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Attention 2015 Bulletin Photo Contest participants:

The 2015 Photo Contest will be held completely online, as it was last year. Please note instructions for participation below:

1. Email your VERTICAL jpg photos with a resolution of 300 dpi or higher to bulletin-contest@acms.org. Photos should be 8”W x 10”H but can be resized if the resolution is high enough.
3. Include the name of the photo (please keep file names short) as well as your name, specialty, address and phone number in the email.
4. You will receive verification that your photo has been received and is eligible to be entered in the contest.
   a) Horizontal photos will not be considered.
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   c) Panoramic shots or photos featuring specifically identifiable individuals/relatives will not be considered.
5. The deadline for submission is Friday, August 28, 2015. Voting will open after this date.
6. Participants are permitted to submit three photos but are limited to two winning entries.
7. Voting will close Friday, October 2, 2015. Voters should vote for 12 photos, as in previous contests.
8. Winners will be announced on the website, in the Bulletin and via email. The 1st-place winner’s photo will appear on the January 2016 cover; the remaining winning photos will appear on Bulletin covers throughout the year. Entries that were not selected as winners will be used in the Bulletin as space allows.
9. Please continue to check the ACMS website and future issues of the Bulletin for further updates and reminders.
10. If you have any questions, please call Bulletin Managing Editor Meagan Welling at (412) 321-5030, ext. 105, or email mwelling@acms.org.
Many readers are unaware that Sir Arthur Conan Doyle, creator of the famed detective Sherlock Holmes, also was trained as a physician. Holmes himself was modeled directly after one of Conan Doyle’s beloved medical school professors at the University of Edinburgh, Dr. Joseph Bell.

Bell was an esteemed physician and surgeon who taught his students to be observant, resourceful and logical in their deductions. Bell was a master of observation and deduction; he could tell a patient’s profession, provenance and proclivities by keenly observing every detail about him. Thus, Bell already had a wealth of information about his patient before even shaking his hand. This talent led him to help the police on cases as notorious as the Jack the Ripper murders, and Bell knew and was flattered by Conan Doyle’s writings.

Watson, Holmes’ loyal sidekick and biographer, also was a physician, but was clearly cast in the role of Conan Doyle’s student to Bell’s professor. When Holmes asked Watson his opinion and then stated his own, Conan Doyle illustrated the difference between the average practitioner and the exceptional practitioner of observation.

What an amazing experience it would have been to have had Dr. Bell teach us all Physical Diagnosis in medical school! I remember being reminded of the Holmes stories while trying to memorize Barbara Bates’ Guide to Physical Diagnosis and History Taking from cover to cover; it seemed like a perfect how-to guide to emulate the great detective on the wards and in clinic.

Truly, medical diagnosis is the ultimate detective story. This pursuit requires not only talent but also enthusiasm and determination on the part of the detective, and yields excitement along the way and ultimately great benefit to the patient. Whether surgical or medical in our fields, we all recall some element of the thrill of the chase that excited us about our chosen specialty. We’ve all had our eyes light up in delight in making a connection between symptoms and signs and disease; if we’re lucky, we occasionally get to see that same light shine in the eyes of medical students and residents as the light bulbs go on in their heads as well.

How long has it been since you’ve had that intellectual thrill? Yes, so much of daily practice is pattern recognition and quickly sorting problems into categories to receive the appropriate workup. So many hoofbeats, so many horses. But what about those zebras that we loved as medical students? What about those little observations that we made and asked our attendings about to see if they were significant? Can you today tell a patient’s occupation, habits, family life and diseases simply by observing them -- and have those assertions backed up by specific details? (It is easy and lazy and inaccurate, Holmes and Bell would argue, to simply look at someone and paint him or her with a broad brush of stereotype.) If it was possible in Conan Doyle’s era, it is still possible today to be a detective during medical practice.

And these detective skills may be most crucial in our era. As more and more of our time with the patient is consumed by looking away and typing into a computer to satisfy Electronic Medical Record (EMR) requirements, we lose valuable face time with our patients. We lose time to observe and examine, and we lose time to counsel. We can moan this fact all we want, but at least in the short term we cannot change it. Therefore, the sharper our skills of observation and deduction, the more benefit we can bring to our patients in the limited time we now have with them.

There are 56 original Sherlock Holmes stories; if you haven’t read them, or haven’t read them in a while, I would encourage you to read them. These are quick, engaging reads and will fire up your energies for the thrill of the chase at work.

Dr. Paranjpe is an ophthalmologist and medical editor of the ACMS Bulletin. She can be reached at reshma_paranjpe@hotmail.com.

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What does ACMS membership do for me?
As 2016 draws closer, one familiar refrain I start to hear asks a simple question: “Why bother? I’m just one voice, and when was the last time an election was decided by one vote?” By way of an answer, let me share some wonderful news that recently took me by surprise.

In my last editorial, I offered a brief history of Maintenance of Certification in Anesthesiology (MOCA), the anesthesia world’s version of the increasingly mandatory Maintenance of Certification (MOC). At that time, I found little reason to hope that the American Board of Anesthesiology (ABA) would change MOCA, since they had been very clear that this was not part of their plans. To my astonishment, a wondrous thing happened amidst what was fast becoming a mutiny among the ABA membership: The ABA listened.

It’s not entirely surprising when an individual company, subject to market forces, takes back an unpopular decision – as happened during the recent tax season, when Intuit publicly apologized and undid the changes they’d made to their TurboTax software after a groundswell of customer dissatisfaction. But it’s easy to write this off as a nod to the realities of the market: Customers threatened to switch to competing products, and the company took steps to prevent it. Far more impressive to me is what happened with the ABA. Although the ABA faced little competition, its “customers” – that is, anesthesiologists with ABA board certificates – spoke up against the recertification system. Their pressure was calm but unyielding: When the ABA asked for their opinions in a survey, they shared generously; when only the highlights of that survey were released, they spoke out about that, too.

So what were the results? Let’s look at individual complaints, and what ABA did.

Many of us believed that a closed-book exam made the stakes artificially high, emphasized areas of knowledge that were often irrelevant to a given anesthesiologist’s subspecialty, and served mainly to give experienced anesthesiologists an unwanted reminder of how they felt while preparing for their SATs. Result: The test was abolished, replaced by a training app called the MOCA Minute whose name reflects the intended time investment of one minute per day. (One minute per day would be six hours per year, or 60 hours per 10-year MOC cycle; the ABA requires that MOCA Minute be used at least 120 times per year, or roughly one out of every three days.) Instead of maximizing stress, the app shows signs of providing useful review material while nudging its users toward healthy, steady learning.

Many of us also believed that the simulation was unnecessarily expensive and should not have been required. Result: The simulation is now slated to be one option among several other choices. Since it is optional, market forces will presumably bring the price down substantially as sim centers compete with other sources of MOCA Continuing Medical Education (CME). On a side note, I suspect this decision will be a boon for simulation in anesthesia in the long term. Since sim centers will no longer be able to treat anesthesiologists as a captive audience, they will have to provide products that can stand on their own merits in the open market, at a price people are willing to pay.

Many of us believed that $2,100 was an awfully steep price for a single test plus 10 years of minimal, and largely automated, management of CME. While the currently named price of $210 per year is not a change from this in the long run, the $210 per year doesn’t start until 2016. My certification cycle ends in 2019 – so for this cycle, my bill should change from $2,100 to $840, for a savings of $1,260. Apart from those unlucky souls whose cycle ends in the current year, everyone in the MOCA system should see at least some modicum of savings on this go-round. Those who had not yet paid for a visit to a sim center will likely see further savings as alternatives become available. The overall price is still high, but this is at least a step in the right direction.

I’m sure I was not the first voice to speak up against onerous, unnecessary aspects of MOCA. I’m sure I wasn’t the second, or the third, or the hundredth. But I was one of the voices raised against it. I’m proud of the way my profession stood up to insist that our credentialing board represent us fairly, and I’m impressed by the humility...
the ABA showed in admitting – if later than I’d have liked –
that it did not have all the answers.

Long ago, there was a popular bumper sticker seen
on the sort of cars one would find parked outside the East
End Food Co-op. Often found in the company of Grateful
Dead stickers and pleas that we “can’t hug with nuclear
arms,” it proclaimed that “if the people lead, the leaders
will follow.” With MOCA, the people did lead, and the
leaders did follow. As we approach another election year,
let’s not forget that we still have a voice.

Dr. Horton specializes in anesthesiology and is asso-
ciate editor of the ACMS Bulletin. He can be reached at
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I love Pittsburgh. As a kid from Beaver County, coming to Pittsburgh was so memorable and thrilling. Truth be known, I considered myself fully arrived as an adult the day that I was able to drive Route 65 to the city and back home on my own craft and skill. I was around for Renaissance I and II, for the fall of steel, Roberto Clemente, and the ascension of the Steelers Nation. Having returned as an adult after capturing an outsider for a wife, my family and I have made our home within the city limits to rear our children and work in our professions. Although we have lived in a neighborhood that has a lot of challenges, we have rich relationships, rich stories and gritty kids to show for it – I am grateful to the ‘Burgh; we have prospered here.

What of the next season for Pittsburgh? There is an undeniable turning again – a moving forward. There is a vitality, energy, innovation and interest that are undeniable. Neighborhoods that we thought had the last nail in the coffin are being reborn. Some of our arts and cultural centers are recognized on the world stage. Our universities excel; the stadiums, restaurants and entertainment venues put a wonderful evening in easy reach. Our business and innovation centers seem to be firing on all cylinders, and visitors come just to experience our city. If you needed proof that we have arrived … we have a bike lane downtown!

Having passed through some very tight stretches, it is indeed a good time to be a part of Pittsburgh.

These changes, this energy has prompted me to puzzle about the nature of prosperity, economics, community and civic life. What is the nature of Pittsburgh’s current prosperity? How much of it is driven from the energy sector and the shale industry? Is it sustainable, or are we creating a bubble? What will we leave as a legacy from this era? Are all of the boats rising from this tide?

