Update from the PAMED Board of Directors

Ransomware: Resources for the smaller practice
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.
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Ransomware: Resources for the smaller practice
Beth Anne Jackson, Esq.

**Practice Management**

Is your team drama from overstaffing?
Joe Mull, MEd

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Jennifer Elliott, PharmD
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Dr. Starz specializes in rheumatology and internal medicine.
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Leadership and Advocacy for Patients and Physicians

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Leadership and Advocacy for Patients and Physicians
Keeping up with MACRA and other important updates affecting your practice is no easy task. It seems like things are constantly changing, and physician practices say they don’t have time to keep up with it all.

Don’t miss the Pennsylvania Medical Society’s (PAMED) popular practice administrator meetings this fall for the expert advice and help you need.

Topics to be discussed:

• Recent Pa. Supreme Court ruling changes to informed consent
• 2018 proposed Medicare Physician Fee Schedule
• Medicaid updates
• What’s in store for MACRA Year 2
...and more legislative, regulatory, and payer updates!

Is it worth my time to attend? YES!
Some of the things past attendees say about these meetings:

• Invaluable
• Relevant to my job
• Always walk away with important updates

2017 Fall Meeting Schedule

Pittsburgh—Sept. 13
Allegheny County Medical Society
713 Ridge Avenue
Pittsburgh, PA 15212
1-3 p.m. (Registration and lunch at Noon)
Thank you to USI Affinity for supporting the program.

Warrington—Sept. 19
Doylestown Health and Wellness Center
847 Easton Road, Route 611
Warrington, PA 18976
9-11 a.m. (Registration and breakfast at 8:30 a.m.)

Harrisburg—Sept. 27
PAMED* 
Penn Grant Centre
777 East Park Dr.
Harrisburg, PA 17111
8:30-11 a.m. (Registration and breakfast at 7:45 a.m.)

Register online at www.pamedsoc.org/ManagerMeeting

* Live webcast is also available; call-in information will be provided prior to the meeting.
August is upon us already. As you get ready to buckle down for school, fall weather and a different mindset, take some time to enjoy the culinary scene in Pittsburgh. Surprise! Our fair city is now a food mecca, and there are more restaurants opening than anyone can keep up with easily. Take a loved one or friend out to a lovely meal and go exploring – it’s the small joys in life that add up and mildly decadent little pleasures that can get you through a tough week.

First of all, get ready for Restaurant Week Monday, Aug. 14, through Sunday, Aug. 20. Twenty-one excellent restaurants will be offering prix-fixe multicourse meals for $20.17 or $35.17 per person in an effort to showcase their talents and entice you back in the fall. For full details including participating establishments and menus, visit http://pittsburghrestaurantweek.com/restaurants/summer-2017-restaurants/.

Ever wish you had a healthy fast food option? CoreLife Eatery on 8009 McKnight Road in Ross Township (in the same plaza as Nordstrom Rack) offers grain, broth and green bowl options which do not contain artificial additives of any kind, sweeteners, or trans fats. Most are well under 600 calories, and filling. No word on sodium content, but chances are that skipping the dressing will help with that.

Check out the on-national-trend Pittsburgh Poke on 500 Liberty Avenue off Market Square. Poke is a fresh Hawaiian fish salad preparation similar to Seviche; it is one of the many protein options (most are cooked) available in bowls and burritos. Each has a base of grains or greens, nine protein options, seven sauce options, and a plethora of mix-ins and toppings.

Feeling more decadent? Try Bakn (335 E Main St., Carnegie). It’s a restaurant featuring all things bacon, from breakfast to starters to mains to desserts (but with plenty of other options as well).

Kevin Sousa’s new jewel Superior Motors has opened in Braddock (1215 Braddock Avenue), serving acclaimed fine cuisine in the setting of an old car dealership. The reviews are in, and the food is spectacular – and well worth the trip to Braddock. Sousa’s project deliberately dovetails into the revitalization of Braddock.

The Twisted Frenchman is moving to 5925 Baum Boulevard from its current East Liberty location. The expansion will yield a downstairs casual bistro-style Bar Frenchman, and the upstairs will be a larger version of the original haute cuisine restaurant, complete with kitchen designed and outfitted by the same company that handled The French Laundry’s kitchen.

Out in the North Hills? The Breakneck Tavern, at the junction of 228 and Mars-Valencia Road, is a gorgeous find in an unlikely location in Mars. Formerly an industrial factory turned dive bar, the new owners have found a renowned chef to produce a delicious American menu that rivals downtown Pittsburgh restaurants but stays satisfying and fulfilling. Brunch is excellent, as are the burgers, the crab cakes, fried green tomatoes and the brilliant desserts. The unexpected piece de resistance would be the housemade pickles, which are the best I’ve ever tried.

Avor Thai in Cranberry is tucked in a tiny strip mall (900 Commonwealth Drive), but this new Thai restaurant offers a delicious menu of classics which is slowly expanding. The restaurant is spacious and soothingly decorated, and the service is unfailingly gracious.

Take time to enjoy Pittsburgh’s food scene, share it with someone you enjoy, and feed your body and soul.
and perfect. Takeout and delivery also are available.

Lastly, do check out the food blog www.goodfood-pittsburgh.com, which gives daily and weekly updates concerning upcoming local food and beverage festivals, farm-to-table and other special dinners, and new restaurants.

What a wonderful surprise to suddenly be living in a culinary wonderland. Take time to enjoy Pittsburgh’s food scene, share it with someone you enjoy, and feed your body and soul.

*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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**Don’t forget to submit your photos for the 2017 Bulletin Photo Contest!**

The deadline for submitting photos is **Friday, September 1, 2017.**

All photos should be vertical with a resolution of at least **300 dpi** and should be emailed to **bulletin-contest@acms.org.**

For more information, email Bulletin Managing Editor Meagan Sable at msable@acms.org.
As a physician, there is an intrinsic desire to make things better. Initially, improvements involve work, technology and productivity. As we age, we generate more connections throughout our Pittsburgh community. Pittsburgh is a unique small city because it has experienced tremendous periods of growth punctuated by periods of decline. Pittsburgh knows how to help its neighbors but maintains its individuality. The goal of the Pennsylvania Medical Society (PAMED) and the Allegheny County Medical Society (ACMS) is to help each physician have his or her voice heard in Harrisburg and Washington, D.C. I would like to outline some of the activities that the state and county societies have collaborated on in the past few months.

State Rep. Mark Mustio met with the PAMED Board of Directors, and earlier this year ACMS, to discuss legislation co-sponsored by Sen. Guy Reschenthaler to allow nurse practitioners full independent practice. Currently, 21 states allow this to varying degrees. PAMED endorses a continued collaborative agreement to assure access to physicians. Numerous practitioners in our area rely and respect the counsel of the nurse practitioner; we want to work together and assist in improving arrangements that are mutually beneficial. This emphasizes a “team” approach and a continuum of care.

The American Board of Internal Medicine, ABIM, received a vote of no confidence at the last American Medical Association (AMA) meeting with presentations by past PAMED President Scott Shapiro, MD, and current PAMED President Charles Cutler, MD. Both have requested that all specialty societies sign on to this; however, some societies have reported that they are content with their board recertification process and are unsure about their jurisdiction in the process involving other unrelated medical societies. Oklahoma has delinked Maintenance of Certification (MOC) from licensure. James Goodyear, MD, head of the PAMED Delegation, said there was little interest on the legislative level. Furthermore, he stated that grassroots advocacy on behalf of internists is needed and development/endorsement of other credentialing bodies may be needed if the current MOC process for internists cannot be improved.

