 weeks. Bictegravir/emtricitabine/tenofovir alafenamide was non-inferior to abacavir/dolutegravir/lamivudine and dolutegravir/emtricitabine/tenofovir alafenamide in both phase 3 “switch” trials.3-7 Although data is limited, clinical trials have shown a low risk of HIV drug resistance with bictegravir/emtricitabine/tenofovir alafenamide.2

Price

The wholesale acquisition cost of bictegravir/emtricitabine/tenofovir alafenamide for a 30-tablet bottle is $2,945.65, or $35,839 for 12 months of therapy. Other first-line ART regimens are of similar price comparison. Gilead Sciences offers a Patient Assistance Program for the underserved and uninsured; eligibility may vary. Additionally, they offer co-pay support for patients with commercial insurance.

Simplicity

Bictegravir/emtricitabine/tenofovir alafenamide, is a once-daily, fixed-dose combination of bictegravir, a new INSTI, and the nucleoside reverse transcriptase inhibitors (NRTIs) emtricitabine and tenofovir alafenamide (TAF), FDA approved for treatment of HIV-1 infection in adults. It is well-tolerated and can be taken with or without food. It is recommended to take two hours before taking aluminum, magnesium, or calcium containing antacids. Missing doses can result in development of resistance and reduced efficacy. Additional benefits include a reduced pill size (compared to other ART products) for patient comfort.

Bottom line

Clinical trials have shown treatment of HIV-1 infections with bictegravir/emtricitabine/tenofovir alafenamide are clinically efficacious and safe for treatment-naïve patients and patients currently on a different antiretroviral therapy. Bictegravir/emtricitabine/tenofovir alafenamide is an FDA-recommended, first-line agent for treatment-naïve HIV patients.

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References

Legal Summary

Opioid prescription guidelines: Are they mandatory?

Beth Anne Jackson, Esq.

As suspicion – or acknowledgement – that many cases of opioid use disorder (OUD) were iatrogenic and the opioid crisis grew, both federal and state governmental health agencies sought to develop and issue guidance for physicians. Having been fed misinformation by pharmaceutical companies for years, physicians needed evidence-based guidelines to appropriately treat their non-cancer chronic pain patients. The Centers for Disease Control and Prevention (CDC) responded definitively by issuing guidelines after seeking input from experts and stakeholders and combing through the evidence and responses. In addition, legislatures put strict limitations on prescribing in certain situations. It is clear that compliance with opioid prescribing legislation is mandatory, but what about compliance with guidelines?

Background. The most noted guidance is the CDC Guideline for Prescribing Opioids for Chronic Pain – United States, 2016, which was published in the Morbidity and Mortality Weekly Report on March 18, 2016 (the 2016 Guideline). State guidelines followed, as well as legislative limitations on prescribing opioids. Although the 2016 Guideline was rated highly for evidence-based practice, something was not right: Physicians, perhaps fearing investigation, were applying the 2016 Guideline too strictly, often resulting in patient harm.

After an April 2019 commentary in the New England Journal of Medicine described the misapplication of the 2016 Guideline and its consequences, the CDC issued a media statement regarding issues that could put patients at risk (the CDC Statement). The CDC Statement enumerated misuses of the 2016 Guidance: applying it to populations outside of its scope; implementing hard limits or “cutting off” opioids; abrupt tapering; and applying it to patients receiving medication-assisted treatment for OUD. On Oct. 10, 2019, the U.S. Department of Health and Human Services (HHS) bolstered the CDC Statement with a guide of its own: HHS Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics (the 2019 Guide), which advises a more patient-centered, tempered approach that takes into account multiple factors.

For example, the 2019 Guide discusses that the 2016 Guideline recommends avoiding or carefully justifying increasing dosage above 90 MME/day, but it does not recommend abruptly reducing opioids for patients who are already on higher dosages. Alas, the 2019 Guide makes recommendations for tapering that physicians may be unprepared to do, such as assessing for OUD. If the patient meets the criteria for OUD, the 2019 Guide recommends transitioning the patient to buprenorphine for treating the OUD, which requires the prescribing physician to have a DATA 2000 waiver. However, if the patient does not meet the criteria for OUD, a slow taper or a transition to buprenorphine for pain, which does not require a DATA 2000 waiver, is recommended. The 2019 Guide also recommends ensuring that patients receive appropriate psychosocial support: “Ask how you can support the patient.”

