Care is Your Business, Change is Ours

The healthcare environment is changing. Physicians must focus on providing the highest quality care with intense competition for their time. Medical practices face increased challenges tied to changes to regulation, insurance protocols, cost-management and revenue management.

Houston Harbaugh has over 30 years of experience in helping physicians and medical practices manage change through contract negotiations with hospitals and payors; contract management; advocacy and new practice start-up counsel. We have provided critical support in practice mergers and acquisitions. And we have provided sound advocacy on issues ranging from HIPAA compliance to medical staff and peer review matters.

Every challenge a medical practice can face, we have seen. We have helped practices of all size and structure meet these challenges. And we know what is ahead.
Care is Your Business, Change is Ours

The healthcare environment is changing. Physicians must focus on providing the highest quality care with intense competition for their time. Medical practices face increased challenges tied to changes to regulation, insurance protocols, cost-management and revenue management.

Houston Harbaugh has over 30 years of experience in helping physicians and medical practices manage change through contract negotiations with hospitals and payors; contract management; advocacy and new practice start-up counsel.

We have provided critical support in practice mergers and acquisitions. And we have provided sound advocacy on issues ranging from HIPAA compliance to medical staff and peer review matters.

Every challenge a medical practice can face, we have seen. We have helped practices of all size and structure meet these challenges. And we know what is ahead.

Opinion

Editorial .................................. 121
Patient care vs. privacy, or HIPAA, takes a holiday
Deval (Reshma) Paranjpe, MD, FACS

Miller Time .............................. 124
What we leave behind
Scott Miller, MD, MA, FAAHPM

Perspective .............................. 128
Walking wounded: The epidemic of PTSD in the inner cities
William Simmons, MD

Perspective .............................. 130
How to recognize bipolar disorder in a country where everyone is diagnosed with it
Leo Bastiaens, MD

Society News ............................ 132
• Science & Engineering Fair held at Heinz Field
• Pittsburgh Ophthalmology Society
• PAMED Foundation offers medical student loans

ACMS Alliance News ........... 137

In Memoriam ......................... 138
• Thomas E. Starzl, MD, PhD
• Herbert G. Kunkel Jr., MD
• Morton L. Goldstein, MD

Features

Feature .................................... 140
2017 ACMS Foundation Gala

Materia Medica ...................... 149
Atypical antipsychotics in elderly patients with dementia
Spencer K. Yingling
Mia L. DiGiammarino
Karen M. Fancher, PharmD, BCOP

Legal Report ............................. 154
Immigration turmoil affects physicians
Catherine V. Wadhwani, Esq.
William H. Maruca, Esq.

Special Report ......................... 157
National Healthcare Decisions Day

On the cover

Peacock
Michelle Kirshen, MD

Dr. Kirshen specializes in diagnostic radiology.
News flash: At this point in time, the private medical records of nearly any citizen of Pennsylvania can be accessed by any Pennsylvania provider who has purchased access to a regional Health Information Organization (HIO).

An HIO functions as a regional repository of health information so that the myriad electronic medical record (EMR) systems used by the area’s multiple hospitals and medical practices do not have to be software-compatible with each other. Medical information about a given patient would be condensed into a portable format that could be accepted by any EMR. If you buy access to an HIO, all of your patients’ data is uploaded to the HIO, whether or not your patient opts out of the HIO. Patients cannot contact the HIO to obtain their own medical data; instead, they are instructed to contact their providers directly for this.

Currently, there are five HIOs in Pennsylvania; each functions as a repository of patient records. The PA eHealth Partnership Authority has launched P3N, a network which does not serve as a repository but rather a connection viaduct between HIOs. If you as a provider have purchased access to any PA HIO, you can use P3N to obtain patient information about a patient whose records are in another HIO than your own. All patient data is automatically included in your local HIO if you are a member of your local HIO, unless your patient has specifically gone through the trouble of opting out of P3N. I am not aware of a way for patients to opt out of their data being included in their local HIO.

Pros:
• Allows quick access to vital patient information (allergies, past medical and surgical history, recent labs/studies, etc.) in the case of urgency or emergency. For example, an unconscious patient in the ED, or a patient who is a poor historian, could benefit from this service.
• Potential for reduction of medical errors by giving clinicians the complete picture of a patient's history and disease state.
• Cost savings for insurance companies and patients in reducing the ordering of duplicate tests and labs. In some ways, P3N is similar to the Pennsylvania Drug Monitoring Program (PDMP), which shares information to reduce redundant or excess opioid prescriptions, but this would do the same for studies/meds.
• Cuts down on “doctor shopping.”

Cons:
• Sensitive protected health information (PHI) also is included in the data stored by the HIO and is accessible to any provider across the state with access to P3N. This includes HIV status, among many other pieces of information that have historically been privacy-protected. Our regional HIO and P3N currently have no way of segmenting or protecting sensitive data.
• The vast majority of patients do not know about this program, or that the health data that they assume is private is not really so. Therefore, patients have no idea that someone from Philadelphia with P3N access can view their HIV status without their permission, knowledge, or consent. HIPAA, or at least the protection most patients assume they have, has effectively been bypassed.
• As the patients are unaware of the program to begin with, they also are unaware that they can opt out, at least from P3N. They also can opt back in to P3N. Our local HIO has this to say to patients who want to opt out: “Yes, you may opt out during the registration process when you visit a participating healthcare provider. Regardless of whether you choose to

Continued on Page 122
opt out of ClinicalConnect HIE, your health information will still be provided to the HIE. However, if you choose to opt out, the HIE will prevent your information from being searchable and will not exchange your information with other providers.”

Patients are not able to access their own records or see who has searched their records; they also are not able to download or request records from the HIO, not even for a fee. One might think this would be a good thing and the ultimate in portability, for example, if a patient were to go abroad or even travel to another state. Hopefully, this might be a capability of HIOs in the future.

Many physicians do not know about HIOs or P3N, and some do not have access to their local HIO due to either cost concerns or lack of reliable high-speed Internet access.

Physicians must pay a fee to access their regional HIO (naturally, as each HIO is a business). At the March 2017 State Board of Medicine meeting, I asked how much these fees typically were for individual physicians or practices, and while the P3N representative could not answer this question, I was told that “grants are available” from the state to help cover the cost. Therefore, I might deduce that the cost may be considerable. P3N does now charge a fee to regional HIOs for its services, and this cost is presumably passed on to providers.

Also, there is no legal provision to protect physicians who may not be able to access an HIO or P3N for any reason if they are sued and the plaintiff’s attorney makes the case that had the HIO or P3N been utilized, the bad outcome might have been prevented. The P3N representative acknowledged at the State Board meeting that this circumstance had not been considered yet. In other words, this has the potential to become an unfunded, sometimes unfeasible (in the case of poor Internet access) mandate in order to avoid liability.

In summary, the HIO is a well-intentioned idea that needs careful improvements, which would include enhanced privacy protection for patients, legal protection for physicians, and improved affordability and accessibility. And needed above all is widespread notification to all citizens of Pennsylvania that one of five third-party businesses is currently storing and sharing their private health records (and that this could be lifesaving in time of need).

Important information and links:

- Information about our regional HIO: http://www.clinicalconnecthie.com
- Information about the five regional HIOs and their capabilities and limitations: http://dhs.pa.gov/cs/groups/webcontent/documents/document/c_256403.pdf
- How to choose an HIO: http://dhs.pa.gov/provider/healthinformationexchange/choosetheirhio/
- Form to opt out of P3N form: http://www.dhs.pa.gov/cs/groups/webcontent/documents/document/c_256396.pdf (see page 123)
- More information on P3N: www.paehealth.org

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

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.
OPT-OUT OR OPT-BACK-IN FORM
FOR THE PENNSYLVANIA PATIENT & PROVIDER NETWORK (P3N)

INSTRUCTIONS:
STEP #1 - Please read the back of this form before completing this side.
STEP #2 - Complete Section 1 to opt out OR Section 2 to opt back in to the P3N. Please initial that you have read and understand each of the statements in either Sections 1 OR 2.
STEP #3 - Please complete ALL of the remaining sections of the form and sign.

SECTION 1 - To OPT OUT of the Pennsylvania Patient & Provider Network (P3N) complete this section:

| Initial | By submitting this Opt-Out Form information about me will NOT be accessible to health care providers and other authorized users (including for emergency services) by use of the P3N. |
| Initial | I understand that by opting out, this form will be shared with health care providers and other authorized users so they know that I do NOT want my information accessible in P3N. |
| Initial | I may choose to participate in the P3N again at any time by submitting this form as an Opt-Back-In form. |

SECTION 2 - To OPT BACK IN to the Pennsylvania Patient & Provider Network (P3N) complete this section:

| Initial | By completing this section, information about me (including information created prior to today’s date) WILL be accessible to health care providers and other authorized users (including for emergency services) by use of the P3N. |

SECTION 3 - Please complete each area below (please print CLEARLY):

First Name: ________________ Middle Name: __________________ Last Name: ________________
Maiden Name: __________________ Date of Birth: __________/______/______ Gender: □ Female □ Male
Street Address: ________________________________________________
City: ___________________________ State: __________ Zip Code: __________
Phone 1: ___________________________ Phone 2 (optional): ___________________________
Email Address (optional): __________________ Last Four (4) Digits of Social Security Number (optional): __________

By signing this form, I verify that I am the person named above, or that I am legally authorized to complete and sign this form for the person named above. The information provided on this form, and the preferences expressed herein, are true and correct to the best of my knowledge, information, and belief. I understand that false statements made on or through this form are subject to the penalties of 18 Pa. C.S.A. Section 4904 relating to unsworn falsification to authorities, and I am making this statement under penalty of perjury.