I propose that the benchmark for how well a community is doing is not how well the most prosperous of us are faring, or even how well the middle class is scoring, but how the most marginalized amongst us are getting along.

I think a lot about our at-risk schools where our at-risk kids get their education. What are we doing to get resources to the students who are hanging in the balance? How are we innovating for them, and with them? How much of a priority are they in our thinking, and in our spending?

Public transportation deserves its place at the table for discussion. Keeping a job without a car in the ‘Burgh can be a challenge in and of itself. Or, how about our courts and the criminal/penal system? We have a lot of attention and energy right now around the relationship of the police with the community. Are we asking the right questions, even if they are tough? What are we doing for those coming out of the penal system – are we there with a hand up, or a stiff arm?

Lastly, how are we doing delivering health care? What does the data show? Are we doing BOTH the liver transplants and the asthma prevention? How easy is it for the uninsured or underinsured to get attention before small problems become big problems? How accessible are mental health services to those who need them? Pittsburgh has a rich tradition of caring for
its own – there are models of incredible generosity, innovation and community: Emergency child care centers, health clinics, community gardens, youth development programs – the list is stunning. We also have seen darker times where the “haves” ignored or exploited the “have nots.” What will the legacy of this era be?

Obviously there are not a lot of easy answers, but are we willing to ask the questions? Answers are not as simple as a political party, or technology, or financial windfall. Any solutions are likely “yes, and” – some responsibilities lie at the feet of good government, some with our educators, some with business, some with those of us in health care. Somehow it will likely involve us just being good neighbors to one another – especially for our neighbors who are having a tough time of it. And it will be in that very reaching beyond our own needs, with some cost or risk to ourselves, that we will paradoxically find the richness of being human as individuals and as a community.

A recent letter to the editor in the Pittsburgh Post-Gazette bemoaned the demise of the North Side. The author wrote of the current violence, how we must scurry for shelter here, and how bleak the present day is when juxtaposed to the richness of the neighborhood life of his childhood on the North Side. I noted the neighborhood that the author lives in now – he has moved up and out. I would like to invite him back. There surely are some jagged edges, but life in Pittsburgh can be good, and we can always make room for another neighbor.

Dr. Guy is a primary care physician with Allegheny Health Network. He lives on Pittsburgh’s North Side with his wife, Christine. He can be reached at bulletin@acms.org.

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.
We call residency our training. We go to medical school, then head to residency to train, to get our 10,000 hours purportedly needed to become "expert." Then we finish and head out into the void. Anyone who has completed that first year out of residency knows that you learn as much that year about being a doctor as you did the years before. You learn how to be the One Who Makes the Decisions. And then you make them.

About a year out of residency, I had a patient with congestive heart failure. She was working hard to breathe, and I put her on BiPap. I started a nitroglycerin drip and gave her Lasix. This seemed to ease her symptoms somewhat. But she continued to have increased work of breathing. Of course she was headed to the ICU. I made the requisite phone calls.

Sometime later, she was transferred out of the Emergency Department. She had been taken off of the ventilator for transport, and the respiratory therapist planned to use the bag valve mask to ventilate the patient in the elevator. I honestly don't recall whether I was included in that decision. The patient became unresponsive in the elevator. Of course she was headed to the ICU. I made the requisite phone calls.

Sometime later, she was transferred out of the Emergency Department. She had been taken off of the ventilator for transport, and the respiratory therapist planned to use the bag valve mask to ventilate the patient in the elevator. I honestly don't recall whether I was included in that decision. The patient became unresponsive in the elevator. Of course she was headed to the ICU. I made the requisite phone calls.

The next day, I opened the chart to discover what had happened. I felt horrible. I called the pulmonologist and asked about the event. He said, "She was just working too hard; she was not going to fly." In the end, the patient did well. But what happened? Did she fail because I didn't intubate her sooner, or did the removal of the ventilator cause the problem? Should I have discussed transport with the respiratory therapist? Where did we go wrong, or did we?

Of course, we don't always make the right choices. But outside of training there is little room for feedback. In the Emergency Department you may hear from the director if a case bounces back, a patient is transferred, or a complaint was lodged. What about the other cases? What about the cases that turned out OK but could have been managed better? Critique is generally scarce. Why?

For one, physicians don’t want advice. It may feel like criticism or direction for practice. Studies have shown that physicians are happiest in their profession when they are most autonomous. Second, mistakes will happen and we learn from them, but neither physicians nor patients want to discuss this fact. Finally, fewer and fewer colleagues seem qualified to provide constructive criticism as we mature in our craft. Who will debrief the surgeon who has been operating independently for years? How do we give feedback without offending? So we struggle valiantly, no matter the career stage. We undoubtedly learn the wrong thing at times.

Atul Gawande wrote an article in The New Yorker on coaching. He asked someone he esteemed to help him grow: a surgeon who had trained him during residency. Coaching is an invitation for critique, and the relationship is trusting. He found the experience to be a positive one. He got tips on teaching and mechanics and achieved his aims of lowering his infection rate. And, when a case went bad, the “coach” respected Dr. Gawande’s role and ability, and simply watched and debriefed him later.

Maybe we can do that, too. We can ask a colleague or mentor to watch us for a few shifts or operations, and offer advice. But is that realistic? Is everyone good at constructive criticism? And, how many of us know a fellow physician who would willingly work extra hours for our benefit? We can (and do) Continuing Medical Education (CME) to improve our skills, yet the golden nugget in this experience seems to be the direct feedback on patients you are managing. Dare I say it, like in residency, only refined.

Perhaps the answer, then, is a more formalized arrangement. What about the creation of fellowships for ad-
Advanced practitioners, a sort of “executive course” for physicians? The course could be one or two weeks long and covered by CME. It would either take you in-depth in your own specialty or it could allow you to “cross train” in an area of interest, all with direct feedback. There are myriad ways this could be designed.

What can we do in our own environment, on a more regular basis? Morbidity and mortality conferences are a great way to review cases, although they often are focused on mistakes causing harm and attended by members of only one specialty. Further, they are primarily confined to academic settings. Perhaps we could create an interdisciplinary workshop, to focus on a patient’s course of illness. It could even begin in an outpatient setting and conclude with rehabilitation. Various specialties could weigh in or provide insight.

Finally, we should invite feedback in our regular practice, and maybe even offer it.

If we are collegial, it shouldn’t be difficult to ascertain who is receptive. I know that I can improve my practice, and much of that work will be on my own. But when I hit the wall, I hope to find someone to help me grow.

Dr. Farrell is a board-certified Emergency Physician working for Emergency Resources Management Inc. (ERMI) at UPMC Passavant. She can be reached at farrellk@upmc.edu.

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We are overwhelmed with the onslaught of technology not only in our everyday world, but also in our very complicated medical world. Maybe the older one gets (me), the more overwhelming it seems. When does technology become mainstream? When is it truly relevant? You cannot bury your head and hope for tech and the change it brings to go away. To answer my own question, I believe that technology is necessary when you can’t live without it.

When I started orthopedics, open meniscectomy surgery was the “gold standard.” Seasoned surgeons of the day laughed at the technology of arthroscopy. They maintained the one-inch incision where the surgeon could see everything was far superior to the arthroscopy and its half-inch incision. You had to physically look into the scope creating an awkward sterile situation since cameras were not initially used. Now I don’t think there has been an open meniscectomy done in this country for the last 25 or more years. The technology of arthroscopy and arthroscopic surgery is the only approach for most non-replacement surgeries. It is not just mainstream. We cannot live without it. Not only did the orthopedic community embrace this approach, our patient population expected and expects nothing less. You can easily parallel laparoscopic gall bladder surgery with arthroscopy. And by the way, high-definition cameras that show vivid detail of surgery are an example of something you cannot live without, either.

I just saw a patient that I performed an active computer (Robo-Doc) total hip replacement now 20 years later— not just computer assisted. At that time, we had to place localizing pins into bone 24 hours before the computer surgery followed by a CT scan the day of surgery in order for the computer to identify the bone. It then shaped the femur, actively drilling the bone for the prosthesis. That was the rage of the moment. Of course we were told everyone in Europe (Germany in particular) did it this way. Today, very few orthopedists have ever heard of this technique. It is certainly not mainstream, and we have lived without it for 20 years without any regrets. I think the computer cutting apparatus cost Shadyside Hospital (the pre UPMC-Shadyside name) in excess of $1 million. Maybe small change now, but this was a significant investment at that time. That investment sat in the corner for years collecting dust.

Laser surgery also was a passing fad with the laser center at Saint Francis Hospital. It seemed you couldn’t turn on the radio or TV without hearing about laser surgery. Yet all they did was make a skin incision with the laser. I apologize in advance to anyone who actually used the laser for more. That was a passing fad, but we have embraced lasers in ophthalmology and urology. These are now techniques that are mainstream and we do not live without them, and they are not advertised in mainstream media.

Minimally invasive total joint surgery has been the buzzword in joint replacements for almost 10 years. It is important to point out that there is no true definition of minimally invasive surgery. Does it mean a smaller incision, less muscle or bone insult, different surgical approach, or all of the above? Coupled with this, there has been an explosion in improved anesthetic techniques specifically with pain management. So the improvements have been nearly impossible to measure.

At six weeks, most of the so-called minimally invasive techniques have not been shown to offer much benefit. Early recovery is the hoped-for result. Unfortunately, some smaller incision surgery has resulted in less than ideal results. In this regard, one might expect that advertising is as much to blame as the quest for improved outcomes. Patients really want to think they are getting the most up-to-date, less-invasive technique. We have improved our techniques over the years, and the younger surgeons have learned from and fine-tuned the surgical skills of the generation of surgeons before them. We certainly cannot live without total joint replacements; and the subsequent improvements and smaller incision surgery is a natural improvement of wonderful surgery. That improvement is something we cannot live without, and if we name that minimally invasive, then it has merit.
Computer-assisted surgery is the most recent development on the horizon. Computers play a huge role in our lives and in the operating rooms. Once again, they are being advertised to improve the surgical technique. We are in an operative technical revolution that is steam rolling through health care. Time will only tell which of these techniques we are not able to live without. The expense of acquisition is immense and the time-consuming aspect of the implementation also is very expensive since it lengthens surgical time. It is extremely difficult to cut costs, improve outcomes, shorten length of stay and cut down operative complications – that coupled with the addition of sophisticated technology and the manpower that is the driving force.