In the specialty leadership portion of the meeting, balanced billing for ER doctors/hospital-based groups was discussed. This has become more problematic with narrow networks and tiered payment products. PAMED has initiated discussions with the insurance commissioner, and on the national level, Sen. Lindsey Graham has introduced The Patient Freedom Act.

The specialty society dermatology representative gave an update on the FDA requirements for sterile compounding. Staff expects a two-year time frame for implementing these new changes.

The representative for the Pennsylvania chapter of the American Congress of Obstetricians and Gynecologists discussed the changes that may ensue with the repeal of the Affordable Care Act (ACA). Moreover, funding for the state Children’s Health Insurance Program (CHIP) was placed in question. Psychologist and Congressman Tim Murphy met with ACMS members concerning his thoughts on the ACA and discussed how the legislation would be treated as line items.

Angela Botaeng, PAMED legal counsel, and Michael Siget discussed the initial proposed regulations concerning the implementation of marijuana for medical use. PAMED responded in the comment period and will provide information as it becomes available. Plans include a CME course that will aid physicians who are interested in prescribing marijuana.

Additional legislation has been introduced involving opioid prescribing.
PAMED has worked to avoid additional CME requirements as a mandate. Some states have moved solely to electronic prescribing for controlled medication. There is particular interest in making opioid prescriptions e-prescriptions only. Currently, insurance has variable coverage for addiction services and rehabilitation success has been limited. The cost of Narcan has sharply increased and while the number of prescribed narcotics has declined, the number of overdoses has not. Allegheny County Health Department Director Karen Hacker, MD, and her staff gave an excellent presentation to ACMS to discuss the need for additional rehabilitation facilities but expressed frustration with limited insurance payments for these services. A bed registry for addiction services has been proposed. Moreover, when the Pennsylvania attorney general was at the last board meeting, the topic of Narcan distribution and new state expenditures for Narcan were discussed. Drug take-back boxes are available in some areas, but disposal and security have been prime concerns.

The Right to Try legislation, which may be introduced, was discussed. These devices or medicines often are in phase 1 trials. Different types of practitioners who will not be recording data or outcomes may be deemed prescribers, which would allow expanded access for investigational drugs. There is no language discussing patient protections, care for side effects or supportive care.

Pharmacies have expressed an interest in providing childhood immunizations. Currently, many pharmacies provide flu shots and shingles vaccinations, but the American Society of Pediatrics has voiced concern about documentation and record keeping of these vaccinations. Bob Cicco, MD, vice president of ACMS, again reminded the ACMS board that immunization rates have declined in the United States and that here in Pittsburgh, we have had outbreaks of measles and illnesses that could be avoided by simple vaccination in a timely manner. A recent article in the Pittsburgh Post-Gazette lamented that Dr. Jonas Salk, a University of Pittsburgh physician, would be astounded by this new trend after years of hard work and research.

The Pennsylvania Orthopedic Society has been instrumental in bringing attention to the problem of retrospective denials. Legislation that would limit the practice to 24 months is in the legislature now.

The Quinn Bill on test results, which would require radiologists to provide direct patient results, seems to have little support.

This year, a bill reintroduced a national Workers Compensation Fee Schedule. Many companies worry that this may spill over into a national fee schedule for medical services. Currently, the country is divided into regions. Pittsburgh falls into the region with the lowest reimbursement for federally funded insurance.

On June 28, the U.S. House of Representatives passed a bill placing caps on no economic damages similar to legislation in California. The American Association for Justice, a lobbying firm for plaintiffs’ attorneys, sent a letter to the House prior to the bill passing that urged legislators to oppose the bill. More than 75 organizations signed the letter. “Even if HR 1215 applied only to doctors and hospitals, recent studies clearly establish that its provisions would lead to more deaths and injuries and increased health care costs due to a broad relaxation of care,” the letter stated. “The latest statistics show that medical errors, most of which are preventable, are the third leading cause of death in America. This intolerable situation is perhaps all the more shocking because we already know how to fix much of this problem. Congress should focus on improving patient safety and reducing deaths and injuries, not insulating negligent providers from accountability, harming patients and saddling taxpayers with the costs.” The legislation would apply to any patient who receives medical care provided via a federal program, even plans purchased under the ACA or employers’ plans that allow for federal subsidies. As part of HR 1215, courts would limit how much attorneys receive from a patient’s ultimate award. This is the first such legislation to be passed in five years.

Topics including telemedicine, POLST and credentialing will be introduced in the state legislature. In October, the Pennsylvania House of Delegates advocated a moratorium on fracking in the state of Pennsylvania, similar to those in Maryland and New York. There is no legislative appetite for this at this time, and the governor has not made any comments on the topic.

Jaan Siderov, MD, gave an update on the Practice Options Initiative to the PAMED Board and also recently gave a presentation to the ACMS. The mission triangle includes membership, revenue and independence to preserve physician autonomy, patient-centered, physician led. There has been a strong

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interest in assistance to meet MACRA/MIPS requirements (webinar available at the PAMED website). Once the final rules are announced, data may be collected beginning in January 2018 and if submitted correctly, practitioners may avoid a 4 percent Medicare cut. Keep in mind that doctors with low overall Medicare payments will be exempt from this penalty. The submissions are due March 31, 2018, for the performance data. The Centrally Integrated Network has contracted with Mingle analysis as a turn-key product directed by a physician. A June 18 webinar is archived for viewing. In the past, this company had a 98 percent success rate with the Payment Quality Reporting System (PQRS) and the registry is adaptable, Qualified Clinical Data Registry (QCDR) certified, and may be used in offices with EMR. Currently, PAMED members receive a discount resulting in payment of the administrative fee only. Forty-two percent of all Pennsylvania physicians are independent and are concentrated in Berks, Dauphin, Lancaster, Lehigh and York counties, according to Pennsylvania Department of Health data.

In June 2017, Pennsylvania Supreme Court Justice Wecht delivered the majority court decision concerning Shinal v. Toms involving informed consent. The majority of the Supreme Court (Wecht, Dougherty, Todd and Donohoe) felt that a physician may not delegate his obligation to provide sufficient information in order to obtain informed consent. The majority opined that “informed consent requires back and forth face to face exchange which might include questions that the patient feels the physician must answer personally before the patient feels informed and becomes willing to consent.” The preceding case, Valles v. Albert Einstein, was used to illustrate that the hospital is not liable but the physician is for informed consent. This case specifically addressed information that physician extenders give to patients in a neurosurgical case with an unexpected outcome. In malpractice cases, this often is a fall-back plan; if the plaintiff attorney cannot prove negligence, then the attorney will attempt to prove that the plaintiff would have made different decisions if they had known all of the risks. Justice Baer provided the dissenting view: “A physician cannot assign duty to obtain a patient’s informed consent to a member of his staff or anyone else and thus avoid liability … however, this does not mean that a physician is barred from using qualified staff members fulfilling the physician informed consent.” If you have concerns that were addressed in this article, please contact me at apare@acms.org. As your Board representative, I want your voice to be heard. Change takes time, but we want to build consensus with our patients, other medical practitioners and insurance carriers to help shape healthy, productive members of society. We may have different specialties, but our goals are the same: We want to make things better.