Legal perspective. In order to understand the legal effect of guidance, we need to understand how regulations are issued. Under the Administrative Procedures Act, which governs how federal agencies issue and implement regulations, there are two types of rules: “legislative” rules that go through the required notice and comment rulemaking procedures, and “interpretive” rules that may be issued without prior notice or public comment. In notice and comment rulemaking, a proposed rule is published in the Federal Register. The public has the opportunity to review and comment on the proposed rule. After considering the comments, the agency publishes the final rule in the Federal Register. Comments can significantly change the content of a final rule. These legislative rules are legally binding; however, interpretive rules, to the extent that they exceed the parameters of legislative rules or the underlying statute, are generally not. In recognition of this important distinction, the U.S. Department of Justice (DOJ) recently updated its Justice Manual to formalize prior Attorney General memoranda prohibiting the DOJ from relying on agency guidance/interpretive rules in enforcement actions. So technically, the 2016 Guideline and other guidance is just that: guidance. From a practical standpoint, however, well-documented and widely accepted guidance can become the standard of care, and significant deviation can result in malpractice claims in the event of adverse events or governmental investigations.

Conclusion. The CDC Statement and the...
2019 Guide were essentially issued to put a stop to physicians “over-correcting” their opioid prescribing practices because of the 2016 Guideline. Although the 2019 Guide asks much of prescribing physicians, its basic premise should be embraced: “Review the risks and benefits of the current therapy with the patient, and decide if tapering is appropriate based on individual circumstances.” (Emphasis added.) But be sure to document those circumstances thoroughly: Your evaluation of the risks and benefits of opioid and alternative treatments as the basis for your medical decision making should be clear to a third party reviewing the medical record.

DISCLAIMER: This article is for informational purposes only and does not constitute legal advice. You should contact your attorney to obtain advice with respect to your specific issue or problem.

Ms. Jackson is a shareholder in the Health Care Practice Group of Brown & Fortunato, P.C., which is headquartered in Amarillo, Texas, and serves healthcare providers nationally. She is licensed in both Pennsylvania and Texas and maintains an office in the greater Pittsburgh area. She may be reached locally at (724) 413-5414 or bjackson@bf-law.com. Her firm’s website is www.bf-law.com.

2019 Bulletin Photo Contest

Congratulations to Jared Knickelbein, MD, PhD, whose photo, “Mount Hood Reflection,” was the first-place winner of the 2019 ACMS Bulletin Photo Contest. His photo will appear on the January 2020 cover of the Bulletin.


These photos also will appear on 2020 Bulletin covers.

Congratulations to all winners, and thank you to all who participated in the 2019 ACMS Bulletin Photo Contest!
While deaths in childhood comprise a decreasing minority of overall deaths in the United States, their untimely occurrence with lost future potential is particularly tragic. It is critical to gather and assess data reviewing the cause of these deaths to learn how to best prevent them in the future.

To describe child mortality in Allegheny County, data were compiled from vital statistics information on death certificates of all individuals aged 21 years and younger at date of death, and included deaths recorded from 2008-17. Deaths were categorized into six mutually exclusive categories: sudden unexpected infant deaths (SUID), neonatal, medical causes, unintentional deaths, homicides, suicides and unknown.

SUIDs were defined as deaths in children <1 year of age due to sudden infant death syndrome (SIDS), asphyxiation, or suffocation. Neonatal deaths were defined as deaths in children 28 days or younger due to natural causes such as prematurity/low birth weight (LBW), congenital anomalies, infections, respiratory failure and not better described by another category. Medical causes of death were defined as deaths in children one month (29 days) and older due to a primary medical etiology (e.g. infection, malignancy, congenital syndromes) and not better described by another category. Unintentional deaths include motor vehicle collisions (MVCs), drownings, fire-related deaths, overdoses (including toxic ingestion and poisoning) and trauma unrelated to motor vehicles (e.g., deaths due to mechanical injuries, falls). Homicides were defined as deaths explicitly described as resulting from assault or firearm injuries inflicted by another person. Suicides were defined as deaths resulting from intentional self-harm. The remainder of deaths held little information to classify and were categorized as unknown.