We cannot live without new technology that improves our techniques, but the explosion in the number of varying sophisticated items is straining the health care dollar and possibly bloating patients’ expectations. Not every new technique will survive the test of time. Some will fall by the wayside, as did Robo-Doc. Some will be modified and adjusted to create new frontiers in health care that solve problems we can’t solve now. That, by definition, makes technology something we cannot live without. I just hope direct patient advertising in this very competitive health care arena will not be a significant driving force.

Dr. Miller is in active clinical practice at Greater Pittsburgh Orthopaedic Associates and can be reached at (412) 661-5500 or mdmiller49@gmail.com.
In the March 19, 2015, issue of the New England Journal of Medicine, David Ansell’s perspective article called “Bias, Black Lives, and Academic Medicine” showed graduation numbers of medical students nationwide by race and gender. In 2012, actual graduation numbers of new doctors by race and gender were: white males, 6,763; white females, 5,533; Asian males, 2,427; Asian females, 2,434; black males, 517; black females, 880; Hispanic or Latino males, 766; and Hispanic or Latino females, 696. The numbers represent a steady decline in white male numbers from the exclusive 11,281 in 1982, to white female numbers grown to near parity with white males from 2,589 in 1980. Black males graduated 411 in 1980 and 517 in 2012, which shows no significant change in more than 30 years. Black females showed upward motion from 286 graduates in 1980 to 880 graduates in 2012. Asian males were equal with black males at 400 graduates in 1980, and Asian females had 120 graduates in 1980. In 2012, both have increased to more than 2,400 graduates, which is five times the black male numbers.

A report generated by the U.S. Census Bureau’s American Community Survey from its 2012 data shows that 6 percent of African Americans with bachelor’s degrees are unemployed compared to 3.5 percent of college-educated whites. If you isolate only the recent graduates, Jones and Schmitt from the Center for Economic and Policy Research wrote in their 2014 paper, “A College Degree is No Guarantee,” 12.4 percent of the recent African American college graduates were unemployed. The Journal of Blacks in Higher Education, March 30, 2015, further clarifies that specific degrees in communication, literature and languages or visual performing arts have even higher unemployment than the national average, while those with degrees in biological science, science and engineering have a significantly lower unemployment rate. Under-employment, defined by the Pew Research 2013 data as low-paying jobs that didn’t require the attained college degree, is about 55.9 percent among African American recent college graduates.

A 2013 report by the U.S. Department of Education entitled “STEM Attrition: College Students’ Paths Into and Out of STEM Fields” shows that more than half (65 percent) of African Americans who enter bachelor’s degree programs in Science, Technology, Engineering and Mathematics (STEM)-related disciplines either drop out of college or change majors and graduate with a degree in a non-STEM field. They tracked students entering into bachelor degree programs in the 2003-04 academic year and showed that by 2009, 29.3 percent of African Americans had left college without earning a degree. Another 36 percent of the African American students who started out in STEM-related fields graduated with a degree in a non-STEM related field.

The National Science Foundation, in their 349-page report entitled “Women, Minorities and Persons With Disabilities in Science and Engineering: 2015,” analyzed enrollment in graduate school by scientific discipline. In the 2012-13 academic year, they found 561,418 students enrolled in science and engineering graduate programs in the United States. They reported 31,338, or 5.6 percent, were black. Under further evaluation of these numbers, the official government definition of STEM includes computer and mathematical occupations, engineering, life scientists, physical scientists and social scientists. This data included psychology and social sciences in the science and engineering data pool, which account for half of the black students’ numbers. Using the National Science Foundation data and looking at STEM fields
individually, blacks were 10.2 percent of the graduate students in psychology, 10.4 percent of all graduate students in social science, 2.5 percent in physical sciences, 2.6 percent in engineering fields and 0.6 percent in graduate programs in astronomy.

In 2007, Congress passed the America COMPETES Act, which was reauthorized in 2010 to increase funding for STEM education and research so the United States can remain competitive in patents and technology. One of the focus areas is to reduce disparities in STEM employment by sex, race and origin. In the American workforce itself, the U.S. Census from its 2012 data reported the need for further efforts to attract women, blacks, Hispanics and other minorities into STEM fields. Blacks are 10.8 percent of all employed workers but 6.4 percent of employees in the STEM field with nearly 50 percent of that number being in psychology and social science.

The first step in increasing African Americans in STEM curriculum is to address attrition. As mentioned previously from the U.S. Department of Education report, 65 percent of African Americans who enter bachelor’s degree programs in STEM-related disciplines either drop out of college or change majors and graduate with a degree in a non-STEM field. A novel approach to the retention of STEM students is the Washington State University STate Academic RedShirt (STARS) program. It’s common for athletes at universities to “redshirt” players, allowing them to sit out for a year so they can train to compete at the collegiate level and still be eligible to play for four years. The University of Washington and Washington State University has created an “academic redshirt” program for low-income students that qualify for the federal Pell Grants and have agreed to major in STEM. In this program, the students get five years to finish their major in STEM. The first year allows them to get acclimated to academic rigors of the university, participate in extensive counseling and advising while mapping out an academic strategy and appropriate course load for the next 4 years and take any remediation courses they need.

The Kentucky-West Virginia Louis Stokes Alliance for Minority Participation in STEM was established with a grant from the National Science Foundation. Nine colleges and universities in the two states will seek to increase the minority students in STEM disciplines by 15 percent by 2016 and boost graduation of minorities in these fields by 50 percent. The nine participants are University of Kentucky, the University of Louisville, Western Kentucky University, West Virginia University, Centre College, Marshall University, West Virginia State, Bluegrass Community and Technical College and Kentucky State University.

Morgan State University, a Historically Black College or University (HBCU), has entered into a STEM partnership with Johns Hopkins that will allow undergraduate and graduate students at Morgan State to participate in research internships with the Hopkins Extreme Materials Institute. The first student will participate this summer 2015 with a grant from the U.S. Army Research Laboratory.

University of Iowa has started a new program to fund 24 underrepresented minority students in any one of their 22 STEM PhD programs. The scholarship is from the Alfred P. Sloan Foundation with matching funds from the university. Faculty mentors will be provided for each scholar. The University of Iowa has a solid track record of providing educational opportunities to minorities. As reported by the university, 41.2 percent of all graduate students at University of Iowa are non-white.

The Meyerhoff Scholars Program at University of Maryland Baltimore County (UMBC) has a stellar record of graduating blacks and other minority students in STEM disciplines. More than half of the students enrolled in the program are African American. Now, the Howard Hughes Medical Institute in Chevy Chase, Md., will provide grants to try to replicate the Meyerhoff successful experience at Pennsylvania State University and University of North Carolina at Chapel Hill.

The National Science Foundation has selected seven universities to participate in the Institute for African American Mentoring in Computer Sciences. The goal is to increase the number of African American students in graduate studies of computer sciences. The National Science Foundation states that African Americans make up only 1.3 percent of graduate degree recipients in the field and only 1.2 percent of tenure track professors in computer science. The seven universities selected for the grant are Auburn University, Carnegie Mellon University, Clemson University, Rice University, University of Alabama, University of Wisconsin and Winston-Salem State University.

The California Alliance for Graduate Education and Professoriate is a new program to increase the numbers of underrepresented minorities in PhD programs in mathematics, computer science, engineering and physical

continued on page 242
science. The consortium includes Stanford University, California Institute of Technology and University of California at Los Angeles and is led by University of California at Berkeley.

The University of California-HBCU Initiative brings undergraduate students from HBCU schools to the University of California campuses for summer STEM internships. The students spend eight weeks doing research and are mentored on the process of applying to graduate school and taking the Graduate Record Exam.

The University of Pittsburgh has a multiyear, ongoing project called the Hot Metal Bridge Program that is a one-year, post-baccalaureate research and training program for underrepresented minorities preparing to apply into a STEM PhD program. This program has had success in preparing and placing students in STEM PhD programs around the country.

Finally, the Virginia-North Carolina Alliance includes nine partner institutions that has sent black students to University of Virginia for a summer research program since 2007. The enrollment into STEM at the nine partner schools is up 39 percent, and graduation in the STEM fields is up 67 percent. This program has been funded by the National Science Foundation since 2007.

The hope of increasing STEM opportunities and mentoring in undergraduate and graduate programs for African Americans is that this will manifest into increased numbers in the STEM workforce. This growth may not be immediately noticeable because of a constant attrition of more senior STEM-trained African Americans into the non-STEM sectors. There is a great demand for bright, well-trained, often STEM-trained individuals for leadership positions in non-STEM sectors. In the American Institute for Research July 2014 issue, Lori Turk-Bicakci and Andrea Berger wrote an article called “Leaving STEM: STEM PhD Holders in Non-STEM Careers.” Of those who leave the STEM field, the article states that the largest percentage of the white males (40 percent), Asian males (51 percent), Asian females (49 percent) and Hispanic males (48 percent) will go to private, for-profit companies, while the largest percentage of the black males (42 percent), black females (46 percent), white females (31 percent) and Hispanic females (39 percent) will get positions in the U.S. government. Seventy-one percent of all individuals who leave STEM positions report that their current work revolves around managing, marketing or providing professional services with 30 percent in positions of top management or academic administration.

Dr. Simmons is an anesthesiologist at UPMC Shadyside and serves as president of the Gateway Medical Society. He can be reached at wsimmonsmd@me.com.

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Suicide prevention is a high priority for all physicians, but especially for those serving our nation’s veterans. Sadly, death by suicide occurs at a higher rate for America’s veterans than for the general public, but studies have shown that veterans who use Veterans Administration (VA) health care have a lower rate of suicide than those who do not.