Many months ago, my dog, Scooter, graced the pages of this magazine and he has since passed away. My husband asked me why I missed him so much. I replied, “Scooter was a good listener; he did not always have the right answer, but I felt that he listened.” I have tried to learn from my dog to be a good listener; I want to help. Join me and the Allegheny County Medical Society to help make our medical community better and stronger.

Dr. Paré is a plastic surgeon and associate editor of the ACMS Bulletin. She can be reached at apare@acms.org.
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Type II diabetes and the dietary conundrum

WILLIAM SIMMONS, MD

For many, the onset of Type II diabetes is so gradual over many years that it is looked upon as a benign disease. However, by the time you start experiencing the classic symptoms of constant hunger, fatigue, dry mouth, blurry vision, frequent urination, etc., and if you happen to be older, overweight, physically inactive and on a fast food/highly processed food diet, diabetes' devastating affect on organs such as the kidneys, eyes, heart, nervous system, foot and dentition have already been years in the making. When someone underrepresents the potential dangers by giving it a diagnosis like “pre-diabetes,” one may think it’s just a warning shot over the bow; in reality, pre-diabetes puts one on a trajectory that will shorten their lifespan by years. Pre-diabetes signals that continuing on this path could result in progressive renal failure, eventually dialysis, vascular disease, blindness and frequent, long hospital stays with surgeons cutting away at the consequences of diabetes with heart surgery, vascular surgery and amputations.

The death rate from Type II diabetes is devastatingly high among specific ethnic groups but goes frequently unreported because a lot of doctors don’t put diabetes on the death certificate. They say kidney disease or heart disease or vascular collapse, and the ultimate cause, diabetes, goes under the radar.

Death from Type II diabetes is at absolute epidemic proportions, striking people of color, Native Americans, African Americans and Latinos in a disproportionately high fashion. After stating all of that, how can I tell a patient that it didn't have to happen?

According to the National Institute of Diabetes and Digestive and Kidney Diseases in a February 2017 “Type II Diabetes Statistics and Facts” report, the devastating effects of Type II diabetes, in the vast majority of cases, is preventable. Weight loss and increased physical activity can reduce the chance of pre-diabetes turning into Type II diabetes by 58 percent, and 71 percent in people over 60 years old. Glycosylated Hemoglobin (A1C) helps define diabetes. Type II diabetes is an A1C of 6.5 percent or higher; pre-diabetes is an A1C between 5.7 percent and 6.4 percent; and normal is an A1C of less than 5.7 percent. The good news is, according to the Institute of Diabetes and Digestive Disease, for overweight people with pre-diabetes, losing 5 to 7 percent of body weight through exercise and healthy eating could prevent the onset of Type II diabetes completely. Seconding this report, the American Academy of Family Physicians states that obesity is the single greatest risk factor for Type II diabetes.

The Centers for Disease Control and Prevention (CDC) says that Type II diabetes accounts for about 90 to 95 percent of all diagnosed cases of diabetes in adults. They go on to say that 29.1 million people in the United States have diabetes, of which 8.1 million may be undiagnosed, unaware of their condition. The World Health Organization (WHO) states 400 million people live with Type II diabetes worldwide; however, in developing nations, more than half of the diabetic cases go undiagnosed. In the United States, we diagnose 1.4 million new cases of diabetes every year. Compared to the total population, more than one in 10 adults over the age of 20 have diabetes in the United States, and for adults over 65, in the United States, it is one in four. According to the CDC, diabetes is the 7th leading cause of death in the United States.

Type II diabetes used to be called “adult onset” because until 10 years ago, Type II diabetes affected less than 3 percent of adolescents. Now, it comprises 45 percent of all cases of diabetes in adolescents. Type II diabetes is even more common in non-Caucasian pediatric populations like Native Americans, African Americans, Asian/Pacific Islanders and Hispanics. The symptoms of excessive fatigue, excessive
thirst, frequent urination and increased hunger are not easy to spot in kids, but there should be heightened concerns if the child is obese. In the past 30 years, the CDC states that obesity in children has doubled and obesity in adolescents has quadrupled.

Now for the conundrums. The USDA Food Pyramid, now replaced by MyPlate, and food pyramids from around the globe (China’s Food Pagoda to Greece’s Food Pyramid) have a consistent pattern of cereals, grains, breads, pasta and other starchy carbohydrates as the base of the diet, recommending six to 11 servings a day and fats near the top of the pyramid in the “use sparingly” category. What is confusing is that dietary fats from healthy sources have been shown to actually increase weight loss, reduce heart risk, lower blood sugars, lower cholesterol and maintain proper brain function. Yet those same studies tell about carbohydrates causing serious issues from weight gain to fuzzy thinking to heart disease. Furthermore, the “high carb, low fat” mantra doesn’t address the issue of “good carbs” (whole grains) vs. “bad carbs” (highly processed carbs and sugary drinks); “good fats” (polyunsaturated fats: liquid vegetable oil, nuts, and seeds) vs. “bad fats” (trans fats: margarine, packaged baked goods, fried foods in most fast food restaurants and anything made in partially hydrogenated vegetable oil); and “good protein” vs. “bad protein” (processed meats). It also is amazing that the highly subsidized industries (dairy, corn and wheat) are heavily featured on the pyramids.

Another conundrum is high-fructose corn syrup (HFCS), which is a politically strong, highly protected sweetener squarely in the middle of the corn subsidy issue that has made its way into almost every processed food and sugar-sweetened drink in large quantities. I normally don’t read the Huffington Post; however, a Jan. 23, 2014, article by Mark Hyman, MD, founder of UltraWellness Center, states that the average adult consumes more than 20 teaspoons of HFCS per day, which is approximately 150 pounds a year. The average child consumes 34 teaspoons a day. To put this in perspective, the average 20-ounce soda contains 15 teaspoons of sugar and all of it is HFCS. From his research, he claims that the glucose and fructose which are bound together during the chemical process making HFCS become separated in our bodies and the fructose is postulated to have a direct effect on the liver, turning on fat production. Controversy exists about the manufacturing techniques and metabolism of HFCS. But in the midst of the argument, I did find evidence that too much added sugar of any kind can contribute unwanted calories that are linked to health problems, such as weight gain, metabolic syndromes, high triglyceride levels and Type II diabetes, and all of these increase the risk of heart disease. The American Heart Association recommends that most women should get no more than 100 calories a day of added sugar (about 6 teaspoons) and that most men get no more than 150 calories a day of added sugar (9 teaspoons). The heavily processed and fast food that we are accustomed to eating go way beyond those levels.

There are some lessons we can learn from the aboriginal Vedda people of the jungles of Sri Lanka (India) and the Marshallese people of the South Pacific Marshall Islands regarding the evolution of diabetes. In both groups, diabetes or obesity were virtually unheard of. As their hunting lands were encroached upon and government handout of the westernized diet became the norm, these people who lived off the land eating seafood, wild life and edible plants started eating Spam, canned corned beef, soda, ramen noodles, Kool-Aid powder and sugary cereals. The Vedda people could still hunt, so their incidence of diabetes rose but not so much. On the other hand, the new diet became the sole diet for the Marshall Islanders. Their rate of Type II diabetes became 28 percent in the Marshallese people, which is among the highest in the world. More than 75 percent of the women and 50 percent of the men became overweight.

In 2005, Canvasback Missions, Inc., a nonprofit Christian organization that specializes in medical missions, in partnership with the Marshall Island Ministry of Health and Loma Linda University, started a Diabetes Wellness Program and lifestyle intervention for the entire island. They used diet and exercise to overcome insulin resistance and restore insulin sensitivity. They went with a 100 percent plant- and seafood-based diet, minimal refined carbohydrates, high fiber, moderate amounts of good fats (no trans fats), high antioxidants and a low glycemic load. Over the two-year program, a huge number of participants transformed their lives and health, lost significant weight, became highly active again and some were declared diabetes free and others at least didn’t require significant medications anymore.