A total of 1,836 deaths of Allegheny County residents aged 21 and younger were identified from 2008 to 2017, an average of 184 child deaths each year (Figure 1, page 393). About two-thirds (65%) were male. Cause of death varied widely by age with neonatal and SUID predominating in the first year of life, and suicides and homicides accounting for the majority of deaths of youths aged 12-21 years (Figure 2A, page 394). Among the 855 deaths among children <1 year, the vast majority (72%) occurred in the neonatal period (≤28 days), with 43% occurring in the first day of life. At least 45% of neonatal deaths were attributable to prematurity or LBW (Figure 2B, page 394). Additionally, there were 109 deaths of infants <1 year attributed to SUID in this period, with affected infants being more commonly male (54%) or black (55%).

Medical conditions, either acquired or intrinsic, caused 16% of all child deaths in 2008-17, a percentage that remained relatively unchanged across age groups and years. Unintentional injuries caused 17% of all child deaths, and 31% of deaths of youths ages 12-21 years. Homicides remain a leading cause of death of youths, causing 17% of all child deaths overall, over 16% of deaths of youths aged 12-21, and an average of 32 homicides annually. Firearms were used in 88% of all homicides.

Suicides contribute substantially to mortality among adolescents and young adults, causing 13% of deaths of youths aged 12-21, and an average of 10 suicides annually. The most common methods of suicide were hanging (42%) and firearms (39%).

There was an average of four child deaths per year between 2009-17 (range two to eight per year) attributed to child abuse or neglect.

In every category of child death, with the exception of overdose deaths,
black children are overrepresented compared with the overall racial demographic of the county (80% white, 13% black)\(^3\) (Table 1, page 395).

The Public Health Child Death Review Act of 2008 mandates that the state of Pennsylvania conduct periodic comprehensive, retrospective, multi-disciplinary reviews of child deaths. Currently, there are 61 Child Death Review (CDR) teams throughout Pennsylvania. The Allegheny County CDR team conducts this review monthly in an effort to gain more insight into the trends and causes of child mortality.

The high incidence of death in infants under 1 month old emphasize the fragility of life in the immediate newborn period. Many of these fatalities occur in children who suffer complications in the neonatal period related to prematurity. Although this review details at least 45% of neonatal deaths attributed to prematurity and low birth weight, gestational age at birth was not available for most neonatal deaths; it is estimated that at least two-thirds of neonatal deaths among “other” were among premature infants, bringing the total neonatal deaths attributable to prematurity closer to >60%. While most of these deaths are not preventable once a child is born, this information highlights the need for further investigation into the causes of preterm birth.

SUID remains an area of critical concern and a cause of death with highly modifiable risk factors. Safe sleep recommendations have been shown to reduce SUIDs, including having the infant sleep alone, on their back, on a firm surface, and without any nearby objects that could potentially obstruct the child’s airway, including bumper pads, blankets or toys. Promoting safe sleep practices through Allegheny County WIC offices and distributing safe sleep spaces (portable cribs) in postpartum wards in hospitals remain essential in keeping SUIDs low.

While the CDR team largely assesses deaths outside of natural causes, child mortality from medical conditions continues to be well-described. Most of these deaths occur in an inpatient setting, and current emphasis on reducing mortality is largely placed on improving treatment of existing conditions. Given the breadth of medical conditions that result in death, prevention methods will vary widely.

Unintentional injuries are largely preventable. Risk of mortality from motor vehicle crashes can be reduced by avoiding distracted driving, operating vehicles or crossing streets while under the influence of drugs or alcohol, and wearing helmets while on motorcycles or bicycles. Drownings decrease when pools are enclosed by a fence and children are supervised, and fire-related deaths drop with functioning smoke detectors. Overdoses have become an increasing cause of mortality among teens and young adults, in part driven by the opioid epidemic; however, wider distribution of naloxone, increased

Continued on Page 394
access to drug treatment centers and further community education can begin to mitigate this risk.

Homicide and suicide together comprise the majority of deaths of youths 12-21 years of age. Risk factors for homicide include substance abuse, poor mental health and prior criminal history, whereas suicide was more closely associated with a history of chronic disability as well as a history of poor mental health. As most homicides are committed by firearms, prevention strategies for homicides include safe firearm storage and reducing the access of youth to firearms, in addition to targeting the problem of drugs in communities facing these problems. Given that suicides occur by both firearm and non-firearm related methods, preventing suicide relies on not only reducing access to firearms but also increasing access to mental health care.

While unintentional deaths from physical abuse or neglect occur rarely in Allegheny County, their continued occurrence remains disturbing. As these children will likely present to healthcare facilities with complaints attributable to abuse or neglect prior to death, multiple initiatives have been put in place to increase recognition of physical abuse and neglect among healthcare providers.

