Joint statement: MAT for opioid use disorders

Mentoring in medicine

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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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Oh, it’s that time of winter again. It’s cold, and grey, and snowy, and politics is making your head hurt no matter whom you voted for in the election. At times like these, we need something to unify us and make us feel warm and happy inside. Something which will soothe our souls and smooth over our differences. Something to bring us together in the act of sharing, and in doing so, provide balm to our wounds.

(No, not alcohol.)

Food.

Hunger is a basic, primal urge; while music may soothe the savage beast, a large pan of macaroni and cheese would probably do twice as well at that task. This month, I dare you to venture out into the cold and the slush in search of food and fellowship with those you love, and perhaps those you don’t know so well. The hours of daylight are slowly waxing, and you may find that sharing a good meal may grow your budding friendships and repair grievances in old ones. Nourish your heart as well as your stomach; the act of cooking for others is one of intrinsic love and generosity. The dishes made may be healthy or not; but there are few better ways to wordlessly show love than to cook for someone, and to eat and appreciate the efforts of someone who has made a dish for you. But the sentiment matters as well; the plainest carrot sticks served with a joyful heart are more nourishing to the spirit than the finest Beef Wellington served with bitter words. And the recipient whose only comments on the meal are to find fault and suggest ways it could have been better prepared sours the joy of the cook. Appreciate, enjoy and dance the dance of nourishment.

In case you need to be fed, here are some lovely newer places you may not have tried yet in Pittsburgh. Treat and nourish yourself and your friends and family – and none of you needs to cook!

1. DiAnoia’s Eatery – 2549 Penn Avenue in the Strip District. Serves breakfast, lunch, dinner and weekend brunch. Bright and clean, a 1950s diner feel with Dean Martin and Bobby Darin tunes wafting warmly in the background. Delicious authentic Italian food with a plethora of pasta dishes and some of the best meatballs in the city. Wine and cocktail bar, and a great selection of desserts and pastries including a sublime cannoli. Also check out the coffee bar, which includes a pistachio and cardamom cappuccino.

2. Muddy Waters Oyster Bar – 130 South Highland Avenue, East Liberty. All sorts of oysters, all different ways. A New Orleans-themed seafood restaurant with all the expected Cajun/Creole delicacies and, of course, a selection of excellent raw oysters from both coasts. Hush puppies and fried green tomatoes to boot. The cocktails are great, too; watch out for the French 75.

3. The Twisted Frenchman – 128 South Highland Avenue, East Liberty. Next door to Muddy Waters, this tiny upscale modern French place is a hidden and delicious gem. Not only can you come here for all of your foie gras, truffle and tartare needs, but stunning duck and venison dishes stand alongside steaks. Three and fourteen course tasting menus with wine pairings exist; needless to say, make reservations.

4. Pork and Beans – 136 6th Street, Downtown. Another Rick DeShantz creation (if the name sounds oddly familiar, think Meat and Potatoes, Butcher and the Rye, Tako). It features Texas barbecue served in a rustic roadhouse setting with communal tables (also bar seating) and is a restaurant version of a love letter to smoked meats. Also boasts a fantastic high and lowbrow beer selection.

5. Totopo – 660 Washington Road, Mt. Lebanon. Delicious Mexican cuisine at the site of the old Walnut Grill.

www.acms.org
Excellent quality food and good prices for the value from starters to dessert. Worth a trip to the suburbs!

6. Apteka – 4606 Penn Avenue, Bloomfield. Central and Eastern European cuisine so rich and divine that you'll completely forget it's vegan. Pierogies, Haluski, Kluski and other delights, decadent desserts and reasonably priced cocktails.

7. Morcilla – 3519 Butler Street, Lawrenceville. If you haven't been yet, you need to try this place. A huge Spanish tapas/pinxtos menu with each dish more delicious than the next, complete with the legendary acorn-fed Jamon Iberico de Bellota. The cocktails are amazing. You could dine here every night for two weeks and still not run through the entire menu. Make reservations.

8. Smallman Galley – 54 21st Street, Strip District. An incubator concept, this space features four different pop-up eateries which hold their place for a certain length of time and then give way to another set of four. Order at each counter, and either collect your dishes or be served. Choose an off-peak time (i.e., NOT Saturday lunch rush) for the best experience. A great way to experience four different cuisines at once – something for everyone.

9. Whitfield – 120 South Whitfield Street, East Liberty. On the ground floor of the trendy Ace Hotel, this place specializes in steak, steak and more steak, and does a delectable job of it. Eastern European inspired dishes round out the menu. Pro tip: Get the steak. Good desserts and great cocktails, too.

10. Ki Ramen – 4400 Butler Street, Lawrenceville – COMING SOON. Eagerly awaited 70-seat Ramen noodle shop with noodles made in-house. A collaboration between the chefs of Piccolo Forno and Umami which will serve many different kinds of authentic Ramen dishes with a variety of broths and toppings. This isn’t your college memory of Maruchan Instant Ramen. Instead, it is a deeply flavorful and fresh dish described as “soul in a bowl.” Opening date TBA; in the meantime, monthly pop-up Ki Ramen experiences will be held at various locations around town to build anticipation and sample the wares.