Continued on Page 286
African Americans are dying in large numbers from the consequence of Type II diabetes because of the kind and quality of food that they had to eat. My father, aunt and a cousin suffered from the consequences of poorly controlled Type II diabetes. Two had to have lower extremity amputations, one suffered blindness and all died from the complications of Type II diabetes, but diabetes was never mentioned on their death certificates.

What I have learned in my investigations of this topic is that the treatment of Type II diabetes doesn’t fall on the doctors. Patients should see their doctors only as a periodic coach/consultant. Instead, the real responsibility lays squarely on the shoulders of an educated patient and his family. Patients should spend more time with nurse diabetes educators and dieticians who are willing to think outside of the USDA Food Pyramid box and truly learn the life-saving value of a low-glycemic, low-carbohydrate, high fiber and good (no processed/fast food) protein diet and exercise to avoid the horrific consequences of poorly controlled Type II diabetes in its latter stages.

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

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

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Managing Editor
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Frustrated With Insurance Delays Standing Between You and Your Health?

Was your physician-approved treatment plan/medication delayed by an insurance company’s prior authorization process? This outdated process jeopardizes medical practices’ ability to provide you with timely care.

You can help reform this process by supporting current state legislation.

Visit [www.pamedsoc.org/ShareYourStory](http://www.pamedsoc.org/ShareYourStory) or call the Pennsylvania Medical Society at (855) 726-3348 to share your story and communicate with your local legislators.

The Pennsylvania Medical Society supports legislation that reforms prior authorization in Pennsylvania, and needs your help to identify patients who have experienced prior authorization delays.

- Please share the information below with your patients.
- Visit [www.pamedsoc.org/PriorAuth](http://www.pamedsoc.org/PriorAuth) to learn about the legislation and how physicians can contribute.

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Visit [www.pamedsoc.org/ShareYourStory](http://www.pamedsoc.org/ShareYourStory) or call the Pennsylvania Medical Society at (855) 726-3348 to share your story and communicate with your local legislators.

The project is supported by the Pennsylvania Medical Society and our physician-led medical specialty partners.

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Ah, the “R’s” have it. Not the “arrrgh” attributed to pirates (derived from gravelly voiced British actor Robert Newton, famous for playing Long John Silver in movies and on television, who often exclaimed, “Har har, me lads …”). I mean a group of other “R” words – recovery, reuse, repurpose, recycle, restore, recondition, rebuild and repair. More on that later.

Retirees (another “R” word) often fill their time volunteering their services for a large variety of charitable organizations. Two years ago, while working on a carpentry project at the food pantry at South Hills Interfaith Movement (SHIM), I met my now-retired ophthalmologist, Dr. Irving Weinberger. He and his wife, Joan, had been volunteering at the SHIM food pantry. Irv told me that he and Joan also had been working every other week at Global Links, where they, along with another couple, had been packing surplus medical supplies for shipment to Central and South America. He found the work interesting and suggested that I could use my skills with tools to repair and recondition wheelchairs. I have been volunteering at Global Links ever since.

Global Links is a nonprofit organization that was founded in 1989 with three primary goals: the recovery of medical surplus from local hospitals; the establishment of long-term programs in the Caribbean and Latin American countries to improve and to have a sustained impact on health care; and the reliance on volunteers for most of the labor-intensive sorting, preparation and packing of the recovered materials. For nearly 30 years, Global Links has developed a productive partnership with the Pan American Health Organization/World Health Organization (PAHO/WHO) as well as with in-country ministries of health and the medical and administrative leaders of existing public health systems in their target regions.

In addition, Global Links has a worldwide impact through their Suture Donation and Medical Service Trip programs. Global Links collects surplus sterile sutures, not only from the Pittsburgh region, but also from hospitals across the United States. These vitally needed sutures are redistributed to resource-poor hospitals around the world. The medical service trips allow health care professionals from Western Pennsylvania to improve health conditions in communities throughout the world.

More recently, Global Links has started Community Partners, a branch that partners with local safety net organizations such as free clinics, human services charities, women’s shelters, crisis nurseries and maternity care homes. Community Partners provides basic first-aid and hygiene supplies for the homeless as well as mobility devices (canes, crutches, wheelchairs) for Western Pennsylvania residents. The majority of the donations come from the two large hospital systems in the Pittsburgh region, Allegheny Health Network and UPMC. Other, smaller independent facilities also donate their surplus. In addition, individuals are encouraged to donate surplus mobility devices (wheelchairs, walkers, crutches, canes). There are two drop-off points – the main Global Links facility on Trumbull Drive, Greentree, and at Construction Junction in the East End.

In 2013, Global Links moved to their present location in Greentree and consolidated its warehouse and administrative and volunteer operations in one site. The present building is 40,000 square feet and houses approximately 5,000 boxes on the shelves as well as another 3,000 furnishing items – hospital beds, tables, chairs, examining tables, IV poles. In addition, there are several thousand pieces of durable medical equipment – canes, walkers, crutches and wheelchairs. Global Links has, in addition, an active recycling program for paper, cardboard and “grayboard,” glass and plastic.

Donated supplies, many of which are in original manufacturers’ cartons, are carefully sorted and then packed...
after being entered into the inventory. When Global Links receives an order, they can quickly obtain the items using their computerized inventory system.

I am one of a group of about six “wheelchair wranglers” who work mostly solo in our wheelchair workshop that is separate from the main machine shop. Volunteers in our wheelchair facility should have basic mechanical skills and should be familiar with bicycle maintenance/repair. Our job is to select chairs, do a thorough inspection of all parts, make sure that wheels turn, that brakes hold and that all parts are present. Most of the wheelchairs that are donated to Global Links are well-used. Many have IV pole/oxygen tank holders attached (to prevent theft from the hospitals) that have to be removed. Many chairs are missing parts, which we endeavor to replace from our supply of spare parts either cannibalized from chairs deemed unusable or donated from local hospitals. In addition, we have a small supply of new parts, such as wheels and seats. My colleagues and I have found that the hardest part of our job is finding compatible parts for those chairs that are missing theirs. It is not unusual for us to adjust the brakes, straighten leg rests, patch small tears in arm and leg rests, seats and seat backs or replace them if the tears are too large. Every attempt is made to pay attention to cosmetics, that is, to assure that the colors of the seats, leg pads and arm rests match. Any labels, including painted ones on the seat backs, are removed or painted over. Thus, we recondition, restore and repair the chairs. Once all repairs are made, each chair is given a thorough cleaning and then tied up for shipping. On average, it takes about four hours to recondition one wheelchair from start to finish.

There are, inevitably, a small number of chairs that are deemed unsuitable for repair. These are carefully disassembled and stripped for parts. Anything we remove that cannot be reused is recycled.

Our rebuilt wheelchairs do not stay at Global Links for long. In recent weeks, there have been shipments of 10 chairs each to Bolivia and Honduras. I am sure that the people in these medically indigent areas are grateful for the caring volunteers and staff at Global Links. I am proud to be part of the team helping people in medically indigent areas. Individuals interested in volunteering their services at Global Links may contact Stacy Bodow, community engagement manager, at (412) 361-3424.