As a psychiatrist with VA Pittsburgh Healthcare System for the past three decades, it has been my honor to serve many of our region’s veterans. While not all who served in the military qualify for VA medical benefits, some erroneously presume they are not eligible. If your practice has a patient who recently served our country in Iraq or Afghanistan, it is important they visit VA Pittsburgh for one visit within five years of leaving active duty. This single visit could establish their right for VA health care in the future.

Earlier this year, a two-part news story entitled “Dishonorable Treatment” aired on a local television station. This news story presented a poignant example of the tragic death by suicide of an American hero who bravely served in the Marine Corps. While the story did not accurately portray the care the veteran received at VA Pittsburgh, it is my hope that it helped raise awareness of the importance of suicide prevention in our community, particularly amongst veterans. Due to privacy, we were unable to share many of the details of the veteran’s care, and I hope this inaccurate portrayal did not dissuade veterans from seeking care at VA Pittsburgh and receiving support from our state-of-the-art behavioral health services. VA behavioral health services are proven to help save veterans contemplating suicide.

Just as you do in your practices, VA Pittsburgh and its dedicated staff work diligently every day to strive for the best possible outcomes in care. As an integrated health care system with a national electronic medical record system, VA has a unique advantage to assist with suicide prevention efforts through a number of programs and initiatives:

**Screenings**

In an effort to link veterans to behavioral health care as early as possible, we routinely screen in primary care for suicide risk, alcohol and substance abuse, possible depressive symptoms and possible PTSD-like symptoms.

**Walk-in clinics**

VA Pittsburgh offers walk-in behavioral health clinics at our University Drive campus every weekday for both new and current patients. New patients and patients who haven’t recently received behavioral health care can see a clinical psychologist for complete treatment planning without a prescheduled appointment. Current behavioral health patients can see a psychiatrist or a psychiatric nurse practitioner to resolve medication concerns or any issues that require immediate attention.

**Telemental health**

We offer telemental health services at all five of our community-based outpatient clinics. These services enable a Pittsburgh-based VA medical provider to treat behavioral health concerns while eliminating patient travel to Pittsburgh. In addition, we also offer in-home telemental health services to select veterans in need.

**Evidence-based care**

Providers at VA Pittsburgh are trained in multiple evidence-based, time-limited psychotherapies and are monitored for the safe use of psychotropic medications.

**Suicide prevention coordinators**

Our dedicated suicide prevention team works directly with veterans who are at risk for suicide. These social workers serve as an important resource for veterans and their loved ones.

**Safety plans**

We develop personalized safety plans for each veteran in need. Each plan identifies a veteran’s preferred coping skills and strategies as well as their designated emergency contacts.

**Free gun locks**

VA Medical Centers in our region, including VA Pittsburgh, provide free gun locks to veterans as a child safety
and suicide prevention measure. A veteran can receive free gun locks in person at the Medical Center, and there is no registration or tracking. It is simply to help save lives at no cost to the veteran.

As you can see, VA Pittsburgh has the resources in place to help veterans at risk for suicide. If you know of a veteran who is in emotional distress and in need of immediate support, please encourage them to call VA’s free and confidential Veteran Crisis Hotline at any time: 1-800-273-8255 and then press 1. Or, if you know someone needs help and won’t pick up the phone, you can call on their behalf.

I appreciate the opportunity to share my thoughts with the members of the Allegheny County Medical Society. Thank you for all the excellent care you provide to our area’s veterans, and I hope we can continue to work together to prevent veteran suicide.

Dr. Peters is associate chief of staff for Behavioral Health, VA Pittsburgh Healthcare System, and associate professor of psychiatry, University of Pittsburgh School of Medicine. He can be reached at jeffrey.peters@va.gov.

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.

Residents attend leadership program

The ACMS Residents and Fellows section hosted “Leading a Healthcare Team: 5 Things You Need to Know” May 13 at the Industry Public House. The program was presented by Joe Mull, MEd, president of Ally Training and Development. Attendees learned how to develop multiple leadership competencies related to people management, including listening skills, teambuilding, trust-building and consensus-building. In the back row, from left, are Munish Lapsia, Robert Newmyer, Mahesh Sardesai and Andrew Klobuka; in the front row, from left, are Teresa Walker, Kathleen Tyson, Joe Mull and Hilary Michel.

Society News

DOROTHY HOSTOVICH / ACMS
Diabetes Club to meet at ACMS

The newly reorganized Greater Pittsburgh Diabetes Club (GPDC) will host a meeting on Thursday, June 25, at the Allegheny County Medical Society, 713 Ridge Avenue, North Shore, Pittsburgh, 15212.

The dinner meeting is open to anyone whose primary care and concern is those with diabetes. Doors will open at 6 p.m. to provide an opportunity for networking with vendors and other practitioners in the area.

Amy Rothberg, MD, assistant professor of Internal Medicine at the University of Michigan, will be the guest speaker. Dr. Rothberg attended Wayne State University Medical School, where she received academic honors that included the Upjohn Award for Excellence in Endocrinology and Metabolism. She served both her internship and residency at the University of Michigan (Ann Arbor) Medical Center’s Department of Internal Medicine. Dr. Rothberg then completed a fellowship program in the MEND Division at the University of Michigan Health System in Ann Arbor and joined the MEND staff following.

The topic of Dr. Rothberg’s presentation will be “Obesity Review – What Do We Need to Know?”

If you wish to learn more about the GPDC, contact any of the officers: Jennifer Holtz, MD; Rose Salata, MD; or Jann Johnston, MD; or board members: Michael Korczynski, PharmD, BCACP, CDE; Mary Korytkowski, MD; Janis McWilliams, RN, MSN, CDE, BC-ADM; Deborah Rotenstein, MD; and Linda Seminario, RN, PhD, CDE.

For more information, contact Dianne Meister at (412) 321-5030 or dmeister@acms.org.

Most Interesting Cases presented to ACS

Members of the Southwestern Pennsylvania Chapter of the American College of Surgeons (ACS) met in the Ohio Room in the Rivers Casino overlooking Three Rivers Point May 11. The chapter was hosting residents from local programs for the annual “Most Interesting Cases” for presentation and discussion with members.

Residents from UPMC St. Margaret’s, UPMC Shadyside, UPMC Mercy, Conemaugh Memorial Medical Center and Allegheny Health Network (AHN) Allegheny General Hospital submitted a total of 17 abstracts which were reviewed by council, and from that number, six were selected for oral presentation at the May 11 meeting.

Opening the meeting was Sheri Mancini, MD, chapter president. Dr. Mancini introduced Chris Daly, MD, former chapter president, who gave a brief presentation on the ACS Foundation and why it is so important to the overall functioning of the College. Membership dues provide fundamental services, which is only a portion of the ACS budget. The ACS Foundation provides the funds to manage programs such as trauma center verification, professional development, research and advocacy. You designate where you want your funds dedicated. The Southwestern Pennsylvania Chapter each year contributes to the Foundation with the funds dedicated to the Thomas Russell Education Fund. Dr. Daly encouraged the members to make an annual donation to the Foundation.

Following Dr. Daly, Dr. Mancini introduced the residents and their cases. They included:

- The Tuberculous Peritonitis – A Rare Cause of Abdominal Pain & Ascites in a young male – Ravi Ambani, MD, AHN, Allegheny General Hospital
- Acetaminophen Overdose Mas-
querading as Cholecystitis after Bariatric Surgery – Jason M. Bregg, MD, Conemaugh Memorial Medical Center
  • Left Atrioesophageal Fistula after Pulmonary Vein Isolation for Atrial Fibrillation – Michael A. Archer, DO, AHN, Allegheny General Hospital
  • Traumatic Esophageal & Tracheal Disruption – Tad Witek, MD, UPMC Mercy Hospital
  • Acute Trauma in Pregnancy: Perimortem C-section Results in Survival of the Fetus – Michael Stellmaker, MD, AHN, Allegheny General Hospital
  • Clostridial Necrotizing Enteritis: A Rare Cause of Necrotic Bowel – Andrew Yeh, MD, UPMC St. Margaret’s

Following the presentations, selections were made for the best three of the “Most Interesting Cases of 2014.” Honorariums and certificates have been provided to Drs. Tad Witek (UPMC Mercy Hospital), selected for 1st place; Michael Stellmaker (AHN, Allegheny General Hospital), 2nd place; and Ravi Ambani (AHN, Allegheny General), 3rd place.

Chapter members interested in running for a position on the chapter council please contact the chapter office at (412) 321-5030 and ask for the chapter administrator. Elections will take place in November.

ACMS Foundation offers medical student scholarship

The Allegheny County Medical Society Foundation is offering a $4,000 scholarship to a qualified medical student. Applications will be accepted from July 1 to September 30, 2015.

Eligibility for scholarship applicants:
  • Applicant must be a Pennsylvania resident from Allegheny County.
  • Applicant must be a Pennsylvania resident for at least 12 months prior to registering as a medical student.
  • Applicant must be enrolled full time in a fully accredited Pennsylvania medical school.
  • Applicant must be enrolled or entering his/her 3rd or 4th year of medical school.

Applicant must submit:
  • A completed scholarship application form.
  • Two reference letters, from persons other than family members, documenting the applicant’s integrity, interpersonal skills, and potential as a future physician. Note: One reference letter must be from either a medical school professor or a physician.
  • A letter, on school letterhead, from the applicant’s medical school verifying that he/she is enrolled full time as a third- or fourth-year medical student at that institution.
  • A typed, one-page essay addressing the following: How do you hope to be involved in your community beyond clinical care of patients? In what ways would you hope to demonstrate leadership as a physician in your community?

Application materials must be postmarked by September 30, 2015. Applicants will be notified of the committee’s decision in December 2015. Students can download an application and review eligibility requirements at http://www.foundationpamedsoc.org/SFS/Scholarships/Allegheny.aspx.