Patient Signature: ___________________________ Date Signed: __________/______/______
(Signature of patient, parent, legal guardian, or legal representative, where required.
If legal guardian or representative, please state your relationship to the patient.)

Guardian or Representative: ___________________________ Relationship to Patient: __________________
(Print Name)

This form must be returned with original signatures in black or blue ink. All non-optional fields must be filled out in order for your request to be processed. A separate form must be filled out for each family member. A contact phone number is required in case we must contact you to ensure the accuracy of the information provided above. You will receive an acknowledgement of the receipt of this form.

Return Form To:
Pennsylvania Department of Human Services
eHealth Partnership
605 Health & Welfare Building, 6th Floor • 625 Forster Street • Harrisburg, PA 17120
ra-consentmgt@pa.gov • www.dhs.pa.gov/learnaboutdhs/dhsorganization/ehealthpartnership • 717-214-2490
I need to get home.

These were his first words to me when I walked into his room to evaluate him. He had been admitted to the inpatient hospice the previous evening in a much more sedated and somnolent state, but overnight he had not required any additional doses of his pain or dyspnea medication, and he was now much more awake and able to communicate. Given his recent medical history, I was somewhat surprised.

“Doctor. You have to help me get home.”

I didn’t know how much he knew about what had happened to him over the last 10 days. He had become acutely ill at work, and when he suddenly lost consciousness, he required ambulance transportation to the hospital emergency room. He had then suffered a seizure on the way to the hospital. It took the hospital less than a day to make the tragic discovery of an aggressive and metastatic lung cancer which had already spread to the brain and bone. This explained the seizures. He had lost consciousness from the hypotension due to sepsis from an obstructive pneumonia due to the size of the lung tumor.

He was 52 years old. He was divorced from his wife and lived alone. He had two adult children.

The aggressive hospital care treated his seizures, his sepsis and his pneumonia with intravenous medications and antibiotics. He improved enough to understand there was nothing to be done about the widely metastatic cancer. His hepatic and renal function declined rapidly. He had agreed to inpatient hospice care to help manage his pain and shortness of breath, and the hospital had transferred him to our facility the last evening.

In less than two weeks, he had gone from working at his desk to dying from his disease. At best, he had another two weeks. But I knew he could not go home as there was no one there to care for him and manage his medications.

“I don’t think there is any way we can provide all the care you need at home, I’m sorry to say,” I told him.

And he seemed to understand this. “No, Doc, you don’t understand. I don’t want to go home.”

Now, I didn’t understand. But I would shortly.

“I don’t want to go home and STAY home. You just need to get me home. As soon as possible. I only need an hour or two to take care of some things, and then you can bring me back here.” He was visibly less anxious at being able to clarify this to me.

In general, this is not a very common end-of-life request. Most patients have someone to take care of things at home, like recent bills, or pets, to name a few. Other patients have had all the time they need to get all their affairs in order by the time they require inpatient hospice care. And the last and smallest group are just way too sick to even make the request.

But, to my surprise, his day-to-day condition had improved overnight. His symptoms of pain and shortness of breath had required much smaller and less frequent doses of medication overnight, and as a result, he was much more alert and functional that morning. The strength of his determination was clearly high. And he explained why.

“There are things in my apartment that I don’t want anyone to stumble across after I’ve died. Things I’d like to stay private and confidential and wind up buried with me. Things that might be misunderstood. I don’t think I can rest in peace otherwise. …” The urgency in his voice was clear.

We managed to get him to his apartment that afternoon. An LPN from the hospice stayed with the ambulance crew while the patient took care of the last thing he still had some control over. The exact items he would, and wouldn’t, leave behind.
He returned that evening, and of course he appeared extremely relieved. And tremendously grateful. I never asked, and he never said, exactly what it was that needed never to be discovered. But I’ve always had a gut feeling that, whatever he did, it made a huge difference to his family.

Dr. Miller, associate editor of the ACMS Bulletin, is clinical associate professor of medicine in the section of Supportive and Palliative Care at UPMC. He also serves as full-time medical director of the inpatient hospice facilities for Family Hospice. He can be reached at millers8@upmc.edu or (412) 572-8850.

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.
It was a usual Monday morning until the phone call rang in. The hospital wanted to send a terminally ill patient on life support to die at home. It is not every day that the hospice agency gets a request like this. On the surface it sounds simple, right? Set up the ambulance, transfer the patient home, and withdraw life support. That’s it. A big goal of hospice is to allow people to die at home, but this was someone in the ICU, on BiPAP ventilation, and on pressors. After starting the planning process for her to go home that night, it became clear that it was going to take moving heaven and Earth to make this happen. And we did.

The woman was 47 years old. From the day she was born with a congenital heart defect, her parents were told she was not going to survive. She was born with one ventricle instead of two, and underwent innumerable operations through the years. What she did with her life was more than most would have done with her condition. She became a cardiac care nurse and worked with the same doctors that had cared for her, before she entered health care administration. She loved to garden and be social. She continued to outlive every short prognosis that the doctors always gave her, until now. Her heart could not hold out any longer and had finally started to fail. After three weeks in the hospital, it became clear that this time, death was inevitable.

Her husband was not in denial and knew death was near. He also knew that her one final wish was to die at home, and that he was going to do everything in his power to make it happen. In the preceding week, he was preparing the room at home where she could rest during her final time. In his strong requests to bring her home, he was NOT going to take no for an answer. He would bring her home to die, if it was the last thing he ever did. Bound and determined, he convinced her hospital care team, who were understandably skeptical, to call hospice to arrange the transfer home for a terminal wean. After numerous phone calls with the many different parties involved (hospital, hospice, nursing, physicians, pharmacy, ambulance service, home equipment supplier), everything was set in place.

The doctor and hospice nurse arrived at the house at 6:30 p.m. in anticipation of her arrival. They went early to ensure that everything was ready. After all the planning, they had to make this work. They walked into the house and the sight took their breath away. It was a stately home with dark wood interior. French doors led into the room that her husband had been preparing. White carpet. Huge windows. Dark wood crown molding. Large regal bed in the center of the room with the sheets turned down ready to receive her. Disney paraphernalia scattered all around (she loved Disney). Disney music playing in the background. A bouquet of 12 yellow roses on the nightstand. Her husband saw the looks on their faces as they scanned the room, and he said, “It’s our anniversary today.”

She arrived home around 8 p.m., and looked as blue as could be. The site of her made everyone wonder how she had survived the ride home, let alone the hospital stay up until now. She was taken into the room her husband had prepared with such careful detail. The drastic difference between her mangled physical condition and the beautiful surroundings was impressive. Her husband and sister helped the nurse put her favorite pajama top on and settle her into bed. Surprisingly, her eyes were open. She looked around the room but could not comment with the BiPAP face mask blowing fierce air into her lungs.

What happened next was a beautiful thing. Friends and family surrounded her bed, and her pastor conducted a prayer service. Her eyes were open...
the whole time. Afterward, it was time for her husband to have some alone time with her. After all, it was their anniversary. Her eyes were still open despite her profoundly ill and rapidly deteriorating physical condition. She was medicated to help her breathing and the BiPAP mask was removed. He laid in bed with her, holding her in his embrace. They were looking into each other’s eyes, and one could see through the French doors that she was actually talking to him. One can only imagine what they were saying to each other.

She died peacefully about two hours after arriving home while still in her husband’s arms. Her husband seemed relieved that despite his loss, her suffering had come to an end. They had been at a holiday party together hardly six weeks prior. She had remained strong for so much longer than her doctors expected and through so much physical turmoil, but her eventual decline was inescapable. He sat at the large wooden dinner table in the room next to hers and shared more about her life story, about how she had persevered through so much, and about how badly she wanted NOT to die in the hospital. The team eventually left the house speechless, pondering the beautiful end.

**Author’s note**

Although research shows that the majority of Americans prefer to die in their own homes, nearly one-third of all deaths in the United States still occur in a hospital. The volume of inpatient hospital deaths is down 8 percent for the first decade of this millennium, according to the CDC, despite an 11 percent increase in hospital admissions.