Go forth, and nourish yourselves.

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.
The high cost of doing business

JOHN KOKALES, MD
ASSOCIATE EDITOR

The cost of purchasing products and services in the health care industry continues to spiral upward. Justification often is provided by the “cost of doing business.” This is not always the case, as we have witnessed in our own practices when our patients are not able to afford drugs, treatments, or adequate health care insurance. Payers, providers and pharmaceutical companies all contribute to this.

Where is our health care dollar going and what is its value? The answers are too complex to answer here, but I’d like to explore some examples of cost drivers whose prices far exceed the cost of doing business. Unfortunately, we as practitioners are both unwilling enablers of this and at times benefactors, too.

Examples would be:

1. The unjustifiable cost increases in commonly used drugs like many generics. When generics first become available, an open market should determine the price. That is not the case. Brands protect their drugs beyond the patent through fancy legal maneuvers and modifications in delivery systems. Generic companies buy up suppliers at exorbitant prices and buy up competition so as to name their own price. According to the National Average Drug Acquisition Cost pricing file, the price of captopril (12.5 mg) increased by more than 2800 percent between November 2012 and November 2013, from 1.4 cents to 39.9 cents per pill. Similarly, the price of clomipramine (25 mg) increased from 22 cents to $8.32 per pill, and the price of doxycycline (100 mg), that has been around since 1967, increased from 6.3 cents to $3.36 per pill. Brand-name drug makers are just as guilty. As an example, spending on insulin and other diabietic medications is expected to rise 18.3 percent over the next three years, which is 60 times greater than the recent income growth average of just 0.3 percent across all households. The victim is the consumer (our patients) who has to pay higher health insurance premiums, co-pays, deductibles, or out of pocket for those who have no insurance.

2. What about the outrageous pricing of truly remarkable drugs for previously untreatable diseases like hepatitis? Their price has been set based not so much on a reasonable return of investment but rather on what the cost of taking care of a person with Hepatitis C would be over their lifetime if this drug were not available. In the past, we did not price penicillin based on the cost of curing the diseases it cured. We did not price a carotid stent based on the cost saved of preventing a stroke. So why the change? Because they could! No regulatory agency or lawmaker has been able to stand up to pharmaceutical or medical device lobbies and apply reasonable restraints around the pricing of their products. Instead, Medicare continues to refuse to even negotiate drug prices. So, when you have a life-saving drug, companies can charge and get whatever they want for it. The government is not acting in the interests of the common good. Instead, it is only acting in the interest of the lawmakers and the drug firms that support them. We as a profession have stood idly by.

3. Then there is the practice of providers charging for every aspect of caring for a patient. Providing these services was previously just part of what we did in taking care of the “whole patient.” Now, we get paid separately for managing chronic care, or filling out forms, or providing counseling on tobacco cessation, or having family meetings or ... or ... or, on and on, by adding a code for each service. That logic has its origins in the underpayment for primary care practitioners and the perceived lack of providing these services only because they often were not documented in the record. Now, we can document with a click in the EMR and receive extra payment. The
difference is that as we are now mostly employed, our employers receive the extra payments and the PCP is still underpaid. Furthermore, documentation does not always mean it was done. So, if the lack of documentation didn’t always mean it was not done, and the presence of documentation does not always mean that it was done, then what have we gained? Documentation has become so generic that it’s hard to really know what has transpired at a visit. It only matters that the documentation matches the code so as to maximize reimbursement. I don’t see the value. Value comes by reimbursing providers for value-driven care measured by outcomes and not only by just documenting that I don’t wet my pants every time the doctor sees me. Get rid of the waste and pay us for our results. The system, in the end, will save money. There is a lot more value in that compared to a note written to satisfy innumerable “quality” measures.

4. What about the huge difference in charges based on site of service? Cost can vary greatly for the same service depending only on where the service is provided. The consumer often is unaware until they get the bill. It is estimated that these fees can generate an additional $30,000 annually per physician for hospitals. According to a 2012 report by the Medicare Payment Advisory Commission, hospital facility fees result in an 80 percent increase in reimbursement for a 15-minute office visit. Did the patient get any increased value of care for that? Alan Sager, a professor of health policy and management at the Boston University School of Public Health, has called these fees “a tax on sick people” reflecting the “financial anarchy that pervades health care in the U.S.”

There are many other examples, but the theme is the same. Use the system to raise the price, exploit every possible reimbursement rule, and expect to be paid by the payers who have to abide by the same government regulations that enable the exploitation. This results in additional costs being passed on to patients through premiums, deductibles and co-pays.

So, when the pharmaceutical companies, payers, or providers complain of the high cost of doing business, it is many times a false rationalization. Our health care system has become a victim of those taking advantage of poorly crafted rules. The consumer pays the high cost of doing this type of business. There is no common good in that.

If aspirin were developed today, I probably couldn’t afford to buy it for the headache I got writing this article. However, our high premiums will enable our insurance companies to pay an exorbitant price for the antidepressant we may all have to take if this continues.