Large disparities remain in childhood mortality with respect to race, consistent with trends in racial disparities of health outcomes nationally. These data highlight the need for further examination into the underlying factors driving these disparities.

The leading causes of child mortality in Allegheny County are complications in the neonatal period and unintentional injuries, homicides and suicides in adolescents and young adults. While many risk factors for child death are well-known and prevention methods have been established, further efforts to implement prevention measures are necessary.

Dr. Freedman is a pediatrics resident pursuing additional training in critical care. He is interested in population health, epidemiology and critical illness. He can be reached at bulletin@acms.org.
Table 1. Number of deaths of Allegheny County residents ages 21 and younger from 2008 through 2017 by race and cause of death.

<table>
<thead>
<tr>
<th>Category</th>
<th>White</th>
<th>Black</th>
<th>Total*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(n)</td>
<td>(n)</td>
<td>(n)</td>
</tr>
<tr>
<td>Neonatal (≤28 days)</td>
<td>267 (45%)</td>
<td>241 (41%)</td>
<td>593</td>
</tr>
<tr>
<td>Prematurity/LBW</td>
<td>100 (37%)</td>
<td>114 (43%)</td>
<td>267</td>
</tr>
<tr>
<td>Anomalies</td>
<td>54 (59%)</td>
<td>29 (32%)</td>
<td>92</td>
</tr>
<tr>
<td>Infectious</td>
<td>19 (41%)</td>
<td>23 (50%)</td>
<td>46</td>
</tr>
<tr>
<td>Respiratory failure</td>
<td>13 (57%)</td>
<td>8 (35%)</td>
<td>23</td>
</tr>
<tr>
<td>Other†</td>
<td>81 (49%)</td>
<td>67 (41%)</td>
<td>165</td>
</tr>
<tr>
<td>SUID</td>
<td>40 (37%)</td>
<td>60 (55%)</td>
<td>109</td>
</tr>
<tr>
<td>Medical Etiology</td>
<td>204 (59%)</td>
<td>123 (36%)</td>
<td>344</td>
</tr>
<tr>
<td>1mo - 1yr</td>
<td>54 (47%)</td>
<td>54 (47%)</td>
<td>115</td>
</tr>
<tr>
<td>≥ 1yr</td>
<td>150 (66%)</td>
<td>69 (30%)</td>
<td>229</td>
</tr>
<tr>
<td>Unintentional deaths‡</td>
<td>225 (72%)</td>
<td>79 (25%)</td>
<td>312</td>
</tr>
<tr>
<td>MVC</td>
<td>77 (73%)</td>
<td>22 (21%)</td>
<td>106</td>
</tr>
<tr>
<td>Drowning</td>
<td>9 (50%)</td>
<td>8 (44%)</td>
<td>18</td>
</tr>
<tr>
<td>Fire</td>
<td>8 (30%)</td>
<td>19 (70%)</td>
<td>27</td>
</tr>
<tr>
<td>Overdose§</td>
<td>109 (92%)</td>
<td>10 (8%)</td>
<td>119</td>
</tr>
<tr>
<td>Traumatic accidents (non-MVC)§</td>
<td>22 (54%)</td>
<td>19 (46%)</td>
<td>41</td>
</tr>
<tr>
<td>Homicide</td>
<td>42 (13%)</td>
<td>268 (85%)</td>
<td>317</td>
</tr>
<tr>
<td>Firearm involved</td>
<td>29</td>
<td>246</td>
<td>281</td>
</tr>
<tr>
<td>Suicide</td>
<td>71 (71%)</td>
<td>21 (21%)</td>
<td>100</td>
</tr>
<tr>
<td>Firearm involved</td>
<td>25</td>
<td>14</td>
<td>39</td>
</tr>
<tr>
<td>Child Abuse or Neglect‡</td>
<td></td>
<td></td>
<td>40</td>
</tr>
<tr>
<td>Unknown</td>
<td>24 (39%)</td>
<td>30 (49%)</td>
<td>61</td>
</tr>
</tbody>
</table>

* Total includes all races, as well as cases with race not specified.
† Gestational age not specified, likely includes cases related to prematurity.
‡ Includes one case of toxic exposure / overdose not clearly identified.
§ Includes deaths by toxic ingestion, not specifically labeled as suicide.
¶ Not mutually exclusive from other categories, as child abuse data derived from different source. Data only available for 2009-2017, race not available.