Application materials should be mailed to: ACMS Scholarship, c/o The Foundation, 777 East Park Drive, P.O. Box 8820, Harrisburg, PA 17105-8820.

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For more information, call (717) 558-7852 or (717) 558-7854, Fax: (717) 558-7818, or email: studentservices-foundation@pamedsoc.org. The website is www.foundationpamedsoc.org.

TAPI Annual Educational Program held

The Tristate Association of Physicians of Indian Origin (TAPI) held its Annual Educational Program and Dinner May 16 at Airport Hyatt, Pittsburgh.

The educational topics included presentations from Curt Solomon, NORTCAL risk management specialist, titled “EHR Best Practices: Lessons Learned in Litigation” and “E-Communication: The Potential and the Pitfalls.” Two CME credits were available for the program.

Non-CME medical presentations included:
- Burton Singreman, MD, FAPA: Explore and options for treatment of Major Depressive Disorders
- Ashtok Shetty, MD: How to prevent rehospitalizations
- Parth Bharill, MD: GI update

Lawrence John, MD, ACMS president-elect, was the keynote speaker and provided an update on current issues, including: Mcare; Medicare and the replacement of the Sustainable Growth Rate (SGR) payment formula; Scope of Practice; Telemedicine; and Maintenance of Certification (MOC).

For more information on TAPI, visit www.tapi.us.

ACMS to host HIPAA, OSHA, OIG program

The Allegheny County Medical Society (ACMS) will host “Checklist Review for HIPAA, OSHA, and OIG” from 8 a.m. to noon Thursday, August 13, at the ACMS building.

The presenter will be Joe Suchocki, president of Eagle Associates Inc., a nationally recognized speaker and compliance consultant for medical practices.

The program will provide updates on the following:
- OSHA: How up-to-date is your practice for major safety requirements?
- HIPAA: A review of Privacy, Breach Notification, and Security Rules will provide a quick status check for compliance with current requirements.
- OIG: Participants will be guided through steps or actions published by OIG to meet OIG requirements.

The cost to attend the program is $125 for ACMS members and staff and $160 for non-members. To register, visit https://www.eventbrite.com/e/checklist-review-for-hipaa-oshia-and-oig-registration-17047113375. For more information, call (412) 321-5030, ext. 110.

ICD-10-CM program planned at ACMS

“ICD-10-CM Made Easy” will be held from 8:30 to 11 a.m. Thursday, August 20, at the ACMS building. The program will be presented by Linda Benner, CPC, CPMA, CASCC, COBGC, AHIMA-Approved ICD-10-CM/PCS Trainer, manager of consulting for PMSCO Healthcare Consulting.

The course objectives include:
- Contrast the structure and concepts in ICD-9-CM versus those in ICD-10-CM
- Recognize the impact of the change in coding systems to various functional areas of a physician practice
- Apply concepts such as laterality, specificity and granularity as specific ICD-10-CM chapters are discussed
- Identify the importance of specific-
society news

Physician Advocacy program held

Representatives of the American College of Emergency Physicians (ACEP) participated in a Physician Advocacy program May 7 at Allegheny General Hospital; Pennsylvania Speaker of the House of Representatives Mike Turzai, center, was the keynote speaker. At right is ACMS member and former Pennsylvania Medical Society President Bruce McLeod, MD, FACEP.

Activities & Accolades

Allegheny County Medical Society (ACMS) President John P. Williams, MD, was elected to the American Medical Association’s (AMA’s) Council on Medical Education during the AMA Annual Meeting in Chicago June 9.

Dr. Williams is board certified in anesthesiology and critical care medicine and has devoted his career to education and research with a clinical emphasis on cardiac illness and cardiac surgery.

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Bulletin / June 2015
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Past President’s Luncheon

More than 20 years ago, Rose Kunkle Roarty, (three-term) past president and now a director of ACMSA, initiated the tradition of Past President’s Luncheon (PPL). The purely social gathering of Alliance leaders offers a time out to reminisce and to casually comment on present issues and future matters of the organization.

Most certainly, the PPL provides a time and place to keep in touch, fortify friendships, and to keep up with family news and summer plans. Rose planned PPL at Longwood in Oakmont and hosted a wonderful wine reception in her new home before lunch.

Attending past presidents were Liz Blume, Patti Hetrick, Martha Burkholder, Barbara Wible, Rose Kunkel Roarty, Grace Ghoshhajra, Patty Barnett and Joyce Orr. Rose arranged a private dining room with lovely floral table centerpieces, and small boxes of chocolates at each place. Always an innovator, Rose extended invitations to spouses. Drs. Robert Blume, William Hetrick, Joseph Roarty and Leroy Wible contributed a wonderful new dimension to the great gathering on April 28.

Alliance website unveiled; new member brings great talent

Appreciation goes to new ACMSA Executive Committee member Elena Cerri for the skill and experience she has brought to us in her pro bono work in layout design, continuity and production of the ACMSA Newsletter since summer 2011.

Elena is a CMU graduate and for several years has been art director for PITTMED, the prestigious, award-winning publication of University of Pittsburgh School of Medicine. Elena is very active in art and culture communities in the Pittsburgh area. She spends quality time with her family: her husband, ophthalmologist Hugo Cerri, MD, and young son Antonio.

Elena will be working with James Ireland, assistant executive director, ACMS. Together, they will be managing and updating the Alliance website on a regular basis. To access our website, visit www.acms.org, click on About ACMS, and click on ACMS Alliance.
Angelo S. Runco, MD, 88, of Highland Park, died Thursday, May 21, 2015.

Dr. Runco graduated from the University of Pittsburgh School of Medicine and served his residency at Children’s Hospital of Pittsburgh.

He specialized in pediatrics during a medical career spanning six decades, participating in field testing Jonas Salk’s polio vaccine with fellow residents at Children’s Hospital.

After running a solo practice, Dr. Runco was on staff at West Penn Hospital, Magee-Womens, Shadyside and Children’s hospitals.

Surviving are his wife, Marjorie Boehmer Runco; children Paul, Robert (Sherry), Carol Emmons, Mark (Nora), John (Kelly), David and Thomas (Hollybeth); grandchildren Stephen and Chris Emmons and Michael, Maddy, Lincoln, Ben, Ally, Killian and Ravenna Runco; siblings Theresa, Tony and Sam Runco; and many cousins, nieces and nephews. Deceased is a daughter, Mary Ellen Jesse.

Services were held in Sacred Heart Church, Shadyside.

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Dr. Sieber graduated in medicine from the University of Pittsburgh and served his residency at Boston City Hospital. He specialized in pediatric surgery.

Dr. Sieber was a veteran of the U.S. Army, serving from 1942-46 and achieving the rank of captain.

Surviving are his wife, Anne M. Sieber; children William Karl Sieber Jr., Frederick Edmund Sieber, MD, and Kurt Delance Sieber; and six grandchildren.

Services were private.
Allegheny County Medical Society members:

The new world of Health Care ushered in by the Patient Protection and Affordable Care Act (ACA) has created uncertainty and confusion for most people. There are new regulations and requirements. Individual and employer mandates. Penalties for not purchasing coverage. On Exchange and Off Exchange access. As an Allegheny County Medical Society member, you have help.

Talk to USI Affinity, the ACMS’s endorsed insurance broker and partner. Our benefits specialists are experts in Health Care Reform. We can help you choose a health plan that provides the best coverage and value while ensuring you will be in compliance with complex new IRS and Department of Labor regulations. We’ll also provide you the kind of world class service and support you need to make sure you get the most out of your health care benefits after you buy.

You can also check out the NEW Allegheny County Medical Society Insurance Exchange, a convenient and secure online portal where you can find competitively priced insurance coverage for all your needs, including a wide variety of medical and dental plans.

To learn more, contact USI Affinity today!

Call 800.327.1550, or visit the ACMS Insurance Exchange at www.usiaffinityex.com/acms
Antimicrobial resistance continues to be an increasing threat to worldwide public health. In 2010, the Infectious Diseases Society of America began a program to stimulate research in novel and effective antibiotics to combat the growing concern of antimicrobial resistance. This initiative, known as “10 x 20 Initiative,” is a global commitment to creating sustainable antimicrobial research and development, with a short-term goal that calls for 10 new antibiotics by the year 2020. In addition, the U.S. government has adopted the Generating Antibiotic Incentives Now (GAIN) program as part of the Food and Drug Administration (FDA) Safety and Innovation Act, which provides fast-track priority review for regulatory approval and a five-year market exclusivity extension for qualifying antibiotics.

In “New antimicrobials for ABSSSI,” (Bulletin, February 2015, page 72) reviewed three newly approved antimicrobial agents that primarily treat infections caused by Gram-positive organisms. This article serves as a complement and reviews two newly approved antimicrobial agents that primarily treat infections caused by Gram-negative organisms.

Current options

Agents in the cephalosporin class demonstrate broad-spectrum activity against both Gram-positive and Gram-negative organisms. Like other β-lactam antibiotics, cephalosporins inhibit penicillin-binding proteins which leads to an unstable peptidoglycan cell wall. The disruption of peptidoglycan synthesis ultimately results in cell death.

Unfortunately, the utility of cephalosporins to treat infections involving Gram-negative bacilli has become compromised over time. The worldwide presence of extended-spectrum β-lactamases (ESBLs), Klebsiella pneumoniae carbapenemases (KPCs), and metallo-β-lactamases (MBLs) in Gram-negative bacilli has reduced the utility of cephalosporins and increased the difficulty of treating multidrug-resistant organisms (MDRs). Recent surveillance data from both Europe and the United States indicates that less than 75 percent of nosocomial isolates of Pseudomonas aeruginosa and Klebsiella species are sensitive to ceftazidime, and resistance to ceftazidime in Escherichia coli isolates now exceed 10 percent in many North American hospitals. Carbenpenemers are currently the antibiotic group of choice for the treatment of ESBL-producing organisms, but there is concern that the widespread use of carbenpenemers may lead to further emergent strains. As a result, the options for the treatment of Gram-negative infections are likely to become even more limited.