Dr. Daffner is a retired radiologist who practiced at Allegheny General Hospital for more than 30 years. He is emeritus clinical professor of radiology at Temple University School of Medicine and is the author of nine textbooks. He can be reached at bulletin@acms.org.
PHP medical director presents program on physician burnout

At the July 11 ACMS Board of Directors meeting, Jon Shapiro, MD, medical director of the Pennsylvania Physicians Health Program (PHP), presented via Skype “Addressing Physician Burnout and Stress.”

The purpose of the program was to allow participants to “identify and implement practical approaches and utilize available resources to effectively recognize and address concerns related to physician impairment, specifically burnout and stress, in the workplace.”

The full PowerPoint presentation can be found at www.acms.org/office-resources/addressing-physician-burnout/.

ACMS parking pass information available

To purchase an ACMS lot parking pass for Steelers or Pittsburgh Panthers football games, please visit https://www.acms.org/parking-for-steelers-and-pitt-football/.

• Parking permits are presold on a “first come” basis.

• Parking availability for games is guaranteed for permit holders.

• Passes will be mailed to you at your designated address.

• Parking passes are non-refundable.

• Keep your passes safe; no duplicates will be issued.

• Parking will be supervised by a commercial operator, and passes will be collected at each game.

Pittsburgh Ophthalmology Society meeting scheduled

The Pittsburgh Ophthalmology Society (POS), under the leadership of President Sharon Taylor, MD, starts the monthly meeting series Sept. 14 by welcoming John C. Hart Jr., MD, FACS, as guest speaker.

Dr. Hart is professor of ophthalmology at Oakland University/William Beaumont Hospital School of Medicine and co-chief of Anterior Segment Surgery in the Department of Ophthalmology, William Beaumont Hospital, Royal Oak, Mich. Dr. Hart was invited by POS member Ian Conner, MD, PhD.

Dr. Hart received his medical degree with distinction in biomedical research from Wayne State University School of Medicine, before completing transitional and ophthalmology residency training at William Beaumont Eye Institute, where he served as chief resident during his final year. As an active member of the medical community, Dr. Hart is a member of several professional organizations. Throughout his practice experience, Dr. Hart’s work has appeared in numerous publications, award-winning presentations and abstract papers.

Meeting registration begins at 4 p.m., with the first lecture at 4:30 p.m. Kenneth Taubenslag, MD, resident at UPMC Eye Center, will present a case.
after the first lecture. Dr. Hart’s second lecture is scheduled for 7 p.m. Dr. Hart will present: “Conquering the Complex Cataract” and “Malpositioned IOLs – Diagnosis and Management.” Vendors who participated in the 2017 annual meeting are invited to attend the social, which takes place in between the first and second lectures.

Please note registration is required for each meeting and is handled online at www.pghoph.org. Registration questions may be directed to Nadine Popovich at npopovich@acms.org or (412) 321-5030.

POS announces speaker for October meeting

The Society will welcome Sanjay Asrani, MD, as guest speaker for the Oct. 5 meeting. Dr. Asrani is professor of ophthalmology at Duke University and director of the Duke Eye Center of Cary and the Duke Glaucoma OCT Reading Center. He actively pursues research on pressure fluctuations, new devices and drugs for glaucoma treatment, drug delivery and new imaging modalities for glaucoma.

Dr. Asrani will present “Intermittent Angle Closure: The Missed Epidemic” (first lecture) and “Pearls and Pitfalls of OCT in Glaucoma” (second lecture). Anagha Medsinge, MD, resident at UPMC Eye Center, will present a case after the first lecture.

PAMED Foundation offers medical student scholarships

The Foundation of the Pennsylvania Medical Society offers several scholarships available to Pennsylvania residents enrolled in fully accredited medical schools.

“We recognize that medical students play a vital role in the future of medicine in Pennsylvania so we proudly administer scholarships to deserving students across the commonwealth,” said Executive Director Heather Wilson. Additional scholarships are offered throughout the year and information can be found on the Foundation’s website at www.foundationpamedsoc.org.

Allegheny County Medical Society Medical Student Scholarship

Allegheny County Medical Society (ACMS) Foundation, in conjunction with the Foundation of the Pennsylvania Medical Society, is offering a $4,000 scholarship to third- or fourth-year Pennsylvania medical students from Allegheny County. Applicants must be U.S. citizens enrolled full time in an accredited Pennsylvania medical school.

The Foundation of the Pennsylvania Medical Society administers the fund for the ACMS Foundation, which encourages physicians to contribute to the scholarship to help area students offset the cost of medical education. In 2004, ACMS Foundation established the scholarship and distributed its first award in 2007.

Applications are accepted through Sept. 30.

Scholarship for Students of South Asian Indian Heritage

The Foundation of the Pennsylvania Medical Society is offering a $2,000 scholarship from the Endowment for South Asian Students of Indian Descent. Students must be of South Asian Indian heritage and enrolled full time in their second, third, or fourth year at an accredited Pennsylvania medical school.

Jitendra M. Desai, MD, and Saryu J. Desai, MD, Sewickley, Pa., initiated this scholarship within the Foundation in 2002 to provide an opportunity for South Asian Indian students who demonstrate academic excellence. They invite others to contribute to the fund to secure its future.

For information about these scholarships, call the Foundation’s Student Financial Services office at (717) 558-7852, or visit www.foundationpamedsoc.org.

Retiring?

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SAVE THE DATE
Tuesday, September 26, 2017
ACMSA Autumn General Meeting
and Luncheon
South Hills Country Club
Meet and Greet: 10:30 a.m.
Commence Meeting: 11 a.m.

Renowned researcher and ACMSA Autumn General Meeting guest speaker Judith L. Yanowitz, PhD, Magee-Womens Research Institute, will present: “Chromosomes you can count on: What worm germ cells teach us about fertility.”

Luncheon proceeds benefit ACMS Alliance community service projects and organizations in Allegheny County and beyond.

Another spectacular season and another fine reason to get together conducting work of the Alliance combined with social benefits of fellowship among our friends and family, all together sharing many common bonds. Leadership chair of General Meeting is Mrs. LeRoy Wible with Committee members Mrs. Robert Bloom, Dr. and Mrs. William Hetrick, Mrs. F. Byron Kennedy and Mrs. Eugene Delserone. The program of the day includes a brief business meeting of the Alliance, with summary of the Governing Board’s Wrap Up 2017-Kick Off 2018 meeting in June. There will be formal recognition of ACMS Alliance Past Presidents in attendance. Also slated is Alliance Year 2016-17 check presentation to ACMS Executive Director, Mr. John G. Krah, for ACMS Foundation.

There will be wonderful door prizes and as always, an exciting 50/50 drawing is planned. Valet parking is available. ACMSA members and spouses will be in attendance, along with Alliance and ACMS family, friends and guests. Expect a formal invitation with full particulars soon.

For interested parties not on the Alliance mailing list, email invitations can be arranged by contacting Amy G. Stromberg at (412) 321-5030 or astromberg@acms.org. We are deeply grateful for the leadership of Barbara Wible, and of event Committee Members Doris Delserone and Margaret Kennedy for engaging an acclaimed guest speaker!

Pennsylvania Medical Society Alliance Annual Meeting

“If your actions inspire others to dream more, to learn more, and to become more, you are a leader.” – John Quincy Adams

The Alliance of the Pennsylvania Medical Society (PAMED) will be holding its Annual Meeting Oct. 14-15 at the Hershey Lodge in conjunction with the PAMED House of Delegates. The planning committee will meet July 17 to finalize the details but basic information follows. PAMED Alliance membership is not required for the business elements of PAMED Alliance’s Annual Meeting.