Interestingly, the percentage of patients older than 65 has decreased, while the percentage of hospital deaths has INCREASED in the 45-64 age range. This latter anomaly could possibly be explained by an increase in hospice use amongst Medicare decedents, as well as more life-prolonging technology available to younger chronically ill hospitalized patients.

Dr. Glaser is clinical assistant professor of medicine, Section of Palliative Care and Medical Ethics, Division of General Internal Medicine, University of Pittsburgh Medical Center. She can be reached at garciacm@upmc.edu.

Dr. Lagnese is chief medical officer at Family Hospice and Palliative Care. He can be reached at klagnese@familyhospicepa.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.

---

**Let your next job find you.**

Choose from hundreds of practice opportunities in the Great Lakes Region.

- Receive alerts when new jobs match your preferences
- All specialties and practice settings represented
- Connect directly with in-house recruiters

Create a free profile at [www.medopps.org](http://www.medopps.org)
We are constantly bombarded with military metaphors in the media when they refer to communities plagued with gun violence as “war zones.” They talk about children killed by random gun shot as “caught in the crossfire.” I’d like to propose one more: It is the hidden “collateral damage” of psychological injury and broken lives that trauma-related stress inflicts beyond the actual victims of shootings or assaults. Friends, neighbors, families, schools and communities forced to cope with the fear and anxiety that the aftermath of traumatic violence creates often are pressed into service to handle a spouse’s debilitating panic attack or a child’s unrelenting nightmares. Too often, these scenarios are played out behind closed doors in poverty-stricken communities with no hospitals, doctors’ offices or mental health professionals nearby to guide these new victims through the emotional “mind fields” of Acute Stress Disorder.

Immediate maladaptive responses to trauma within the first month after an incident is called Acute Stress Disorder. Mental health professions reserve the title Posttraumatic Stress Disorder (PTSD) only after the persistence for four weeks or more of symptoms following a traumatic event (RA Bryant, AJP 1999;156(11), 1780-1786). Although many publications reserve PTSD for victims of war, terrorism and catastrophe, a progressively larger amount of physicians and concerned citizens agree that urban violence traumatizes civilians the same way war affects soldiers. The accumulative effect of depression, fear, anxiety, sexual violence and murder in the neighborhoods has an insidious effect of undermining the fundamental institution of the family, the ability to work, care for your children and concentrate on education.

The symptoms of PTSD can be quite varied. Some can have dissociative phenomena like flashbacks, panic attacks; others will have profound depression and desire toward isolation. Some patients only experience physical symptoms like increased blood pressure and heart rate, fatigue, muscle tension, nausea, joint pain, headaches, back pain or other types of chronic pain. No matter what the symptoms, people of color are less likely to seek psychiatric treatment. As hardships drive people with PTSD into crisis, they end up in the emergency rooms or the prison system. The National Association for Mental Illness states that 70 percent of youth in state and local juvenile facilities suffer from mental health problems. These children are cut off from mental health care, their communities and families. Many will eventually be released back into society as hardened, unstable adults. PTSD does not go away without treatment. If you or a loved one are struggling to cope with the effects of a trauma, it would be useful to seek professional help.

Dr. Simmons is associate professor, University of Pittsburgh School of Medicine, UPMC Department of Anesthesiology. He can be reached at bulletin@.
NOBODY CAN DENY YOUR PATIENTS ACCESS TO OUR LESS EXPENSIVE AND CONVENIENT MEDICAL TESTING.

Med Health Services (“MHS”) is the leading cost effective provider for the following testing in Central and Western PA, Ohio, West Virginia and New York.

- Complete laboratory testing
- All modalities of sonography
- Cardiac nuclear stress testing
- Nerve conduction testing services

We work with physicians by serving select outpatient practices with our sophisticated mobile devices to ensure patients receive the lowest out-of-pocket prices for outpatient diagnostic testing and specialized disease markers.

Physicians get the information they need for early detection and effective treatment in a timely and convenient manner.

AT MED HEALTH SERVICES, WE ARE THE FUTURE IN MEDICINE.

200 James Place
Monroeville, Pa 15146
Phone: 1-800-443-2035, ext. 104
www.medhealthservices.com
Perspective

How to recognize bipolar disorder in a country where everyone is diagnosed with it

Leo Bastiaens, MD

In 2007, an epidemiological study in the United States identified a 4,000 percent increase in the diagnosis of pediatric bipolar disorder between 1997 and 2007.¹ A much higher prevalence of adult bipolar disorder in the United States, compared to European countries, has been documented as well. While it is beyond the scope of this article to discuss the reasons for this phenomenon, it is clear that there are no plausible biological reasons to explain this magnitude of increase over such a short period of time. Changes in diagnostic criteria or better screening techniques have never led to such an increase in any other diagnosis, and cannot explain the bipolar explosion.

So, what has happened? Several factors, including the lack of critical thinking among many clinicians, are more than likely responsible for this inflation.²

How does this impact the primary care medical practice? With conservative numbers obtained in other countries, bipolar disorder ranks 14th on a list of chronic conditions primary care physicians encounter on a daily basis.³ The core treatment of manic-depressive illness is pharmacological mood stabilization with lithium, certain anticonvulsants, or second-generation antipsychotics. Physicians, other than psychiatrists, are frequently responsible for the management of medical conditions caused or influenced by these medications. Thyroid dysfunction and kidney problems related to lithium, weight gain, dyslipidemia and diabetes mellitus related to atypical antipsychotics, and blood dyscrasias related to anticonvulsants are examples regularly encountered in clinical practice. But what if these medications are prescribed for a misdiagnosed disorder? How can a PCP recognize bipolar disorder and as such justify a recommendation to continue medications with, at times, serious general health consequences?

In order to answer this question, one must consider what bipolar disorder is and what it is not.

What it is: a cyclical condition with discrete episodes, which last many days or longer, of core hypomaniac or manic symptoms, consisting of elevated mood and energy, grandiose ideas, decreased need for sleep, increased speed of thoughts and speech, increased activity level, at times leading to reckless, impulsive behavior. These symptoms are a clear change from the patient’s baseline functioning. When one observes such an episode, and can exclude organic or substance related etiologies, a diagnosis of bipolar disorder is more than 90 percent certain. However, most clinicians, primary care or not, will not observe a manic episode during the diagnostic process.

What it is not: explosive angry outbursts, persistent moment to moment mood lability, daily “mood swings,” emotional dysregulation with quick irritability, chronic restlessness and hyperactivity, or episodes of normal mood against a background of chronic depression. Over the last 20 years, in the United States, the term “bipolar” has become synonymous with these types of symptoms. A large majority of the time, they are part of other conditions, such as ADHD, personality disorders, substance use disorders, or trauma-related conditions.

“Prozac nation” of the 90s was a concern, but “bipolar nation” of the 21st century is a disaster. A misdiagnosis of bipolar disorder has far-reaching consequences in terms of misguided pharmacotherapy, medication-induced health problems, the enabling of the lack of responsibility and ownership of behavioral problems by the patient, and inappropriate disability assessments. At the same time, it does a disservice to people truly suffering from this chronic condition.

While national professional organizations and bipolar experts have been quiet about this phenomenon over the past 20 years, it behooves all physicians to recognize it and be prepared
to deal with it. At the very least, physicians should not accept a bipolar disorder diagnosis at face value but instead should recommend a second opinion if no discrete episodes with core manic symptoms are described, either in a mental health document or by the patient through an authentic individual narrative.

Dr. Bastiaens is a board-certified general and child and adolescent psychiatrist who received psychiatric training at Mount Sinai Medical, N.Y., and Harvard University, Boston. He is a clinical associate professor of Psychiatry at the University of Pittsburgh School of Medicine, and is a certified member of the Academy of Cognitive Therapy. 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.

References
2. Bastiaens L: Poor practice, managed care, and magic pills: have we created a mental health monster? Psychiatric Times, April, 2011

For classified or display advertising information, call Bulletin Managing Editor Meagan Sable at (412) 321-5030, ext. 105, or email msable@acms.org.
Science & Engineering Fair
held at Heinz Field

The 78th Annual Covestro Pittsburgh Regional Science and Engineering Fair was held March 31 at Heinz Field. More than 1,200 of the region’s youth participated, representing more than 100 schools from across Western Pennsylvania.

Allegheny County Medical Society Foundation participates as a corporate sponsor and provides two student awards. Additionally, ACMS Foundation members Maryann Miknevich, MD, and Ellen Mustovic, MD, and ACMS Alliance members Dr. and Mrs. John (Sandra) Da Costa participated as sponsor judges, as well as category judges for the fair.

2017 Award Winners

- Jahnik Kurukulasuriya (Pittsburgh Allderdice High School, Grade 12); Project: “Fusion Genes as Drivers of Breast-Brain Metastasis”
- Haley Ross (Northern Garrett High School, Garrett County, Md., Grade 11); Project: “Is it possible to produce medical equipment for less?”