A common strategy to inactivate β-lactamase activity is the alteration of side chains to create a molecule for which the β-lactamase has poor affinity. An alternative strategy is the pairing of the β-lactamase agent with a β-lactamase inhibitor that ultimately inactivates the β-lactamase. As part of the GAIN program, the FDA has recently approved two new combination products that contain both a cephalosporin and a β-lactamase inhibitor: ceftazidime-avibactam (Avycaz®) and ceftolozane + tazobactam (Zerbaxa®).

Ceftazidime-avibactam (Avycaz®)

Ceftazidime-avibactam (Avycaz®) was approved by the FDA in February 2015 for the treatment of complicated intra-abdominal infections (cIAIs) when used in combination with metronidazole, as well as monotherapy for complicated urinary tract infections (cUTIs) including pyelonephritis. This product is only indicated for adults with limited or no alternative treatment options. Ceftazidime is a well-known third-generation cephalosporin, while avibactam is a new synthetic non-β-lactam β-lactamase inhibitor that inactivates some β-lactamases. Avibactam also protects ceftazidime from degradation by covalently binding and inactivat-
ing offending β-lactamase-producing Gram-negative bacilli in order to broaden its spectrum of activity and combat resistance to β-lactam antimicrobials. It should be noted that avibactam does not decrease the activity of ceftazidime against susceptible organisms.

Ceftazidime-avibactam has been shown to be effective against several Gram-negative bacteria, including Escherichia coli, Enterobacter, Klebsiella oxytoca, Proteus mirabilis and Pseudomonas aeruginosa. Adding avibactam to ceftazidime improves its activity against Enterobacteriaceae and Pseudomonas. However, this product has little to no activity against Acinetobacter baumannii, Burkholderia cepacia and Stenotrophomonas species.

Two phase 2 prospective, randomized, double-blind, comparative trials have evaluated the efficacy and safety of ceftazidime-avibactam. In a prospective, randomized, double-blind phase 2 study evaluating antimicrobial therapy in the treatment of complicated intra-abdominal infections in 204 hospitalized adults, the study regimen of ceftazidime 2000 mg + avibactam 500 mg and metronidazole 500 mg, each given intravenously every eight hours for five to 14 days, was compared to meropenem 1000 mg given intravenously every eight hours for five to 14 days. The results showed a favorable clinical response rate in 91.2 percent of patients receiving ceftazidime-avibactam plus metronidazole compared to 93.4 percent of patients receiving meropenem. Microbiologic responses exceeded 90 percent in both treatment arms. Comparable adverse event types and frequencies were observed between the two treatment groups, with both regimens displaying relatively mild safety profiles. Ceftazidime-avibactam had a higher number of GI adverse events, while meropenem had a higher number of elevated liver enzymes.

The second study was a phase 2, prospective, investigator-blinded study evaluating antimicrobial therapy in the treatment of 135 hospitalized patients with cUTIs, including pyelonephritis. More than 90 percent of the uropathogens isolated during the study were Escherichia coli. Eligible patients were randomized to receive either ceftazidime 500 mg + avibactam 125 mg intravenously every eight hours for a minimum of four days or imipenem–cilastatin 500 mg intravenously every six hours for a minimum of four days. Each regimen permitted patients to step down to oral ciprofloxacin if they met predefined improvement criteria. The primary endpoint was favorable microbiological response, defined as both the eradication of pathogens in the urinary tract and no pathogens in the blood at follow-up five to nine days after completion of therapy. Favorable microbiological rates were 70.4 percent for the ceftazidime-avibactam arm and 71.4 percent in the imipenem–cilastatin arm. The secondary endpoint of favorable clinical response was achieved in 85.7 percent of patients receiving ceftazidime-avibactam and 80.6 percent of patients receiving imipenem–cilastatin. Similar to the cIAI trial, the types of adverse events for each treatment were similar, with the majority being gastrointestinal effects, headache and anxiety.

In summary, two clinical trials have shown ceftazidime-avibactam to have excellent safety and tolerability with few serious adverse events. It should be noted that the manufacturer warns there is a decreased clinical response in patients with baseline creatinine clearance of 30 to 50 mL/min. Furthermore, seizures and other neurologic events were seen in patients with renal impairment.

Ceftazidime-avibactam may be used in empiric monotherapy of cUTIs caused by antimicrobial-resistant pathogens, such as carbapenem-resistant Enterobacteriaceae. It can be used in combination with metronidazole to treat polymicrobial IAIs, as metronidazole is needed to provide anaerobic coverage. Ceftazidime-avibactam may be a reasonable option for salvage therapy after third-generation cephalosporin treatment failure. Additionally, it may be useful in treating Pseudomonas infections due to its increased activity against this pathogen. Although no data are currently available, future uses of ceftazidime-avibactam may include hospital-acquired and ventilator-acquired pneumonia. Another future role may include the treatment of resistant Gram-negative bacilli-producing β-lactamases.

Ceftolozane + tazobactam (Zerbaxa®)

The FDA also recently approved ceftolozane + tazobactam (Zerbaxa®). Ceftolozane is an anti-pseudomonal cephalosporin that covers the majority of Gram-positive streptococci pathogens as well as Gram-negative pathogens such as Enterobacteriaceae, Klebsiella pneumoniae and Proteus mirabilis. Tazobactam irreversibly inhibits the activity of many penicillinases and cephalosporinases. This combination of a cephalosporin and a β-lactamase inhibitor was approved to treat cUTIs, including pyelonephritis. Ceftolozane + tazobactam also was approved in conjunction with metronidazole to treat...
clAIIs. It should be noted, however, that ceftolozane + tazobactam has poor susceptibility against staphylococci and enterococci.\textsuperscript{10}

There have been several trials conducted to display the efficacy and safety of ceftolozane + tazobactam in treating cUTIs and clAIIs, including 2 pivotal phase 3 trials. The first trial was a double-blind, phase 3, randomized, non-inferiority trial comprised of 1,068 patients diagnosed with cUTIs, including pyelonephritis. Eligible patients received ceftolozane/tazobactam 1 gm/0.5 gm intravenously every eight hours or levofloxacin 750 mg intravenously every eight hours or levofloxacin 750 mg intravenously daily for seven days.\textsuperscript{11} The primary efficacy population was the microbiologically modified intention-to-treat (mMITT) population, which included all patients who received study medication and had at least one baseline uropathogen.\textsuperscript{12} The primary efficacy endpoint was the proportion of patients in the mMITT population with both a microbiological eradication and clinical cure at a follow-up visit five to nine days after the completion of therapy. The primary endpoint was achieved in 76.9 percent and 68.4 percent of the ceftolozane/tazobactam and levofloxacin MITT arms, respectively; these results were determined to have reached non-inferiority.\textsuperscript{2,11} The adverse event profiles were mild and analogous between ceftolozane + tazobactam and levofloxacin therapies, with headache, constipation, nausea and diarrhea being reported most frequently.\textsuperscript{2}

The second phase 3 clinical trial compared ceftolozane/tazobactam 1 gm/0.5 gm intravenously every eight hours plus metronidazole 500 mg intravenously every eight hours to meropenem 1 gm intravenously every eight hours for four to 14 days in patients with clAIIs. There were a total of 979 patients in this randomized, multicenter, double-blind trial. For a patient to qualify for inclusion, he or she had to be diagnosed with a clAI which demanded surgery within 24 hours after receiving an antimicrobial agent.\textsuperscript{2} Almost half of the patients in the trial were diagnosed with appendiceal perforation or peri-appendiceal abscess. The primary efficacy analysis population was the microbiological intent-to-treat (MITT) population, which included all patients who had at least one baseline intra-abdominal pathogen regardless of the susceptibility to study drug. The primary efficacy endpoint was the difference in clinical cure rate of the two antibiotic regimens at day 26-30 after initiation of treatment. In the MITT population, ceftolozane + tazobactam plus metronidazole had a clinical cure rate of 83 percent while meropenem had a clinical cure rate of 87.3 percent, which was deemed to have achieved non-inferiority.\textsuperscript{2} The adverse events were mild and similar between both therapies in this trial.\textsuperscript{2}

Ceftolozane + tazobactam has a relatively safe adverse profile, similar to that of other β-lactams. The most common side effects reported with the use of ceftolozane + tazobactam included diarrhea, nausea, headache and pyrexia. Several less common side effects of ceftolozane + tazobactam consist of hypoglycemia, tachycardia, urticaria and dyspnea. Further, decreased efficacy was observed in patients with a creatinine clearance less than 50 mL/min. \textit{Clostridium difficile}-associated diarrhea has been reported with ceftolozane + tazobactam.\textsuperscript{11} Another warning of ceftolozane + tazobactam is hypersensitivity reactions, especially in patients who are allergic to penicillin-derived products, cephalosporins, or β-lactamase inhibitors.\textsuperscript{2}

Ceftolozane + tazobactam is a safe and effective treatment in adults (18 years and older) with cUTIs and pyelonephritis.\textsuperscript{10} In addition, it may be particularly beneficial in cases of ESBL-producing bacteria and \textit{Pseudomonas aeruginosa}. Future clinical directions include analyses of ceftolozane + tazobactam’s role in ventilator-acquired pneumonia in the ongoing ASPECT-NP trial.\textsuperscript{2}

Comparison of agents

A brief summary of both agents’ spectrum of activity, potential advantages, potential disadvantages and possible future uses are provided in Table 1.