References
3. As described by US Census Bureau QuickFacts, Population Estimates Program (PEP) and the American Community Survey (ACS). https://www.census.gov/quickfacts/fact/table/alleghenycountypennsylvania/
In 2018, following a decade of skyrocketing deaths, overdose deaths in Allegheny County decreased by 41%, a drop from 737 in 2017, to 432 deaths in 2018. A review of Allegheny County Medical Examiner’s data, for the past 20 years, shows the largest prior decrease to be no more than 8% in any year. While still an appalling number of deaths, 432 is a dramatic drop in one year and worth examining as we try to learn from experience.

It will take time to develop a comprehensive analysis of contributory factors to this decrease in deaths, but we can begin by providing an overview of one, large-scale, evidence-based, Centers for Disease Control and Prevention (CDC)-recommended intervention implemented in Allegheny County, peer-to-peer naloxone.

Prevention Point Pittsburgh (PPP) first established the Overdose Prevention Project in 2001, working with community stakeholders to develop a plan for implementation of naloxone distribution. In 2005, PPP began distributing naloxone at the syringe service program site on a weekly basis. Volunteer physicians, nurse practitioners and physician’s assistants prescribed and dispensed injectable naloxone kits to each individual trained at the weekly syringe service site. PPP also provided training on overdose prevention and response in the Allegheny County Jail and various other settings, teaching people how to perform rescue breathing and administer naloxone and encouraging those at risk to access naloxone at the syringe service site.

With a spike in deaths related to early incidents of fentanyl in the heroin supply in 2005, PPP met with the Allegheny County Department of Human Services (DHS), the Allegheny County Health Department (ACHD), the Allegheny County Jail (ACJ), and medical and physical health providers. PPP advocated for naloxone distribution through the county jail and buprenorphine dispensing at hospital emergency departments, to address the looming crisis. Both ideas were dismissed as unworkable at the time.

PPP provided technical assistance to forward-thinking medical providers to implement routine naloxone prescribing for patients who were prescribed or used opioids, in order to reach people who didn’t access the SSP. The goal was to help reduce stigma by making naloxone prescription a normal part of medical practice. In 2008, PPP participated in forming a national naloxone advocacy group, “NOPE,” later renamed Opioid Safety and Naloxone Network (OSNN), and helped develop a guide to legislative action, used as a template for state overdose laws throughout the United States. PPP helped form the statewide advocacy organization, PA Overdose Prevention Action Network (POPAN), instrumental in the passage of Act 139 into Pennsylvania law in 2014. Act 139 allowed expansion of naloxone distribution by permitting “third party” prescribing and standing orders, providing liability protection for those who administer naloxone, and “Good Samaritan” immunity from criminal prosecution to those who called for help during an overdose.

In 2015, overdose deaths in Allegheny County increased 38% for a total of 424 deaths. PPP was essentially the sole provider of naloxone for take-home use, along with a small number of direct prescriptions in medical practices. A tiny organization with a total staff of three, PPP undertook the massive effort to provide training and naloxone throughout Western Pennsylvania to meet the burgeoning need as communities reeling from rising deaths were desperate to obtain it. About 950 doses of naloxone were distributed in Allegheny County for take-home use in 2015.

With skyrocketing deaths, PPP asked ACHD Director Dr. Karen Hacker to issue a county-wide standing order for naloxone dispensing by pharmacists.

In 2016, the number of overdose deaths climbed to 650. With backing from DHS, the Allegheny County Jail began providing naloxone to people on release. The largest provider of outpatient buprenorphine treatment in the state began providing take-home naloxone kits to all program participants. Through efforts of the Center for Inclusion Health Addiction Medicine team, Allegheny General Hospital (AGH), became the first local hospital dispensing take-home naloxone through the Emergency Department.
With a record-breaking 737 overdose deaths in 2017, other hospital EDs and healthcare providers began to follow suit. A statewide standing order was issued by Physician General Dr. Rachel Levine. The ACHD began distributing naloxone directly to those who needed it. PPP established a peer outreach program to expand naloxone distribution to neighborhoods without access to a syringe service site. Naloxone distribution grew to around 13,000 doses county-wide. In October 2017, PPP began distributing fentanyl test strips to help people identify fentanyl in their drugs. Program participants report this has been useful to them in figuring out how to use drugs more safely in an environment where fentanyl is ubiquitous in the heroin supply.