Pittsburgh Ophthalmology Society Annual Meeting held

The Pittsburgh Ophthalmology Society’s 53rd Annual Meeting was held March 17 at the Pittsburgh Marriott City Center Hotel. More than 90 physicians attended this year’s meeting, which featured renowned ophthalmologist Warren E. Hill, MD, who served as the 37th Annual Harvey E. Thorpe Lecturer.

Dr. Hill, medical director, East Valley Ophthalmology, Mesa, Ariz., has devoted the majority of his professional activities to performing challenging anterior segment surgery for other ophthalmologists and the mathematics of intraocular lens power calculations in unusual clinical situations. Dr. Hill’s presentations included “Understanding Corneal Aberrations;” “The Toric IOL – What You Need to Know;” and the featured Thorpe Lecture, “Improving IOL Power Selection.”

Attendees also were enlightened by presentations from the following guest faculty: Gaurav K. Shah, MD, professor of Clinical Ophthalmology and Visual
MORE INSIGHT
helps you make the most of your practice’s revenue cycle.

KNOW YOU HAVE A DEDICATED BANKER WHO UNDERSTANDS YOUR INDUSTRY AND YOUR NEEDS.
As a healthcare professional, you want to spend more time helping patients and less time worrying about your finances. With dedicated Healthcare Business Bankers, PNC provides tools and guidance to help you get more from your practice. The PNC Advantage for Healthcare Professionals helps physicians handle a range of cash flow challenges including insurance payments, equipment purchases, and managing receivables and payables. In such a fast-moving business, PNC understands how important it is to have a trusted advisor with deep industry knowledge, dedication and a lasting commitment.

ENSURE ACCESS TO CREDIT | ACCELERATE RECEIVABLES | IMPROVE PAYMENT PRACTICES | MONITOR & PROJECT CASH | PURSUE FINANCIAL WELL-BEING

Call a Healthcare Business Banker at 877-566-1355 or go to pnc.com/hcprofessionals

Cash Flow Optimized is a service mark of The PNC Financial Services Group, Inc. (“PNC”), Bank deposit products, and treasury management services, including, but not limited to, services for healthcare providers and payers, are provided by PNC Bank, National Association, a wholly owned subsidiary of PNC and Member FDIC. Lending and leasing products and services, including card services and merchant services, as well as certain other banking products and services, may require credit approval. All loans and lines of credit are subject to credit approval and require automatic payment deduction from a PNC Bank business checking account. Origination and annual fees may apply. ©2015 The PNC Financial Services Group, Inc. All rights reserved. PNC Bank. National Association, Member FDIC.
This year’s vendor support was exceptional, with more than 32 vendors participating. POS gratefully acknowledges and thanks all industry representatives who participated in the event. A complete list of sponsors can be found on the Society website at www.pghoph.org.

Following the meeting, members and their guests enjoyed networking and dinner at the Duquesne Club. In his opening remarks, Thierry Verstraeten, MD, POS immediate past president, thanked the allied course directors, POS Council, and the membership for their support during his tenure. Sharon Taylor, MD, newly installed POS president, presented a plaque to Dr. Verstraeten in recognition of his two years as president of the Society.

The March annual meeting is the final meeting of the program calendar year, with the 2017-18 series to begin in September. The complete list of monthly meetings will be sent to members in July and will be posted on the society website (www.pghoph.org). Members also are encouraged to visit the site periodically for updates.

The planning meeting for the 2017-18 educational series is scheduled for May. If you know of an exceptional speaker whom you would like to see present to the POS, contact Dr. Taylor or the POS office at npopovich@acms.org or (412) 321-5030.

### 2017 Annual Meeting for Ophthalmic Personnel held

Running concurrently with the POS Annual Meeting was the 38th Annual Meeting for Ophthalmic Personnel. This year, more than 150 ophthalmic technicians, assistants, coders, photographers and front staff attended this full-day program. The well-respected program is designed specifically for ophthalmic personnel to enhance the quality, expertise and safety of ophthalmic patient care.

The program featured 28 breakout sessions, all accredited by JCAHPO. Participants had the opportunity to create their own track of programming, and receive up to 7.0 CE credit hours based on course attendance. A balance of front- and back-office sessions were offered to educate office personnel. Popular workshop sessions also were offered as part of the full day course curriculum.

Course directors Pamela Rath, MD, and Laurie Roba, MD, worked tirelessly to plan this high-level educational offering. The Society depends and relies...
Society News

Our Health Law Practice Group tackles your legal issues and concerns so you can handle the more important work...caring for your patients.

on local expertise and talent to present each session. This year was no exception, with local physicians and health care professionals providing quality presentations.

The Pittsburgh Ophthalmology Society is proud to host this yearly educational forum for ophthalmic personnel. Mark your calendar for next year’s meeting, scheduled for Friday, March 23, 2018, at the Pittsburgh Marriott City Center. If you have a topic that you believe would be beneficial for presentation at next year’s meeting, please contact Dr. Rath, Dr. Roba or Nadine Popovich at npopovich@acms.org.

Sharon Taylor, MD, newly installed POS president, presented a plaque to Dr. Verstraeten in recognition of his two years as president of the Society.
MEDICAL PROFESSIONAL LIABILITY INSURANCE
PHYSICIANS DESERVE

Offering top-tier educational resources essential to reducing risk, providing versatile coverage solutions to safeguard your practice and serving as a staunch advocate on behalf of the medical community.

Talk to an agent/broker about NORCAL Mutual today.
NORCALMUTUAL.COM | 844.4NORCAL
ANNUAL MEETING (GENERAL III) AND LUNCHEON  
TUESDAY, MAY 23, 2017  
PITTSBURGH GOLF CLUB AT SCHENLEY PARK  
5280 NORTHUMBERLAND STREET  
SCHENLEY PARK, SQUIRREL HILL  

Always energetic and imaginative event Chair Patty Barnett, along with Co-Chair Mrs. Rose Kunkel Roarty and Committee members Mrs. John Da Costa, Mrs. Eugene Delserone, Mrs. Marshall Levy, Mrs. Samuel Mines, Mrs. Lawrence Purpura, Mrs. Chandra Reshmi and Mrs. LeRoy Wible, is arranging delightful elements for an exquisite springtime gathering! Features to date include:  
• 11:00-11:30 ANNUAL (GENERAL) MEETING III: WRAP-UP REPORTS and AFFIRMATION OF LEADERSHIP 2017-18; APPOINTMENTS TO GOVERNING BOARD  
• 11:30-AM-12:30PM SOCIAL, MEET AND GREET, CASH BAR, FUNDRAISING ACTIVITIES: AUCTION, BASKET RAFFLE and 50/50 DRAWING. We welcome in-kind items for fundraising via Auction and Raffle Baskets.  
• LUNCHEON: ANNOUNCEMENTS, WELCOME NEW MEMBERS, INTRO GOV. BOARD, YEAR-END GIFTING AND CHECK PRESENTATION  

Do mark your calendar now for an outing certain to facilitate a fine time in the elegant ambiance of the club. Convenient valet parking will be available; musical entertainment is being planned. Annual Meeting and Luncheon provides a wonderful opportunity to catch up with friends and enjoy the fellowship and camaraderie among us. Invitations to ACMSA Members can be expected in mid-April. As always, ACMS family and friends are welcome to attend. Certainly, BULLETIN readers can consider this article an invitation. Proceeds benefit ACMS Foundation, in support of home and community environments which nurture and develop healthy children and families for a healthy Allegheny County!

Call Alliance at (412) 321-5030 to contribute in-kind Auction and Raffle items, for further details, or for RSVP information. Join us for a most delightful spring social afternoon, before the start of summertime scatter!

PAMED Foundation offering medical student loans  
The Foundation of the Pennsylvania Medical Society is accepting loan applications from students attending a fully accredited Pennsylvania medical school. Additionally, the student must be a Pennsylvania resident for at least 12 months prior to attending medical school and not for the sole purpose of obtaining an undergraduate degree. Below are highlights of the program:  
• No payments required during school or graduate training (i.e., internship, residency, or fellowship training).  
• Deferment up to five years for graduate training.  
• Interest rate will not exceed six percent during school or graduate training.  
• School and deferment interest rate is 91-day, T-Bill note plus a margin based upon the first academic year that loan funds were obtained.  
• First loan award obtained prior to July 1, 2013: the margin is 2.0 percent.  
• First loan award obtained on or after July 1, 2013: the margin is 3.5 percent.  
• May choose monthly installments following graduate training by signing a new promissory note for an Amortizing Loan.  
• No application or origination fees.  
• Individual loan awards up to $10,000 (minimum $6,000).  

Application submission deadlines are as follows:  
• Students attending Lake Erie College of Osteopathic Medicine, application should be sent directly to the Foundation’s office by June 1, 2017.  
• Students attending any other fully accredited Pennsylvania medical school, application must be submitted to school’s financial aid office by May 15, 2017.

To apply, download the appropriate application from the website and submit it according to the submission instructions. Call (717) 558-7852, or visit the Student Financial Services page under www.foundationpamedsoc.org for more information.
Thomas E. Starzl, MD, PhD, 90, died Saturday, March 4, 2017, in Oakland.