Guests are encouraged and welcome to participate in all events and social activities. Members and guests must register. For specific information on member and member guest registration, visit https://www.pamedsoc.org/alliance or call (717) 558-7750, ext. 1503.

The Board of Directors meeting will be held Friday, Oct. 13, from 5 to 7:30 p.m. PAMPAC and PAMED will host their welcome reception at 8 p.m. that evening.

The PAMED Alliance Annual Meeting is scheduled for Saturday, Oct. 14, and Sunday, Oct. 15. The annual business meeting, installation of 2017-18 officers and various lectures will take place. PAMED Alliance also will be hosting their annual silent auction to benefit the AMES Fund during the inaugural dinner Saturday. Information on submitting an item for the auction and sponsorship opportunities will be available by mid-August. Back by popular demand is the PMSA Wellness Room that takes place in Cocoa Suite 5 from noon Friday, Oct. 13, through noon Sunday, Oct. 15.

Attendees and their guests to the PAMED HOD and PAMED Alliance Annual Meeting will be able to take time to relax and experience mini sessions of massage therapy, reflexology, Reiki and learn about essential oils. All proceeds from the Wellness Room go to the AMES fund.

New this year: Stop by the PAMED Registration Desk and support the AMES fund by “dipping” your credit/debit card in the “Dip Jar.” For as little as $30, you can lend your support to the AMES fund and help provide medical education scholarships to our Pennsylvania medical students.

Content provided by Robbi-Ann M. Cook, PAMED Alliance Association executive, Pennsylvania Medical Society Alliance, PO Box 8820, Harrisburg, PA 17105, (717) 909-2688, rcook@pamedsoc.org.

Content and text by Kathleen Jennings Reshmi
Group names ACMS member 2017 Man of the Year

ACMS member Joseph Maroon, MD, has been named the Circus Saints and Sinners Club of America, Bob Prince Tent 2017 Man of the Year.

Dr. Maroon is clinical professor and vice chairman of the Department of Neurological Surgery at UPMC. He also is Heindl Scholar in Neuroscience at the University of Pittsburgh, the team physician for the Pittsburgh Steelers and chief medical adviser to World Wrestling Entertainment.

Local chapter president William Wolfe said in a statement, “It is with great honor and privilege that we announce Dr. Joseph Maroon as the 2017 Man of the Year for the Circus Saints & Sinners Club, Bob Prince Tent. This nomination is the result of a distinguished medical and fitness career that has helped a countless number of his patients achieve superior overall health results. Most importantly, Dr. Maroon had served as a friend and mentor to all his patients and colleagues through his daily efforts and community involvement.”

The organization’s website says, “The Circus Saints and Sinners Club is a non-sectarian, non-political association of successful business professionals organized to “promote good fellowship, contribute to worthy charities and to have fun. Metaphorically speaking, the members – due to their human imperfections – represent ‘Sinners,’ who strive to be ‘Saints’ of mercy by helping those less fortunate.”

Past man of the year honorees include Arnold Palmer, Art Rooney, Bruno Sammartino, Myron Cope, Bob Prince, Rocky Bleier and Stan Musial.

Dr. Maroon was honored at the Circus Saints and Sinners Club annual dinner July 25 at the LeMont Restaurant, Pittsburgh.

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Background

Reslizumab (Cinqair®) is a newly approved therapy for patients with severe, eosinophilic asthma.1 Eosinophils are key mediators of inflammatory response and airway remodeling in asthma and are dependent on interleukin-5 (IL-5) for activation. Reslizumab is a monoclonal antibody that acts as an IL-5 antagonist, thereby blocking the formation and activity of eosinophils to reduce inflammation and remodeling.2 Reslizumab serves as an add-on maintenance therapy for those patients with poorly controlled eosinophilic asthma.

Safety

Avoid reslizumab in patients with known hypersensitivity to reslizumab or any of its components. There is a black box warning for anaphylaxis with reslizumab infusion. In placebo-controlled trials, anaphylactic reactions were reported in 0.3 percent of patients who received reslizumab infusions. In those patients, reactions occurred as early as the second dose of reslizumab. Reslizumab should be administered in a health care setting and patients should be monitored for an adequate period of time after administration by health care professionals for signs of hypersensitivity or anaphylaxis.1

Reslizumab is not indicated to treat acute asthma exacerbations or patients with deteriorating disease. If asthma worsens in severity or becomes uncontrolled after infusion of reslizumab, therapy should be reassessed and patients should seek further medical treatment.1

In clinical trials, malignant neoplasm within six months of therapy was reported in 0.6 percent of patients receiving reslizumab infusion compared to 0.3 percent in the placebo group. No distinct neoplasm and no specific tissue site was identified in the trials.1

Another monoclonal antibody used for eosinophilic asthma carries a warning for diminished immune response against parasitic infections. It is unknown if reslizumab has an impact on the immune response against parasitic infections, since patients with parasitic infections were not studied in reslizumab clinical trials. Because of this uncertainty, it is recommended to treat patients with parasitic infections before initiation of reslizumab. If a patient develops a parasitic infection during the course of reslizumab and does not show any response to anti-parasitic treatment, discontinue reslizumab.1

Tolerability

Reslizumab is generally a well-tolerated drug.1-3 The most commonly reported adverse effect was nasopharyngitis.2-3 Its adverse effect profile was similar to placebo in clinical trials. In one clinical trial, nasopharyngitis occurred in 11 patients who received reslizumab; of those 11 patients, eight patients had nasal polyps at baseline before initiation of reslizumab infusion. Other commonly reported adverse effects included upper respiratory tract infections, sinusitis, influenza and headache.2

Efficacy

Reslizumab’s impact on frequency of asthma exacerbations was evaluated in two duplicate, randomized, placebo-controlled trials. The trials included patients aged 12-75 years with asthma who were inadequately controlled by inhaled corticosteroids, had blood eosinophils greater than 400 mcg/mL and had more than one asthma exacerbation per year. In both trials, annual asthma exacerbations were reduced by 50 to 55 percent in patients treated with reslizumab compared to placebo. Reslizumab also reduced the rate of exacerbations that required the use of systemic corticosteroids compared to placebo.1,2 In addition, for those treated with reslizumab, the time to first exacerbation was significantly longer than those in the placebo group.2 There have been no clinical studies to date, however, to assess if the use of inhaled corticosteroids can be reduced or eliminated in patients treated with reslizumab.1

Reslizumab was demonstrated to significantly improve FEV1 at week four, or after one dose, of therapy compared to placebo in those same duplicate trials.2 Reslizumab continued to show forced expiratory volume (FEV1) improvement at weeks 16 and 52 in one of the clinical trials.2 Reslizumab also significantly reduced blood eosinophil counts compared to placebo.2,3

Continued on Page 296
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Reslizumab’s effect on quality of life was assessed using the Asthma Quality of Life Questionnaire (AQLQ) and symptom control was assessed using the Asthma Control Questionnaire-7 (ACQ-7) and Asthma Symptom Utility Index (ASUI). Analysis of these surveys demonstrated that patients who received reslizumab had a significant improvement in both quality of life and symptom control.²

Price
The cash price for one infusion (one 10 milliliter vial) of reslizumab is $1,002. This price is similar to omalizumab, the other monoclonal antibody on the market indicated for asthma therapy.⁵