\begin{table}
\centering
\begin{tabular}{|c|c|}
\hline
Agent & Spectrum of Activity \hline
Ceftolozane + tazobactam & \textit{Pseudomonas aeruginosa}, ESBL-producing bacteria\hline
Levofloxacin & \textit{Enterococcus faecalis}, \textit{S. pneumoniae}\hline
\hline
\end{tabular}
\end{table}
<table>
<thead>
<tr>
<th></th>
<th>Ceftazidime + avibactam (Avycaz®)</th>
<th>Ceftolozane + tazobactam (Zerbaxa®)</th>
</tr>
</thead>
</table>
| **Indications**      | • Complicated intra-abdominal infections (cIAI), when given in combination with metronidazole  
                          • Complicated urinary tract infections (cUTI), including pyelonephritis  
                          • Complicated intra-abdominal infections (cIAI), when given in combination with metronidazole  
                          • Complicated urinary tract infections (cUTI), including pyelonephritis |
| **Spectrum of activity** | Gram-negative organisms:  
                          • Enterobacter cloacae  
                          • Escherichia coli  
                          • Klebsiella oxytoca  
                          • Klebsiella pneumonia  
                          • Proteus mirabilis  
                          • Providencia stuartii  
                          • Pseudomonas aeruginosa  
                          Gram-negative organisms:  
                          • Enterobacter cloacae  
                          • Escherichia coli  
                          • Klebsiella oxytoca  
                          • Klebsiella pneumonia  
                          • Proteus mirabilis  
                          • Pseudomonas aeruginosa  
                          • Bacteroides fragilis  
                          • Gram-positive organisms:  
                          • Streptococcus anginosus  
                          • Streptococcus constellatus  
                          • Streptococcus salivarius |
| **Route of administration** | Intravenous  
                          Intravenous |
| **Approved dosage**  | For cIAI: 2.5 gm over 2 hours every 8 hours for 5-14 days, with concurrent metronidazole  
                          For cUTI: 2.5 gm over 2 hours every 8 hours for 7-14 days  
                          For cIAI: 1.5 gm over 1 hour given every 8 hours for 4-14 days, with concurrent metronidazole  
                          For cUTI: 1.5 gm over 1 hour every 8 hours for 7 days |
| **Dosage adjustments** | Moderate or severe renal impairment  
                          Moderate or severe renal impairment |
| **Common adverse drug reactions** | • Vomiting  
                          • Nausea  
                          • Constipation  
                          • Anxiety  
                          • Nausea  
                          • Diarrhea  
                          • Headache  
                          • Pyrexia |
| **Potential advantages over other available agents** | • Increased activity against *Pseudomonas aeruginosa*  
                          • May be useful for polymicrobial infections  
                          • May have a role in infections caused by multidrug-resistant *Pseudomonas aeruginosa* who have limited therapeutic options  
                          • May be useful for polymicrobial infections |
| **Potential future uses** | • Nosocomial pneumonia (in combination with anti-staphylococcal and anti-pneumococcal agents)  
                          • Diabetic foot infections  
                          • Pneumonia, including ventilator-acquired nosocomial pneumonia  
                          • Diabetic foot infections |
| **Potential disadvantages** | • Cost  
                          • Study findings may not yet be applicable to critically ill patients  
                          • Cost  
                          • Lack of activity against isolates harboring *Klebsiella pneumonia* carbapenemase (KPC) or metallo-beta-lactamase (MBL) enzymes |

Table 1. Comparison of ceftazidime + avibactam and ceftolozane + tazobactam

Continued on Page 258
Future directions

The growing incidence of bacterial resistance has resulted in the development of several new and innovative antimicrobial agents. These new agents provide practitioners with more options for challenging infections. Practitioners must keep in mind, however, that these new agents have not demonstrated a therapeutic advantage over currently available therapies for Gram-negative infections; the published clinical trials have determined that these agents are non-inferior to current standards of care. At present, the role of both of these agents is not in first-line therapy, but only when other options are not feasible due to confirmed resistance, adverse event, or allergy. Likewise, the high cost of these agents may limit their usefulness in routine clinical practice. The results of studies including more patients, as well as other common pathogens and clinical scenarios, are eagerly awaited.

Mr. Walchack and Ms. Bedner are doctor of pharmacy candidates at Duquesne University Mylan School of Pharmacy. Dr. Fancher is an assistant professor of pharmacy practice at Duquesne University Mylan School of Pharmacy. She also serves as a clinical pharmacy specialist in oncology at the University of Pittsburgh Medical Center at Passavant Hospital. She can be reached at fancherk@duq.edu or (412) 396-5485.

References

2016 Board and Delegate Nominations

A Candidate for the ACMS Board of Directors:
• Represents physicians on issues impacting the practice of medicine and makes policy decisions for the medical society.
• Meets four times per year, special meetings as needed.

(Please print name) I am interested in the Board of Directors (Phone)

A Candidate for the ACMS Delegation to the PAMED:
• Represents physicians of Allegheny County in creating statewide policy on issues impacting physicians, patients and the practice of medicine.
• Meets as necessary prior to attending House of Delegates in October in Hershey, PA.

(Please print name) I am interested in the ACMS Delegation (Phone)

I would like to recommend the following individual(s) [Please print]

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______________________________ for ___ Board ___ Delegate

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Pennsylvania Medical Society launches Mcare navigation website

I. Introduction

Most physicians are now aware the Pennsylvania Medical Society (PAMED), along with the Hospital & Healthsystem Association of Pennsylvania and the Pennsylvania Podiatric Medical Association, have successfully settled litigation initiated against the Commonwealth of Pennsylvania regarding excessive Mcare assessments and the transfer of Mcare reserve funds to the state general fund for purposes other than the intended purpose of financing professional liability insurance. The essence of this agreement is:

- $139 million will be refunded to physicians for prior overpayments; and
- $61 million has been returned via reduction of the 2015 Mcare assessment.

Physicians who paid Mcare assessments, or had Mcare assessments paid on their behalf by either a practice or hospital employer in 2009, 2010, 2011, 2012 or 2014, are entitled to refunds. However, this refund process is very complex because it covers Mcare assessments over a five-year period and may involve multiple insurance policies and possibly multiple employers. PAMED has negotiated procedures with Mcare to help navigate that process and has established a website to assist physicians.

II. Critical issues

- **Lines of coverage:** Refunds will be based upon what is referred to as “lines of coverage.” Each separate policy will be a line of coverage, so physicians who worked for multiple employers or who changed policies or carriers will have multiple lines of coverage. Since each policy may have been paid for under different circumstances, the refunds could be owed to different parties.

- **Contractual Refund Rights:** Although the refund process is designed to pay the covered physician as the default refund procedure, there may be multiple contractual issues involved that govern who is ultimately entitled to the refund; these disputes will not be adjudicated by Mcare and must be settled through the appropriate legal process. Physicians should review employment agreements and consult with qualified legal counsel if necessary.

III. Refund process

PAMED has helped to design and structure a refund process which will focus on the physician rather than the source of the premium payment.

- **The physician for whom the assessment was paid, regardless of who paid the assessment, will be the default recipient of the refund, and will receive that refund except as provided by the claimed refund or assignment processes.**

  - The physician will receive a notice at the physician’s last known address for licensing purposes with the Pennsylvania Medical or Osteopathic Board for each “line of coverage” for which an assessment was paid.
  - Those that paid the original Mcare assessments, whether practices or hospitals, will have the opportunity to claim those assessments through a claimed refund process.
  - Physicians will be notified of claims for each line of coverage, and will have the opportunity to agree that the refund should be paid to the entity making that claim or dispute the claim.
  - If the physician disputes the claim, the payment will still be made to the physician.
  - If the physician agrees with the claim or fails to make any choice, the refund will be paid to the claimant.
  - Physicians also may assign a refund to a practice or hospital that paid the assessment for the physician.

IV. Contractual and other issues not adjudicated by Mcare

*The PAMED Mcare website can be accessed at [www.McareRefund.org](http://www.McareRefund.org)*
actions, but that is not a final legal decision.

- Despite the fact that a practice or hospital employer may not receive the refund, they may still be entitled to the refund and may file a lawsuit against the physician in court and litigate that matter based upon the contractual agreement between the physician and the employer.

- The respective rights of the parties, i.e., the physician and the employer seeking the refund, will be based upon the contract that existed between those parties at the time the Mcare assessment was paid. The contract could provide many things, i.e., the employer pays all professional liability premiums and would presumably be entitled to all professional liability refunds, or the physician’s compensation is based upon some expense formula and the physician may or may not be entitled to additional compensation if the premiums are refunded, or some other combination of facts.

- PAMED is having continuing discussions with Mcare as to payment of refunds for deceased physicians.

- Physicians should make sure that their license address is up-to-date so that they will receive their refund notice. If their refund notice is undeliverable, their refunds may be paid to a claimant or escheat to the state.

The settlement and refund process that PAMED and the other organizations have achieved is significant for physicians and hospitals. Please also note that the physician is central in the process of receiving any refunds and directing them to employers, if appropriate. Complete information can be found on the dedicated PAMED Mcare website at www.McareRefund.org. PAMED also is providing assistance to members through calls to (717) DOC-HELP.

Mr. Cassidy is a shareholder with Tucker Arensberg and chair of the firm’s Healthcare Practice Group; he also serves as legal counsel to ACMS. He can be reached at (412) 594-5515 or mcassidy@tuckerlaw.com.

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Pennsylvania Medical Society
Many physicians – regardless of practice type, setting, specialty, or geographic location – are filled with uncertainty with a multitude of changes to the health care delivery system. One of the new buzz phrases physicians and other health care providers have been hearing more of lately is “volume to value.”

Since the inception of the Affordable Care Act, we have seen an evolution in health care delivery models involving value-based reimbursement. The transition from volume to value means many things, but in short, it means the methodology behind physician reimbursement is changing.

For the first time in the history of the Medicare program, in January 2015, the U.S. Department of Health and Human Services announced goals and a timeline to shift Medicare reimbursement toward paying providers based on the quality of care they give their patients, rather than quantity (fee-for-service). (See illustration, page 263.)

Bottom-line: The transition from volume to value is coming and faster than many anticipated, and it will take investments of your time, energy, money, and the learning of new skill sets to be successful. Value-based reimbursement also requires sophisticated, data-driven business decision making, with an emphasis on improving quality and the cost effectiveness of care.