Dr. Starzl graduated in medicine from Northwestern University Medical School in Chicago and served a fellowship and internships in surgery and research at Johns Hopkins, the University of Miami and the Veterans Administration Research Hospital in Chicago.

Dr. Starzl performed the world’s first liver transplant in Denver in 1963 and Pittsburgh’s first liver transplant in 1981 after moving here at the end of 1980. He performed the world’s first heart-liver transplant in 1984. In 1987, he led the five-organ transplant operation on Tabatha Foster, who survived for six months.

Dr. Starzl achieved international renown and celebrity status for those high-profile transplants. As a result, the University of Pittsburgh Medical Center became the busiest transplant center in the world.

In 1989, Dr. Starzl and Dr. John Fung developed FK506 (better known as tacrolimus), still the most widely used immunosuppressant drug in the world.

Dr. Starzl retired from clinical and surgical service in 1991. Until then, he served as chief of transplantation services at Presbyterian University Hospital, now UPMC Presbyterian; Children’s Hospital of Pittsburgh, now Children’s Hospital of Pittsburgh of UPMC; and the Veterans Administration Hospital in Pittsburgh.

He was director of the University of Pittsburgh Transplantation Institute, which was renamed the Thomas E. Starzl Transplantation Institute in 1996. Since 1996, Dr. Starzl held the titles of Distinguished Service Professor of Surgery at the University of Pittsburgh and director emeritus of UPMC’s Thomas E. Starzl Transplantation Institute.

Surviving are his wife of 36 years, Joy Starzl; a son, Timothy Starzl (Bimla); a grandson, Ravi Starzl (Natalie); a sister, Marnie Starzl; and nieces and nephews. Deceased are a daughter, Rebecca Starzl, and a son, Thomas F. Starzl.

A memorial service was held Saturday, March 11, at Heinz Memorial Chapel.

***

Herbert G. Kunkel Jr., MD, 65, of Allison Park, died Saturday, March 4, 2017.

Dr. Kunkel graduated in medicine from Ross University School of Medicine and completed his internship in internal medicine and his residency in physical medicine and rehabilitation at St. Francis Medical Center in Pittsburgh.

Surviving are his fiancée, Michelle Hoak, and her children, Jaclyn (Josh) Cope and Stephen Hoak, and grandson Brian Cope; siblings Susan Borner (Tom) and Frank A., MD (Carol) and Thomas C., DMD (Valerie) Kunkel; and several nieces and nephews.

Deceased is his wife, Dianne E. Kunkel.

Services were held Tuesday, March 7, 2017, at Neely Funeral Home, Glenshaw.

***

Morton L. Goldstein, MD, 84, of Pittsburgh, died Thursday, March 9, 2017.

Dr. Goldstein specialized in gastroenterology and internal medicine.

Surviving are his wife, Sandra Lamfrom Goldstein; children Harvey Alan (Martha) Goldstein and Lynne (Ted) Rudov; a grandchild, Abraham Goldstein; and several nieces and nephews.

Deceased is a brother, Herbert (surviving spouse Sonja) Goldstein.

Services were held Sunday, March 12, 2017, in Ralph Schugar Chapel Inc., Shadyside.
Dr. Alcala specializes in family medicine, non-surgical orthopaedics, sports medicine and concussion management. He has clinical experience in performing ultrasound guided injections and diagnostics as well as stem cell procedures. He provides exceptional sports medicine care for patients aged five years and older, and comprehensive and compassionate primary medical care for patients aged 18 years and older. He is also certified to perform Department of Transportation physicals.

Dr. Alcala is the team physician for Avonworth and Moon high schools and a team physician for the Pittsburgh Pirates. He has medical staff privileges at Allegheny General Hospital and the Wexford Health + Wellness Pavilion.

Call to make an appointment or visit AHN.org.
The Allegheny County Medical Society and ACMS Foundation Celebration of Excellence Awards Gala recognized the achievements of the medical society’s 2016 award winners and raised funds for the foundation’s charitable works in the community. The event included installation of the medical society’s 2017 president, David J. Deitrick, DO.
Matthew Conti, MD, second from left, and Stephen F. Conti, MD, accepted the Physician Volunteer Award, presented by Lawrence R. John, MD, ACMS Board chair, left, and Dr. Deitrick, right.

Jose Miguel Juarez, University of Pittsburgh medical student and nominator, and Maggie Benson, MD, medical director of Birmingham Free Clinic, accepted the Benjamin Rush Community Organization Award, presented by Dr. John and Dr. Deitrick.

Eileen M. Boyle, MD, accepted the Nathaniel Bedford Primary Care Award, presented by Dr. John and Dr. Deitrick.

Joseph E. Imbriglia, MD, FACS, accepted the Ralph C. Wilde Leadership Award, presented by Dr. John and Dr. Deitrick.
Mary Carroll Grimes accepted the Benjamin Rush Individual Award, presented by Dr. Deitrick and Dr. John.

Susan M. Manzi, MD, MPH, accepted the Richard E. Deitrick Humanity in Medicine Award, presented by Dr. John and Dr. Deitrick.

John G. Krah accepted the Executive Leadership Award, presented by Dr. John and Dr. Deitrick.

Special thanks to Rick Dayton of KDKA for emceeing the Gala awards program.
Congratulations on 50 years!

Pictured, from left, are 50-year awardees Fredric W. Martin, MD; Ralph Schmeltz, MD; Fredric Jarrett, MD; Nematollah Mirzabeigi, MD; Allan J. Press, MD; Syed R. Hussaini, MD; Nezam Radfar, MD; and Richard L. Heppner, MD. Not pictured are Paul E. Antalik, MD; Volker Breitfeld, MD; Richard H. Daffner, MD; Christopher J. Daly, MD; Karl R. Fox, MD; Ryon Hurh, MD; Mohammad Idrees, MD; Edward G. Kelly, MD; Jae-Chil Kim, MD; David Y. Liang, MD; John P. Nelson, MD; Rajnikant N. Popat, MD; and Asha V. Potnis, MD.

40 Under 40 awardees

Pictured, from left, are 40 Under 40 awardees Andrew Pogozelski, MD; Nicole Vélez, MD; Keith Stowell, MD; Kristin Ondecko-Ligda, MD; Eric Griffin, DO; Jamie Probst, MD; Tamar Carmel, MD; Andrew Batchelet, MD; and Micah Jacobs, MD. Not pictured is Marc Yester, MD.
At left, ACMS Board Chair Lawrence R. John, MD, right, presents 2017 ACMS President David J. Deitrick, DO, with the president’s pin and installs Dr. Deitrick as president. At right, Dr. Deitrick presents Dr. John with a plaque for his service as ACMS president.
With Sincere Thanks ...

The ACMS Foundation would like to thank the following individuals, businesses and organizations for their generous support and contributions to the 2017 Gala auction and program:

Big Burrito Group
Dr. & Mrs. Robert and Bunny Bragdon
Dr. Marcela Böhm-Vélez
Capital Grille
Carnegie Museums of Pittsburgh
Carnegie Science Center
Caruso Hair & Esthetics
Children’s Museum of Pittsburgh
City Theatre Company
Dave & Busters
Dean of Shadyside Salon
Designs by Dr. Leslie
Fabled Table
Fairmont Pittsburgh
Dr. & Mrs. Kevin Garrett
Gateway Clipper Fleet
Dr. & Mrs. Mark Goodman
Horizon View Farms
Drs. Lawrence and Martha John
Kavic Winery
Mr. & Mrs. John Krah
Drs. Jason and Mary Parks Lamb
Mattress Factory
Dr. & Mrs. Leo and Susan McCafferty
Nemacolin Woodlands Resort
Omni William Penn Hotel
Phipps Conservatory
Pittsburgh Symphony
Pittsburgh Zoo & PPG Aquarium
Rivers Club
Saroj R. Wadhwa, MD
Sleep Center of Greater Pittsburgh
Walt Disney World

Table sponsors:
Allegheny Health Network/Highmark Blue Cross Blue Shield - Platinum Plus Sponsor
Allegheny Health Network Healthcare@Home - Silver Sponsor
Dr. Marcela Böhm-Vélez
Dr. & Mrs. David and Gretchen Deitrick
Huntington Bank - Platinum Sponsor
Dr. & Mrs. Syed and Beverly Hussaini
Dr. Joseph Imbriglia
Dr. Fred Jarrett
Drs. Lawrence and Martha John

The ACMS Foundation expresses sincere gratitude to the following sponsors of the 2017 Gala:

PLATINUM PLUS

Platinum

Allegheny Health Network
HIGHMARK
Huntington

GOLD

UPMC LIFE CHANGING MEDICINE
UPMC HEALTH PLAN

SILVER

UPMC Healthcare@Home

BRONZE

PNC BANK
TUCKER ARENSBERG ATTORNEYS

PHOTOBOOTH SPONSOR

CIRCLE OF FRIENDS
ACMS selects vendors for quality and value. Contact our Endorsed Vendors for special pricing.