Simplicity
Reslizumab is an infusion that is given once every four weeks. Reslizumab has been studied in patients for durations up to one year. There are no set recommendations on duration; patient-specific factors should be taken into consideration to determine length of therapy. The recommended dose is 3 mg/kg given via intravenous infusion over 20 to 50 minutes. It should be given in a health care setting by a health care professional in order to safely monitor for the occurrence of anaphylaxis.¹

Bottom line
Reslizumab (Cinqair®) is a novel biologic therapy used as add-on maintenance therapy for adults with poorly controlled asthma, specifically with an eosinophilic phenotype.¹³ It is generally well tolerated and has been demonstrated to significantly reduce rates of exacerbation, FEV₁, and blood eosinophil counts as well as improve quality of life and symptom control in patients poorly controlled on inhaled corticosteroids who have blood eosinophil counts greater than 400 mcg/mL.²

Dr. Carr is a PGY-1 pharmacy practice resident at UPMC St. Margaret and can be reached at carrm3@upmc.edu. Dr. Bondar is a PGY-2 ambulatory care resident at UPMC St. Margaret and can be reached at bondara4@upmc.edu. Heather Sakely, PharmD, BCPS, served as editor and is director of geriatric pharmacotherapy and director of the PGY2 Geriatric Pharmacy Residency Program at UPMC St. Margaret. She can be reached at sakelyh@upmc.edu.

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References
1. Cinqair (reslizumab) [prescribing information]. Frazer, PA; Teva Respiratory, LLC; March 2016.
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Ransomware: Resources for the smaller practice

BETH ANNE JACKSON, ESQ.

WannaCry, Petya. These two ransomware attacks affected health care providers both globally and locally, encrypting the providers’ data and holding the decryption key for ransom. Think your practice is too small to be a victim? Think again. While hackers may not necessarily be directly targeting your practice computer system, according to Microsoft, ransomware such as any malware or virus can infect your computer by any of the following means:

- Visiting unsafe, suspicious, or fake websites
- Opening emails and email attachments from people you don’t know, or that you weren’t expecting
- Clicking on malicious or bad links in emails, Facebook, Twitter, and other social media posts, or instant messenger chats, like Skype

Even if you don’t have a fully implemented electronic medical record, you still need to be concerned: How would losing all of your billing data impact your cash flow?

How can a physician practice protect itself? The FBI recommends prevention efforts – both in terms of awareness training for employees and robust technical prevention controls and the creation of a solid business continuity plan in the event of a ransomware attack. (It also recommends not paying the ransom if you fall prey to an attack; you may not get the decryption key to unlock your data.) Here’s a more detailed list of steps to get your practice on its way to preventing ransomware, malware and virus intrusions on your systems.

1. Take your HIPAA Security Risk Assessment seriously. Really seriously. If you don’t have the in-house resources to perform the assessment, hire a third-party consultant.

2. Follow through on the weaknesses identified in your Security Risk Assessment. That means, inter alia, that you may need to:
   - Replace unsupported systems, such as Windows XP. (This was a factor in the WannaCry attack on the U.K.’s NHS hospitals.)
   - Ensure that regular backups of all your data occur automatically and daily.
   - Install and maintain high-quality anti-malware software (the one that comes free with your computer or that you can download for free is not necessarily the best and can leave you exposed to new viruses and malware).
   - Encrypt your data and all portable devices.

   • Have a viable business continuity plan – know what your practice is going to do in the event of a system crash or ransomware attack BEFORE one happens – and practice it.
   • Set up your system so that software patches are uploaded and installed automatically on a daily basis.

3. Create and implement a strong data security training program based on strong policies. An employee clicking on a malicious email attachment (from a spoofed email address that makes it look like it’s from a valid source) or infected link or logging into a fake website with their login credentials is all that’s needed to compromise your system, regardless of what security measures you take. Consequently, it is recommended that practices:
   - Firmly limit use of office computers to office business to reduce the risk of a compromise.
   - Don’t click on links even in “valid” emails. Rather, close the email and then log in to your account directly from your browser through the known website, instead of, for example, obtaining your practice credit card statement from the link in an email from your credit card company. It is a couple extra steps, but it’s worthwhile to avoid compromising your account.
4. Consider cyber liability insurance coverage. The process of qualifying can help you get your cybersecurity in order, and many insurers have preferred vendors (technical, legal and public relations) on call that will help you in the event of a breach or ransomware attack.

5. Be aware of and consult the resources available to you. A list of resources is included below.

Physicians can’t be, and don’t need to be, tech experts. However, they do need to be aware of the risks to their practice, hire appropriate employees or contractors to optimize their systems, and set a good example for employees by following the computer security policies in place for the practice.

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

Resources
   This page includes:
   • Cyber Security Checklist and Infographic
   • Ransomware Guidance
   • National Institute of Standards and Technology (NIST) Cybersecurity Framework
   • Office for Civil Rights Cyber Awareness Newsletters
2. The Industrial Control Systems Cyber Emergency Response Team (ICS-CERT) (part of the Department of Homeland Security)
   • Sign up for Alerts: https://public.govdelivery.com/accounts/USDHSUSCERT/subscriber/new
   • Recommended Practices: https://ics-cert.us-cert.gov/Introduction-Recommended-Practices
3. Pennsylvania Medical Society: PAMED members who have questions can contact the Knowledge Center at 855-PAMED4U (855-726-3348) or KnowledgeCenter@pamedsoc.org. Other resources on the PAMED website include the AMA Ransomware Guidance: https://www.pamedsoc.org/PAMED_Downloads/AMA%20Ransomware%20Guidance.pdf

Ms. Jackson is the sole member of Beth Anne Jackson, Esq. LLC, a law firm that serves the legal needs of health care practitioners and facilities in western and central Pennsylvania. She can be reached at (724) 941-1902 or b.jackson-law@verizon.net. Her website is: www.jacksonhealthlaw.com. Follow her on Twitter @bajhealthlaw1.

Thank you for your membership in the Allegheny County Medical Society

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Is your team drama from overstaffing?

JOE MULL, MEd

Recently, the night before speaking at a conference, I had the chance to share dinner with the chief operating officer of a rather large state-wide comprehensive health system in the Midwest. We were joined by a former colleague of hers who also has spent years working in health care.

Throughout the evening, we traded stories, talked about the state of affairs in health care and collectively bemoaned the lack of training and support most front-line leaders get to navigate the people management challenges they face every day. I enjoyed the chance to spit-ball and “shoot the breeze” with these sharp, experienced ladies, especially because they had each spent years on the frontlines in healthcare. They get it.

It was during this conversation that the COO made an observation I hadn’t really considered before. We were talking about what I often talk about in workshops and keynotes: drama. The gossip, infighting, cliques and score-keeping that infect many health care teams to one degree or another. That’s when she said this:

“You know, Joe, I’ve found that if that kind of drama is happening on a team, it’s often because they are overstaffed.”


All at once, I was struck by how absolutely accurate her statement was. As I travel the country training managers from so many walks of life in health care, I’ve seen for years the impact of understaffing. Every day, clinics and hospitals struggle to find and retain talent, suffer budget cuts that lead to barebones staffing and endure the agony of call-offs. These are the understaffing pain points most every health care manager has encountered or lives with regularly. And surely these cause their own kinds of drama in clinics and hospitals everywhere. Truth be told, I can’t remember the last time I met a front-line healthcare leader who told me she thought her clinic was overstuffed. That’s why the COO’s statement initially caught me by surprise.