In 2018, Pittsburgh City Emergency Medical Services (EMS) implemented a naloxone Leave-Behind Program to provide kits to people who had overdosed, and the ACHD kicked their naloxone distribution into high gear. There was hope that pharmacy-based naloxone would broadly expand naloxone access to communities outside of Philadelphia and Pittsburgh, where it was available through SSPs. PPP worked with OverdoseFreePA.org to publicize pharmacies participating in the standing orders. But, with no funding for pharmacist education on the new policies, few pharmacies stocked naloxone and even fewer understood how to bill for it or provide information without stigmatizing those who asked for it. As with pharmacy sales of syringes, people most in need of naloxone fear being identified in their local pharmacies as drug users.

Free, community-based distribution of naloxone continues to be the most effective strategy for expanding naloxone access.

Data from PPP’s naloxone program (published in 2018), revealed that more than 95% of overdose reversals using naloxone obtained from PPP were accomplished by people who use drugs themselves, most likely to be on the scene and often the actual first responders. Nationally, as well, programs directly distributing naloxone to people who use drugs are most effective in reaching this critical

Continued on Page 398
population. PPP’s priority is making sure that naloxone is in the hands of people who use drugs by opening additional SSP sites where naloxone is distributed, establishing active naloxone outreach in communities without access to an SSP site, and continued advocacy efforts focused on increasing naloxone distribution through criminal justice facilities, hospitals, substance use treatment programs and EMS via “Leave Behind” programs.

In 2016-17, advocacy efforts gained traction, resulting in dramatic increases in naloxone distribution in Allegheny County, from a total of around 950 doses in 2015, to more than 29,000 in 2018, a more than 3000% increase in just three years, from the combined sources described above. The accompanying drop in overdose deaths has been equally dramatic, a 41% decrease in overdose deaths to 432 – nearly a return to the number documented in 2015. The decrease of 305 deaths in Allegheny County is responsible for 32% of the statewide decrease.17

Additionally, buprenorphine prescriptions, known to reduce the risk of overdose death, increased countywide by just more than 18% from 2016-18, an increase not seen on a statewide level, despite decades of research demonstrating that maintenance opioid agonist treatment reduces overdose death, reduces HIV and Hep C transmission, and reduces other injection related infections, saving lives and money.18 Further efforts to expand access, including the national campaign to do away with the buprenorphine “X Waiver,” could reduce barriers to accessing this life-saving medication, dramatically reducing drug-related mortality and morbidity.19

Distribution of fentanyl test strips also has helped people who use drugs to have greater ability to know what they have and to be safer. New research confirms that when people have access to harm-reduction tools and strategies such as the ability to learn what is in their drugs, they learn to use drugs more safely.20 Conversely, there is no evidence that law enforcement efforts to disrupt the supply of fentanyl to Allegheny County and Southwestern Pennsylvania have had any lasting impact on the availability of opioids, as is true of interdiction efforts across the United States.

It is now essential that we build on success and expand our efforts: 432 deaths is still unacceptable. Every death is a grievous loss to all who know and love the one who is gone. We must continue to increase access to naloxone, buprenorphine, sterile injection equipment and information for people who use drugs on the contents of the substance they consume and, to even begin to address the morbidity and mortality related to substance use that is unrelated to overdose deaths, it will be necessary to apply these lessons learned to underutilized strategies such as methadone and innovation of novel interventions more broadly concerned with building a continuum of care for drug user health.

While Allegheny County and some of the surrounding counties have seen a drop in deaths, many counties across the state and the country still have extremely limited access to naloxone. We need to increase SSPs in Pennsylvania; we need to see an inexpensive, over-the-counter naloxone product made available; we need to get rid of the X waiver in order to increase access to buprenorphine; and we need to expand access to drug-checking service and safer consumption sites. Rising Hep C, HIV outbreaks and 432 overdose deaths last year show the need to expand harm reduction-based services where people who use drugs can get the tools and information they need to protect their health and be treated with the respect and kindness that all people deserve.

Ms. Bell is a licensed clinical social worker and the coordinator of the Overdose Prevention Project for Prevention Point Pittsburgh, providing naloxone and advocating for naloxone access through the syringe access program and other community settings for 19 years. She can be reached at abell@ppgh.org.
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