### Banking, Financial and Leasing Services
**Medical Banking, Office VISA/MC Service**  
PNC Bank  
Brian Wozniak, 412.779.1692  
brian.wozniak@pnc.com

### Group Insurance Programs
**Employee Benefits, Disability, Dental & Vision**  
USI Affinity  
Bob Cagna, 412.851-5202  
bob.cagna@usiaffinity.com

### Medical and Surgical Supplies
**Allegheny Medcare**  
Michael Gomber, 412.580.7900  
michael.gomber@henryschein.com

### Life Insurance
**Malachy Whalen & Co.**  
Malachy Whalen, 412.281.4050  
mw@malachy.com

### Telecommunications and IT solutions
**connecTel, Inc.**  
Scott McKinney, 412.315.6020  
smckinney@connectelinc.com

### Printing Services and Professional Announcements
Service for New Associates, Offices and Address Changes  
**Allegheny County Medical Society**  
Susan Brown, 412.321.5030  
sbrown@acms.org

### Auto and Home Insurance
**Liberty Mutual**  
412.859.6605  
www.libertymutual.com/acms

### Professional Liability Insurance
**NORCAL Mutual**  
Laurie Bush, 800-445-1212, ext. 5558; lbush@norcal-group.com

### Member Resources
BMI Charts, Healthy Lifestyle Posters, Where-to-Turn cards  
**Allegheny County Medical Society**  
412.321.5030  
acms@acms.org

---

**What does ACMS membership do for me?**
The World Health Organization (WHO) defines dementia as a syndrome in which there is deterioration in memory, thinking, behavior and the ability to perform everyday activities. It is estimated that 47.5 million people have been diagnosed with dementia worldwide, with 7.7 million new cases diagnosed every year. The most common form of dementia is Alzheimer’s disease, which accounts for approximately 70 percent of cases. Dementia can have physical, psychological, social and economical impacts on caregivers, families and society.

There are limited options for treatment of the behavioral and psychological symptoms of dementia (BPSD). BPSD describes behavior or other symptoms in individuals with dementia that cannot be attributed to a specific medical or psychiatric cause; these symptoms may include agitation, anxiety, elation, irritability, delusions, sleep and appetite changes, or disinhibition. Frequent or severe dementia-related behavioral symptoms can be extremely distressing to the patient, family and caregivers. Behavioral, environmental and caregiver interventions are typically recommended, but lack of reimbursement and time needed for these interventions to take effect often leads to the prescription of medications. Unfortunately, there has been no FDA-approved treatment for BPSD for more than 50 years. Thus, off-label prescribing of atypical antipsychotics has been commonly employed to treat symptoms of aggression and agitation in patients with dementia.

Atypical antipsychotics

The use of the typical antipsychotics is severely limited by frequent and often intolerable adverse effects. Atypical antipsychotics were introduced into practice in 1990 with the approval of clozapine. Atypical antipsychotics have clearly demonstrated lower risk of extrapyramidal reactions and other adverse effects compared to conventional antipsychotics. Given improved tolerability, the use of this class of agents has increased worldwide in the past 30 years; it is estimated that there has been a two- to five-fold increase in atypical antipsychotic use over the past 15 years. Atypical antipsychotics became the top-selling drug class in the United States in 2008, surpassing both lipid-lowering agent and proton pump inhibitors. A summary of the currently available atypical antipsychotics is provided in Table 1 (page 150, 151).

The use of atypical antipsychotics in the elderly has likewise become increasingly popular in recent years. This increase is likely the result of attempts to increase quality of life and relieve distress of the patient or family members. Conversely, this use has been widely debated due to concerns regarding safety in elderly patients with dementia and the possible risks for stroke and sudden death. Elderly patients are at increased risk of drug-related adverse effects due to age-related changes in pharmacokinetics and pharmacodynamics, which may lead to higher or more variable drug concentrations. In addition, concurrent medical conditions, polypharmacy and potential drug interactions all play a role in this patient population’s sensitivity to medications.

Non-pharmacologic treatment of dementia

Agitation and aggression related to dementia may occur from numerous causes. It is therefore important to identify any potential contributing factors and modify these factors without the use of medication if possible. Common precipitants of agitation and aggression include pain, medical illness, loneliness, boredom, depression and social or environmental stressors. If any of these causes are identified, they should be addressed through rigorous individual and systemic efforts to eliminate or mitigate the source.

Continued on Page 151
Table 1. Comparison of the currently available atypical antipsychotics.19,20

<table>
<thead>
<tr>
<th>Agent</th>
<th>FDA Approved Indications</th>
<th>Off-Label Indications</th>
<th>Usual Geriatric Dose Range</th>
<th>Common Adverse Effects</th>
<th>Serious Adverse Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aripiprazole (Abilify®)</td>
<td>Bipolar I disorder</td>
<td>Dementia-related agitation / psychosis</td>
<td>Initial: 2.5 – 10 mg once</td>
<td>Headache, dizziness, EPS, drowsiness, sedation, insomnia, N/V, constipation</td>
<td>Altered cardiac conduction, hypersensitivity (anaphylaxis) BBW: suicidal thinking / behavior, increased mortality in elderly with dementia-related psychosis</td>
</tr>
<tr>
<td></td>
<td>MDD</td>
<td></td>
<td>Repeat dose of 2.5 – 5 mg at ≥ 2-hour intervals if needed</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Schizophrenia</td>
<td></td>
<td>Do not exceed 15 mg/day</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tourette disorder</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brexpiprazole (Rexulti®)</td>
<td>MDD</td>
<td>Dementia-related agitation / psychosis</td>
<td>Initial: titrate between 0.5 mg and 4 mg</td>
<td>Headache, drowsiness, akathesia, dyspepsia, increased appetite, nasopharyngitis</td>
<td>Hypersensitivity (anaphylaxis) BBW: suicidal thinking / behavior, increased mortality in elderly with dementia-related psychosis</td>
</tr>
<tr>
<td></td>
<td>Schizophrenia</td>
<td></td>
<td>Dementia-related psychosis / agitation = 1/3 to 1/2 the usual dose to treat psychosis in younger adults or the smallest available dosage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clozapine (Clozaril®, FazaClo®)</td>
<td>Schizophrenia / related suicidal behavior</td>
<td>Bipolar disorder</td>
<td>Initial = 12.5 – 25 mg once or twice daily</td>
<td>Tachycardia, drowsiness, sedation, weight gain, N/V, hypersalivation, headache, tremor</td>
<td>Hypersensitivity (anaphylaxis, photosensitivity, SJS) BBW: agranulocytosis, seizures, myocarditis, orthostatic hypotension, increased mortality in elderly with dementia-related psychosis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dementia-related agitation / psychosis</td>
<td>Titrate by 25 – 50 mg daily</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Schizoaffective disorder</td>
<td>Maximum dose in dementia-related</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Olanzapine (Zyprexa®)</td>
<td>Schizophrenia</td>
<td>Chemotherapy-associated N/V</td>
<td>Initial = 2.5 – 15 mg daily</td>
<td>Drowsiness, EPS, dizziness, headache, insomnia, rhinitis, cough</td>
<td>Hypersensitivity (anaphylaxis) BBW: increased mortality in elderly with dementia-related psychosis</td>
</tr>
<tr>
<td></td>
<td>Bipolar I disorder</td>
<td>Delirium</td>
<td>Maximum dose in dementia-related agitation / psychosis = 10 mg daily</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dementia-related agitation / psychosis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paliperidone (Invega®)</td>
<td>Schizophrenia</td>
<td>Dementia-related agitation / psychosis</td>
<td>Initial = 3 – 6 mg daily</td>
<td>Tachycardia, EPS, drowsiness, headache, decreased HDL cholesterol, vomiting</td>
<td>Hypersensitivity (anaphylaxis) BBW: increased mortality in elderly with dementia-related psychosis</td>
</tr>
<tr>
<td></td>
<td>Schizoaffective disorder</td>
<td></td>
<td>Dementia-related psychosis / agitation = 1/3 to 1/2 the usual dose to treat psychosis in younger adults or the smallest available dosage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quetiapine (Seroquel®)</td>
<td>Bipolar disorder</td>
<td>OCD</td>
<td>Initial = 25 – 75 mg once or twice daily in divided doses</td>
<td>Increased diastolic blood pressure, increased triglycerides, increased LDL cholesterol, drowsiness, headache, EPS, N/V</td>
<td>Hypersensitivity (anaphylaxis) BBW: suicidal thinking / behavior, increased mortality in elderly with dementia-related psychosis</td>
</tr>
<tr>
<td></td>
<td>MDD</td>
<td>PTSD</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Schizophrenia</td>
<td>GAD</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Psychosis in Parkinson disease</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dementia-related agitation / psychosis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risperidone</td>
<td>Bipolar mania</td>
<td>MDD</td>
<td>Initial = 0.5 – 3</td>
<td>Sedation,</td>
<td>Hypersensitivity</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

www.acms.org
Other individualized non-pharmacologic interventions may include exercises to improve or stabilize cognitive function, behavior modification, memory therapy and structured socialization.3 There also is evidence to support the use of exercise and recreation, aromatherapy, music and sound, and sleep hygiene techniques.7