But what if you are overstuffed and don’t realize it? What happens when you have more people working than you truly need?

In short: drama. The truth is that there’s all kinds of research in psychology, sociology and employee engagement that tells us that employees who are engaged live in a kind of intellectual “sweet spot” where the full breadth and scope of their talents and experience must be brought to bear during the workday in order to be successful in their job. If the challenges of the role exceed their abilities or don’t rise to an appropriate level of difficulty, people are less likely to be engaged.

When employees are bored, they look for problems to solve. Sometimes those problems aren’t really problems. They also can spend time, as well as mental and emotional energy, on things that otherwise wouldn’t be worthy of it if the role were indeed more testing of them.

When clinics are overstaffed, there’s not enough to keep everyone firing on all cylinders. Downtime, boredom, or not enough to do simply create opportunities for drama to creep in.

So … if you are experiencing higher levels of drama at your site, ask yourself: Are you overstaffed?

Mr. Mull is a leadership trainer and keynote speaker. He works with health care organizations that want their practice leaders to engage, inspire and succeed. To learn more or bring Joe to your site, visit www.joemull.com.
Asthma is a disease that is increasingly recognized as a major public health concern, especially in the Pittsburgh area. It is one of the country’s most common and costly diseases, affecting one in 13 people with annual costs around $56 billion. Pennsylvania has a slightly higher asthma rate (9.6 percent) compared to the rest of the United States (9 percent), and children (10.2 percent), especially black non-Hispanic children (19.3 percent), are disproportionately affected. Asthma is one of the top causes of missed school days, and chronic school absenteeism can have a profound impact on a child’s ability to learn, participate in physical activities and develop healthy peer relationships.

Despite advances in the treatment of asthma and an abundance of available medical care, Pittsburgh remains a very challenging city in which to live with asthma. The Allergy and Asthma Foundation of America currently ranks Pittsburgh the 27th most challenging U.S. city in which to live with asthma based on a combination of factors including a high prevalence of asthma, high poverty rates, a high rate of poor asthma control and high levels of exposure to known asthma triggers including air pollutants and environmental tobacco smoke (ETS). Numerous studies have shown that air pollution is associated with an increased risk of asthma development, increased respiratory infections and wheezing, and increased emergency visits and hospitalizations for asthma. Particulate matter (PM) affects more people than any other pollutant, and the most health-damaging particles are those with a diameter of 2.5 microns or less (i.e., PM$_{2.5}$) given their ability to penetrate deep within the lung.

Pennsylvania does not have a consistent mechanism in place to reliably predict regional asthma prevalence, and national and state asthma surveillance data cannot be extrapolated to local areas due to inadequate sample sizes. Given that there is currently no cure for asthma, but it can be adequately managed with proper prevention and treatment, it became critical to identify a way to determine regional asthma prevalence as well as the impact of modifiable contributors to the development and control of the disease. With funding from the Heinz Endowments Breathe Project as well as the Jefferson Regional Foundation, three local researchers partnered to conduct the Surveillance and Tracking of Asthma in our Region’s Schoolchildren (STARS) study. Deborah Gentile, MD, and Jennifer Elliott, PharmD, both from the School of Pharmacy at Duquesne University, developed an accurate and efficient method to conduct asthma surveillance and tracking among elementary school children in the Pittsburgh region. They utilized a validated survey to assess asthma prevalence, severity and control among the study population. They also collected information on known modifiable risk factors such as obesity and ETS exposure. Regional air pollution data from the group of Albert Presto, PhD, at Carnegie Mellon University was used to explore associations between asthma outcomes and levels of outdoor air pollutants such as PM$_{2.5}$ and Black Carbon (BC).

A total of 213 children from Clairton Elementary School were enrolled in the study. Results revealed that asthma rates in the children from Clairton are nearly double the rate reported by the state of Pennsylvania (18.4 percent vs. 10.2 percent, respectively). As in previous studies, African-American and poorer children from Clairton have significantly higher rates of previously diagnosed asthma compared to white and wealthier children.

Continued on Page 302
## Allegheny County Health Department Quarterly (Qt) Selected Reportable Diseases

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<tr>
<th>Disease*</th>
<th>2015 Qt 1-2</th>
<th>2016 Qt 1-2</th>
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<tr>
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*Case classifications reflect definitions utilized by CDC Morbidity and Mortality Weekly Report.

**These counts do not reflect official case counts, as current year numbers are not yet finalized. Inaccuracies in working case counts may be due to reporting/investigation lag.

**NOTE:** Disease reports may be filed electronically via PA-NEDSS. To register for PA-NEDSS, go to https://www.nedss.state.pa.us/NEDSS. To report outbreaks or diseases reportable within 24 hours, please call the Health Department’s 24-hour telephone line, (412) 687-2243.

For more complete surveillance information, see ACHD’s 10-year summary of reportable diseases: http://www.achd.net/epi/pubs/pdf/2015_AC_Reportable_Diseases.pdf.

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### Special Report

Additionally, this assessment resulted in the initial identification of asthma in 15 percent of the study population. This rate is striking since it represents at-risk children who were not previously diagnosed with asthma. Obesity and ETS exposure also are highly prevalent among this cohort of children, with one in four children identified as obese and over half exposed to significant ETS. Despite a lack of association between asthma and obesity detected, there were several associations identified between asthma outcomes and outdoor air pollution and ETS exposure.

The mean residential distance from the Clairton Coke Works Plant, the largest coke plant in North America, is one mile, and 25 percent of children reside at least partially in the path of prevailing wind from the plant. Children who reside within closer proximity to and partially in the path of prevailing wind have significantly higher average BC and PM<sub>2.5</sub> exposure than children living farther away or outside the path or prevailing wind. An alarming 60 percent of the children studied from Clairton had PM<sub>2.5</sub> exposures above the recommended World Health Organization threshold to reduce premature mortality. And, unlike other major cities in which the most polluted area is the city center, children living in Clairton have higher exposures than children living in the city of Pittsburgh.

There also was a higher prevalence of previously diagnosed asthma among children exposed to higher levels of PM<sub>2.5</sub>, BC and ETS. In fact, exposures to PM<sub>2.5</sub> and BC in the upper quartile compared to the lower quartile increased the risk of asthma nearly two-fold, the same effect size seen with ETS exposure. There also was a higher prevalence of newly discovered asthma among children exposed to higher levels of PM<sub>2.5</sub> and BC. Uncontrolled asthma was much higher in Clairton children (64.1 percent) compared to all children in the United States (38 percent) and in the state of Pennsylvania (27 percent) with a previous diagnosis of asthma.

The rates of childhood asthma as well as poorly controlled asthma among Clairton children are alarming and unacceptable. This study reveals that asthma prevalence and burden is related to racial and socioeconomic disparities as well as ETS and air pollution exposure. These results highlight the need for state-mandated asthma screens as well as novel treatment delivery models for high-risk groups, such as school-based clinics. Most importantly, primary
prevention measures are imperative to decrease exposures to the harmful air pollutants contributing to the asthma epidemic in Clairton.

**Dr. Elliott is an associate professor of pharmacy practice in the School of Pharmacy at Duquesne University.**

**Dr. Presto is an associate research professor in the Department of Mechanical Engineering and the Center for Atmospheric Particle Studies at Carnegie Mellon University.**

**Dr. Gentile is director of clinical research, Adult and Pediatric Allergy and Asthma, a Division of the Pediatric Alliance, adjunct professor of pharmacy, Duquesne University School of Pharmacy.**

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**References**

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