“A practice moving from volume to value needs people with many skill sets – someone focused on data interpretations; someone to predict financials; a clinical, quality-focused individual; and someone who is good at project management – to move forward,” said Tracey Glenn, director of practice management consulting for PMSCO Healthcare Consulting, a subsidiary of the Pennsylvania Medical Society (PAMED).

Glenn says the key strategies for success in moving from volume to value include:
- Choosing a leader or leadership team who can clearly identify goals and move the organization toward achieving them
- Communicating clearly and regularly with the entire health care team
- Developing a dashboard or using your EHR’s dashboard functions to share data with everyone
- Creating a positive culture focused on continuous quality improvement in patient care and outcomes
- Offering professional development and training to assist in achieving goals
- Including staff in redesigning the processes needed to achieve goals
- Celebrating successes and revisiting areas that need work

To implement new care delivery models successfully, providers also need to develop a set of core strategic competencies. According to IBM Global Business Services, these include:
- Empowering and activating patients to assume more accountability and make better, more informed health and lifestyle decisions
- Collaborating to integrate health care delivery across traditional and non-traditional care venues
- Innovating in operational processes, business models, products, services, and organizational culture
- Optimizing operational efficiencies in both administrative and clinical processes
- Enabling information technology in order to achieve high-value care, efficient operations, and effective management and governance

“Of course, implementing these core strategies also takes money, time, and the acquisition of new skills for physicians, while simultaneously placing constraints on the payment rates dictated by current law,” said Dennis
Olmstead, chief strategy officer and medical economist at PAMED.

"All alternative payment models and payment reforms that seek to deliver better care at lower cost share a common pathway for success. Providers must make fundamental changes in their day-to-day operations that improve the quality and reduce the cost of health care. Skills will be needed by all providers to navigate these new delivery systems and payment strategies."

So, how can you prepare yourself and be ahead of the curve?

A new innovative educational series of online, on-demand courses and live workshops from PAMED can help ensure you have the skills necessary to succeed in the transition from volume to value. Learn more, including the curriculum, and register at www.pamedsoc.org/valuebasedcare.

Earn up to 1 hour of CME for each online course and up to 5 hours of CME for each live workshop.

This series is facilitated by PAMED member Ray Fabius, MD, a nationally respected expert in quality and population health.

What sprung Dr. Fabius into action? It was several years ago when, as a practicing pediatrician in Philadelphia, he was visited by a local medical director.

"I was stunned when I learned that this medical director knew more about my practice than I did," said Dr. Fabius. "He had information that compared my performance on quality, on utilization, and even information on my patient satisfaction. I never again wanted to have someone else know more about my practice than I did."

Learn more at www.pamedsoc.org/Fabius.

This series is designed to help prepare health care providers for the future when reimbursement is based on outcomes, data and analysis are paramount, and population health is the focus.

"As we move toward value-based delivery systems, the focus shifts from volume to cost and quality," said Keith Kanel, MD, MHCM, FACP, Chief Medical Officer at Pittsburgh Regional Health Initiative. "Physicians must outfit themselves with new skills for modern challenges, and the PAMED program will provide the toolkit."

What’s leadership got to do with it and where can I hone my leadership skills?

"What’s needed [to be successful in the transition from volume to value] to tie all of these team members and skill sets together is a strong leader," said Glenn.

In addition to the volume to value educational series, PAMED also offers many leadership resources to Pennsylvania physicians through its Leadership Skills Academy. The Leadership Skills Academy includes a year-round leadership academy; online, on-demand courses; onsite training; and discounts on national seminars and conferences. Learn more at www.pamedsoc.org/leadershipacademy.

"If we [physicians] don’t lead or at least participate in change, it will occur without us, and I’ll wager to our detriment,” said Gus Geraci, MD, consulting chief medical officer at PAMED.

Ms. Damrauer is associate director of communications at the Pennsylvania Medical Society.
Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), H.R. 2, Pub. Law 114-10

2015

- The MACRA was signed into law by President Obama on April 16, 2015.
- The Medicare Sustainable Growth Rate (SGR) formula is permanently repealed.
- In lieu of scheduled 21 percent SGR cut for 2015, MACRA provides updates of:
  - 0 percent through June 2015; and
  - 0.5 percent in July 2015 through December 2019.
- Over 4,000 surgical service codes retain their 10-day and 90-day global periods.
- Provisions of the “Standard of Care Protection Act” prevent quality programs from setting “standards of care” in medical liability actions.
- The MACRA provides quality measure development funding of $15 million per fiscal year, FY 2015 to FY 2019, from Medicare Trust Fund.
- Physicians may opt out of Medicare on a continuous basis, without having to renew their status every two years.
- Members will be appointed to the Physician-Focused Payment Model Technical Advisory Committee, which evaluates alternative payment models (APMs).
- Non-physicians may document their own face-to-face patient encounter under Medicare requirements for durable medical equipment (DME).

2016

- The MACRA provides technical assistance funding of $20 million per fiscal years, FY 2016 to FY 2020, to assist small practices (up to 15 professionals) to participate in APMs and the new Merit-Based Incentive Payment System (MIPS) program.
- Physician groups (as well as individuals) may report quality measures for the Physician Quality Reporting System (PQRS) via qualified clinical data registries (QCDRs).
- A new “Measure Development Plan” sets priorities for new quality measures for MIPS and APM quality reporting.
- Medicare Part D claims must include the prescriber’s NPI number.
- Information blocking by Meaningful Use (MU) professionals and hospitals is prohibited.
- The Secretary of HHS must clarify how the “Common Rule,” that protects research subjects, applies to clinical data registries, including QCDRs.
- Qualified entities and QCDRs may have access to Medicare claims data.
- The Secretary sets criteria for physician-focused payment models.
- The annual list of MIPS quality measures is due by November 1 of each year.
- The IRS may collect up to 100 percent of Medicare payments due to overdue taxes.
2017

- The Secretary begins collecting data on the accuracy of global service packages.
- All physicians are subject to payment adjustments (bonuses or penalties) for their resource use under the Value-Based Payment Modifier (VBM).
- Many federal programs are funded through FY 2017 (September 30, 2017) including the Children’s Health Insurance Program (CHIP), Teaching Health Center GME Payment Program, community health centers, and Medicare-dependent hospitals (MDHs).

2018

- Medicare claims must identify the care episode, patient condition, and patient relationship, to attribute resource use to the appropriate physician or other eligible professional (EP) under the MIPS program.
- Higher income beneficiaries begin paying higher premiums under Parts B and D.
- Separate PQRS, MU, and VBM reporting and penalties sunset on December 31, 2018.
- The MACRA sets a goal of achieving interoperability of EHR systems by the end of 2018 and allows penalties and other consequences if this does not occur.
- The Secretary must inform each physician (and other EP) of their upcoming MIPS payment adjustment, at least 30 days in advance.
- A 3.2 percent increase in the base rate for inpatient hospital payments (scheduled for FY 2018 under the American Taxpayer Relief Act of 2012) will instead be phased in at 0.5 percent per fiscal year, from FY 2018 through FY 2023.
- The 2018 post-acute care update is limited to one percent (for skilled nursing and inpatient rehabilitation facilities, home health, hospice, and long-term care hospitals).

2019

- The MIPS program takes effect, consolidating and replacing PQRS, MU, and the VBM.
  - Annual MIPS composite scores include four categories: quality (PQRS) - 30 percent; resource use (VBM) - 30 percent; MU - 25 percent; and clinical practice improvement activities - 15 percent.
  - The annual “performance threshold” is based on the median/mean performance of all EPs for a prior period.
  - The Secretary may weight the categories differently.
  - Individual EPs can join “virtual groups” and report together.
  - EPs with substantial revenue from qualifying APMs or with few Medicare claims are exempt from the MIPS program.
  - MIPS EPs include physicians, dentists, podiatrists, optometrists, chiropractors, physician assistants, nurse practitioners, clinical nurse specialists, and nurse anesthetists.
- MIPS penalties and bonuses (for scores below or above the annual performance threshold) are on a sliding scale, with maximum MIPS penalties:
  - Up to 4 percent in 2019;
  - Up to 5 percent in 2020;
  - Up to 7 percent in 2021; and
  - Up to 9 percent in 2022 and beyond.
MIPS bonuses can go even higher (up to 3 times these levels). But total MIPS bonuses and penalties must balance each other.

- An extra “exceptional performance” bonus of up to 10 percent is available from 2019 through 2024, up to $500 million each year.
- Physicians and other EPs with substantial revenue from qualifying APMs receive a 5 percent bonus payment in 2019 through 2024.
- MedPAC recommends future payment updates to Congress in its annual report.

2020

- The payment update under MACRA for 2020 through 2025 is 0 percent, subject to further action by Congress (pursuant to recommendations by MedPAC).
- Medigap plans for new enrollees may not offer “first dollar” coverage; beneficiaries must pay at least the Part B deductible (currently $147 per month).

2021

- The Secretary may expand the MIPS program to social workers, psychologists, dietitians, nutritionists, physical and occupational therapists, speech pathologists, and audiologists.
- Medigap plans for new enrollees may not offer “first dollar” coverage. Beneficiaries must pay at least the Part B deductible (currently $147 per month).

2026 and Beyond

- The payment update under MACRA for 2026 and beyond is 0.75 percent for qualifying APM participants and 0.25 percent for all others, subject to further action by Congress (pursuant to recommendations by MedPAC).

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CORRECTION

In the May 2015 edition of the Bulletin, the headline on page 190 should have read, “Considering CTEPH can save lives.” Apologies to Dr. George with many thanks for her contribution.

Writers Wanted
Contribute to our new columns!
Interesting Cases
and
What Are You Reading?

For more information, contact Bulletin Managing Editor Meagan Welling, (412) 321-5030, ext. 105, or email mwelling@acms.org.

Don’t forget to submit your photos for the 2015 Bulletin Photo Contest!

The deadline for submitting photos is Friday, August 28, 2015. All photos should have a resolution of at least 300 dpi and should be emailed to bulletin-contest@acms.org. For more information, call (412) 321-5030, ext. 105, or email mwelling@acms.org.
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