Risk vs. benefit

When used to treat defined symptoms, antipsychotics may be more successful compared to their non-FDA approved, off-label uses. However, atypical antipsychotic medications have not been shown to improve performance status, care requirements or health-related quality of life. According to a large study published in the New England Journal of Medicine involving 22,890 first-time users of typical and atypical antipsychotics, patients who recently began taking typical antipsychotics were less likely than patients who recently began taking atypical antipsychotics to have cerebrovascular disease, dementia, delirium, psychoses, or other psychiatric disorders. However, the new patients taking typical agents had a lower number of total drugs used, including antidepressant agents and other psychotropic medications, as well as lower rates of hospitalization/skilled nursing facilities stays in the prior 6 months of this study. In the first 6 months of use overall, 17.9 percent of patients who began using typical antipsychotic medications died, compared to 14.6 percent of patients who began using atypical agents. The greatest increases in risk occurred soon after therapy was initiated and with higher doses of conventional antipsychotic medications.8

It is estimated that antipsychotics cause up to 20 percent of drug-related hospitalizations in older persons.7 Further, the use of atypical antipsychotics in elderly patients with dementia has been associated with adverse outcomes, including a small but statistically significant increased risk of death.5 Potential causes of increased mortality in this patient population include cardiovascular risk (stroke, heart failure, QTc prolongation or cerebrovascular events), hypotension leading to falls, and/or pneumonia.9

Cerebrovascular events

The first warnings about the possible increase in cerebrovascular events were seen in trials of risperidone and olanzapine in elderly patients with dementia-related psychoses. The Committee on Safety of Medicines reported a three-fold increased risk of cerebrovascular events in elderly patients with dementia who were treated with either risperidone or olanzapine in March 2004.4,10 The FDA subsequently issued an official warning in April 2005 aimed toward healthcare professionals regarding the results of 17 randomized clinical trials: Elderly patients with BPSD using atypical antipsychotics showed a 1.7-fold increase in risk of all-cause mortality.

Continued on Page 152
compared to patients not taking these medications.\textsuperscript{11}

The focus then switched to whether typical antipsychotics would be safer than atypical antipsychotics to use in elderly patients. An analysis was completed using data from an olanzapine trial; however, this trial found no notable changes in death between olanzapine and typical antipsychotics.\textsuperscript{12} Therefore, a safer option was not determined. Based on this information, the U.S. Food and Drug Administration (FDA) extended its warning to conventional antipsychotics in June 2008. However, this data is limited because it only reflects results of one medication from the atypical class compared to multiple typical agents.\textsuperscript{13}

**Cardiac events**

Adverse cardiac events, such as QTc prolongation, can lead to an increase in Torsade de pointes and sudden death in patients taking typical or atypical antipsychotics. According to a joint study between Pfizer and the FDA, QTc interval prolongation is increased from greatest amount of risk to least amount of risk in the following medications: thioridazine, ziprasidone, quetiapine, risperidone, olanzapine, and haloperidol. Thioridazine was issued a “black box” warning to strictly alert prescribers and patients of its hazardous effects after this study.\textsuperscript{14} While ziprasidone has an approval for the indications of schizophrenia and bipolar disorder, it was approved with a label that warned for adverse QTc effects.

**Risk of falls**

Falls are a leading cause of increased hospitalization, morbidity and mortality in frail, elderly patients. Studies have shown that outpatient prescriptions of antipsychotics alone in a group of hospitalized patients were three times higher regarding femur fracture compared to a group of patients with hospitalization regarding acute myocardial infarction or pneumonia. The falls leading to hospitalizations were most likely caused by extrapyramidal side effects, tardive dyskinesias and/or sedation.

While older patients have an increased sensitivity to neurological adverse effects, many are still being prescribed medications that have significant side effect profiles relating to decreased cognitive effects. A propensity-matched retrospective cohort study in older adults using antipsychotic agents concluded that all-cause hospitalization in the previous 6 months was found to be an important predictor of risk of hospitalization/ER visits for falls and fractures, and the importance of this outcome as a measure of severity of illness was thus confirmed.\textsuperscript{15}

**Pneumonia**

When the FDA publically announced the warning regarding the increased risk of mortality associated with both typical and atypical antipsychotic use in elderly patients, community-acquired pneumonia (CAP) was among the common causes of reported deaths. While the risk of pneumonia is already increased in elderly patients with neurological diseases, many studies have been conducted over time to determine if there is a connection between the use of antipsychotics and CAP in elderly patients. Studies conducted in Dutch, British and American elderly populations have shown that an increased risk of CAP is not only dose-dependent but also is noted early in treatment with antipsychotics.\textsuperscript{16,17} No current studies have shown a correlation between the risk of pneumonia with antipsychotic treatment in patients younger than 65 years old. Possible biological causes of increased mortality from pneumonia in elderly patients include antipsychotic-induced dysphagia, caused by blocking dopamine receptors, ultimately resulting in pharyngeal muscle dyskinesia, rigidity and spasm leading to aspiration in a population already at risk for such complications. Additionally, the antihistaminergic effect of antipsychotics may result in sedation, leading to a decrease of swallowing movements that could permit aspiration. Finally, the anticholinergic effect of antipsychotic drugs causing dryness in the mouth and impaired food passage could enhance the possibility of aspiration. Monitoring for pneumonia-like symptoms in patients taking high doses of antipsychotics and patients in early stages of treatment with antipsychotics is the best recommendation for clinicians involved in these situations.\textsuperscript{16}

**Application to clinical practice**

In February 2015, the Center for Medicaid & Medicare Services (CMS) added two measures of antipsychotic use to the algorithm that is used to calculate each nursing home’s Five Star Rating System on the CMS Nursing Home Compare website.\textsuperscript{2,18} CMS and other national organizations also have recently announced an updated goal to...
achieve a 30 percent reduction in the use of antipsychotics nationwide, with the first results of this initiative expected in 2017.2,18

Clinical situations do arise in which the use of atypical antipsychotics may be reasonable, either in the management of acute symptoms or in the long-term treatment of a specific disease.6 In the case of long-term treatment, the clinician’s therapeutic approach should include the specific efficacy of each antipsychotic drug in the varying diseases that occur in the elderly population.4 If the decision is made to initiate an elderly patient on an atypical antipsychotic to treat dementia, the lowest effective dosage should be prescribed for the shortest possible period.4 The risks and benefits should be carefully considered, and patients should be closely monitored during and after therapy. Finally, treatment review points and endpoints should always be identified and frequently reassessed.5

References
As even a casual observer would notice, the Trump administration has prioritized immigration issues in its first months after taking office. Many of the administration’s actions may have serious repercussions for physicians seeking to enter or remain in the United States, as well as for their potential employers and residency programs.

Although the so-called “travel ban” has drawn the greatest attention and controversy, a less-publicized action would temporarily lengthen the time for processing H-1B visa petitions, commonly used by foreign physicians seeking placement in health professional shortage areas as well as residency and fellowship matches in the United States. The H-1B is a non-immigrant visa status which allows U.S. employers to temporarily employ foreign workers in specialty occupations, including medicine.

On March 3, 2017, the United States Citizenship and Immigration Services (USCIS) announced that the use of premium processing for H-1B petitions would be suspended, effective April 3, 2017. The suspension may last “up to 6 months.” USCIS will notify the public before premium processing is resumed.

The temporary suspension applies to all H-1B petitions filed on or after April 3, 2017, which is the date FY2018 cap-subject H-1B petition filings begin. As such, the suspension applies to all petitions filed on or after April 3 for the FY2018 H-1B regular cap and master’s advanced degree cap exemption (the “master’s cap”) as well as to petitions that may be cap-exempt.

During the time that premium processing is suspended, which may last up until Oct. 3, 2017, USCIS will reject any Form I-907 Request for Premium Processing that is filed with an H-1B petition. USCIS also will reject H-1B petitions filed on or after April 3, which contain a combined filing fee check for both the Form I-907 and Form I-129 H-1B Petition.

USCIS will continue to premium process H-1B petitions properly filed before April 3, 2017; however, as usual, USCIS will refund the premium processing fee if the petitioner filed the Form I-907 for an H-1B petition before April 3, 2017, and USCIS did not take adjudicative action on the case within the 15-calendar-day processing period.

The suspension of premium processing falls directly in the sweet spot of filings for residents and fellows who seek to join training programs starting on July 1 after matching to a program.

In addition, premium processing is typically used when a J-1 Waiver sponsor seeks H-1B status for a J-1 Exchange Visitor Physician with an in-country change of status. Efforts are under way to carve out an exception to the suspension of premium processing for J-1 waivered physicians who will practice in designated shortage areas.

If that fails, while premium processing is suspended, petitioners may submit a request to expedite an H-1B petition if they meet the criteria. It is of course the petitioner’s responsibility to demonstrate that they meet at least one of the expedite criteria.

USCIS decides expedite requests on a discretionary, case-by-case basis and may expedite processing of an H-1B petition if it meets at least one of the following criteria:

- Severe financial loss to company or person;
- Emergency situation;
- Humanitarian reasons;
- Nonprofit organization whose request is in furtherance of the cultural and social interests of the United States;
- Department of Defense or national interest situation (These particular expedite requests must come from an official U.S. government entity and state that delay will be detrimental to
Responding to an Industry in Transition

Fox Rothschild’s Health Law Practice reflects an intimate knowledge of the special needs, circumstances and sensitivities of physicians in the constantly changing world of healthcare. With significant experience and a comprehensive, proactive approach to issues, we successfully meet the challenges faced by health care providers in this competitive, highly regulated environment.

After all, we’re not your ordinary health care attorneys.

the government;)

• USCIS error; or
• Compelling interest of USCIS.

New travel order

After President Trump’s Jan. 27, 2017, Executive Order restricting travel from seven countries was enjoined by the U.S. Court of Appeals for the Ninth Circuit, the president issued a new Executive Order on Monday, March 6, 2017, with an effective date of Thursday, March 16, 2017. In the new Executive Order, the president imposed a “temporary pause” (i.e., 90 days from the effective date) on entry into the United States by nationals from Iran, Libya, Somalia, Sudan, Syria and Yemen “subject to (certain) categorical exceptions and case-by-case waivers.” The travel ban applies to those who: 1) are outside the United States on the effective date, Thursday, March 16; 2) did not have a valid visa by 5 p.m. (EST) on Jan. 27, 2017; and 3) do not have a valid visa on Thursday, March 16. “Additional scrutiny” also will apply to those from Iraq.

Nationals of the six countries who are excepted from the ban include: 1) U.S. lawful permanent residents; 2) any foreign national admitted to or paroled into the United States on or after the effective date, Thursday, March 16; 3) any foreign national who has a document (other than a visa) that is valid on or issued on any date after the effective date, that permits the holder to travel to, and seek entry or admission to, the United States such as an advance parole travel document; 4) any dual national of one of the six countries when travelling on a passport issued by a non-designated country; 5) any foreign national travelling on a diplomatic-type visa, NATO visa, C-2 for UN travel, or G-1-4 visa; or 6) any foreign national who has been granted asylum, any refugee already admitted to the United States, or any individual who has been granted withholding of removal, advance parole, or protection under the Convention Against Torture.

The travel ban may have implications for residency matching programs. Continued on Page 156
Questions have been raised as to whether training programs that decline to offer positions to nationals from the listed countries could risk charges of discrimination under the Immigration Reform and Control Act.

And, as described earlier, physician shortages in rural and underserved areas may well be exacerbated by the travel ban. More than 6,000 medical trainees from foreign countries participate in medical residency programs each year through J-1 non-immigrant visas, according to the American Association of Medical Colleges (AAMC). J-1 visa holders from the listed countries who were outside the United States when the ban went into effect may be prevented from returning, and the supply of J-1 applicants may dry up due to the uncertainties created by the ban.

As this article is written, the courts have not yet ruled on the new Executive Order. Although it was crafted to remove or modify elements which led to the successful challenge of the first order, it is uncertain whether those changes will be sufficient to withstand future litigation.

You also should be aware that the March 6 Executive Order leaves open the possibility that restrictions may be placed on nationals of other countries at some point in the future. For now, we caution that even for those who are NOT nationals of the six listed countries, options that involve travelling abroad may NOT be prudent in all situations. We advise that you remain current with the news and contact immigration counsel if you plan to travel abroad and have questions.

Ms. Wadhwani is an immigration law partner with the Pittsburgh office of the national law firm Fox Rothschild LLP. She can be reached at (412) 394-5540 or cwadhwani@foxrothschild.com. Mr. Maruca is a health care partner with the Pittsburgh office of Fox Rothschild. He can be reached at (412) 394-5575 or wmaruca@foxrothschild.com.
National Healthcare Decisions Day  

In September 2014, the Institute of Medicine released the report Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life. The report confirms what health care practitioners know, that most people are unable to make their own decisions about care when they’re nearing the end of life, and recommends advance care planning as a strategy to improve care at that time.  

For 2017, National Healthcare Decisions Day (NHDD) will be a weeklong event, from April 16 to 22. NHDD exists to inspire, educate and empower the public and providers about the importance of advance care planning. NHDD is an initiative to encourage patients to express their wishes regarding health care and for providers and facilities to respect those wishes, whatever they may be. The theme for 2017 is “It Always Seems Too Early, Until It’s Too Late.” To learn more about the weeklong event, visit www.nhdd.org  

It is helpful for medical practices to make advance directives available. The Health Care Power of Attorney and Living Will form endorsed by doctors and lawyers in Pennsylvania is available free on the ACMS website at http://www.acba.org/public/livingwill.  

Medical practices can advise everyone age 18 and older to complete a Health Care Power of Attorney to name their medical decision-maker. It also is useful to convey the importance of patients having an ongoing conversation over the years with their health care decision-maker, family and health care provider about values and goals of care. Discussions with older and sicker patients are more complex. The Serious Illness Conversation Guide can facilitate such conversations between doctors and their patients and families. Patients then have an opportunity to make informed choices that reflect their values, reduce suffering, enhance family well-being and improve quality of life. These are patients who can be advised to document choices in a living will. For patients for whom you would not be surprised if they died within the year, a POLST form can be completed. For information on POLST, contact POLST Coordinator Marian Kemp at PAPOLST@verizon.net.  

Since Jan. 2, 2016, the Centers for Medicare and Medicaid Services (CMS) is reimbursing physicians for conversations with Medicare patients about advance care planning. Payment is not limited to particular physician specialties, and nurse practitioners whose scope of practice allows independent billing to Medicare also may be reimbursed for such discussions. This service is billable in both facility and non-facility settings.  

POLST training announced  

In other POLST news, the Jewish Healthcare Foundation (JHF) is presenting the "POLST: Doing It Right" Training Course at its location in downtown Pittsburgh May 17, 2017. The course offers both 8.0 CME and CEU credit hours. It is presented under the direction of Judith Black, MD, along with Denise Stahl, RN, MSN, ACHPN, and Marian Kemp, RN, POLST Coordinator.  

References  
Let us be the key to your future ...

Specializing in physician practices since 1978

KLINE KEPPEL AND KORYAK
A PROFESSIONAL CORPORATION
CERTIFIED PUBLIC ACCOUNTANTS

412-281-1901 • www.3kcpa.com

MONTAJ HONG KONG CUSTOM TAILORS

SPRING & SUMMER SALE
20%-50% OFF

3 CUSTOM MADE SUITS AND 3 SHIRTS FREE
Made with Sanwa Fabrics
$1,999

3 CUSTOM MADE SUITS AND 3 SHIRTS FREE
Made with Loro Piana Fabrics
$3,499

3 CUSTOM MADE SUITS AND 3 SHIRTS FREE
Made with Scabal and Dormeuil Fabrics
$3,999

3 CUSTOM MADE SUITS AND 3 SHIRTS FREE
Made with Ermenegildo Zegna Fabrics
$4,499

WARDROBE PACKAGE
3 Suits, 3 Sportscoats & Slacks, Tuxedo, Cashmere Topcoat, 12 Shirts
$8,999

6 SHIRT PACKAGES STARTING AT $499 + BUY 6 GET 1 FREE

SCABAL • DORMEUIL • LORO PIANA • ERMENEGILDO ZEGNA
201 Penn Center. Blvd. Monroeville, PA
412-824-9565

Especially for Athletic Builds

What patients don’t see can make all the difference.

This is the lab of Liza Villanueva, MD, the physician and researcher at UPMC Heart and Vascular Institute whose research is leading to new ways to detect and treat heart disease in its earliest stages. Trust your heart to the experts who are setting new standards, not just following them. Visit UPMC.com/heart.

Moving?

Be sure to let us know ....

We can update our system to better serve you! When your patients call, we will know where to send them.

Call (412) 321-5030 to update your information.
Flat Rate Per Box
Local and Family Owned
Flexible Service Options

WHY PAY MORE?
Call Us Today for a NO OBLIGATION Quote!
1-877-861-8970


ONE YEAR CONTRACT
FIRST PICKUP FREE!
When signing up for monthly services.

Flat Rate Per Box
Local and Family Owned
Flexible Service Options

Medical Waste
Pharmaceutical Waste
Secured Document Shredding
and More...

Insurance for the “Not So Perfect Risk”

If you have health issues or even if you’ve been declined for insurance, we may be of help.

www.malachy.com/notperfect