Dr. Kokales is a retired internist and associate editor of the ACMS Bulletin. He can be reached at kokalesjg@yahoo.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.

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2. www.lab.express-scripts.com/drug-trend-report/

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.
As physicians recall the Hippocratic Oath, they often focus on the instruction in those sacred stanzas to heal and do no harm. Less familiar is the first verse’s exhortation to respect the knowledge of our forebears in the field, and the pledge to impart our own knowledge to those who will eventually follow in our footsteps.  

This role of simultaneous mentor and mentee is an integral part of our life as physicians. In medicine, as in any workplace, mentorship can take many forms: patron, sponsor, guide, friend, coach. Early on in residency, it is commonly impressed upon trainees that the key to success in medicine lies in finding a mentor. However, this represents a gross oversimplification of the complex network of professional relationships that must be navigated through each stage of training. Not only do trainees need guidance in their clinical and research experiences, but also for navigating their way through the web of competing priorities and demands on their time. Any current or former trainee, though, knows that this system is flawed: there are loopholes, gaps, redundancies and errors in even the best residency programs. Nevertheless, the difference between a successful experience and a frustrating one often comes down to the presence of a mentor or set of mentors who can help to fill those gaps in training and guidance. 

The etymology of “mentor” can be traced to a specific character in the “Odyssey.” Mentor, a friend of Odysseus, is put in charge of his household while Odysseus is gone, and he is the persona through whom Athena, goddess of wisdom, conveys advice to Odysseus’s son in his father’s absence. Mentor is instrumental in the original meaning – wisdom comes from the goddess herself and is only conveyed through the human form of Mentor. 

A mentor, therefore, can take many different forms. Most conventionally, a mentor is someone senior and more experienced, who can be a source of guidance and inspiration. In 2010, I found myself demoralized and disoriented after embarking on a year of research – a sidestep away from my medical school classmates who would continue in their successive clinical rotations without me. I found it difficult to focus on the hypothetical and complex questions posed in the laboratory, and they seemed so very far from the immediate and innumerable pressing issues I had faced on the wards. My research mentor – a senior scholar in the field – sensed this. He sat down with me and shared his own story: knowing that his route into the laboratory was cemented when he ran out of clinical treatments to offer his patients. 

Faced with the choice of simply saying “we have nothing further to offer,” or setting to work, he chose the latter, and created a life seeking new treatments for patients with severe acute pancreatitis. I chose to borrow that motivation and have since carried it with me. 

Though this may be the stereotypical mentorship experience, figures of intermediate authority in the vast hierarchy of medicine often can be the most helpful for trainees as they are closer to their early experiences. Even the discussion of mentorship as directional – wisdom flowing from higher to lower status – mischaracterizes our medical system as a set of vertical silos. In fact, it is more accurately described as a complex network of people, a network in which hierarchical relationships may not necessarily be clear. Mentorship at its best – the providing of guidance, advice, professional introductions, recommendations, sponsorship, support, constructive criticism – ideally reflects this non-hierarchical interconnectedness. 

That’s because, as the Hippocratic Oath made plain, we all share a responsibility for mentorship. Challenges nevertheless abound: pressures of time and money, expectations of productivity, difficulties of communications and deficits of commitment are common reasons for the failure or nonexistence
of such relationships. There is no clear syllabus or set of guiding principles as to what form any particular mentorship should take. Building on Kathy Kram’s pioneering publications, especially her 1985 book “Mentoring at Work,” new medicine-specific research has begun to codify best practices for mentorship in medical settings.4

One of the most important things we can do as physicians to enrich our community and educate the next generation of physicians is to create a culture in which mentorship is not only expected, but also highly valued. Interestingly, January has been named as national mentoring month by the National Research Mentoring Network, and in a presidential proclamation, President Barack Obama declared, “Let us honor those who give of themselves to uplift our next generation.”5 In whatever capacities we serve in health care, let us all take up the challenge of offering guidance to those who have joined us in providing better health for all. Only by doing so can we truly honor the oath we took as we began our journey as physicians.

Dr. Phillips is a third-year gastroenterology fellow at UPMC. Her research is focused on pancreatitis and genetic cancer syndromes. She 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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4. For an exemplary example of this new work, see Jeffrey L. Houpt, Roderick W. Gilkey, and Susan H. Ehlinghaus. Learning to Lead in the Academic Medical Center (New York: Springer, 2015)

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POS Annual Meeting slated for March 17

The 2017 Annual Meeting will be held Friday, March 17, at the Pittsburgh Marriott City Center, with the Duquesne Club hosting the Annual Banquet.

The Society welcomes Warren E. Hill, MD, medical director, East Valley Ophthalmology, Mesa, Ariz., as the 37th Thorpe Lecturer. Dr. Hill 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. He has published many scientific articles, served as visiting professor for numerous grand rounds, and has delivered more than 550 presentations to ophthalmic societies both in the United States and internationally.

Gaurav K. Shah, MD, professor of Clinical Ophthalmology and Visual Sciences, The Retina Institute, Washington University School of Medicine, St. Louis, Mo., and Arsham Sheybani, MD, assistant professor of Ophthalmology and Visual Sciences, Washington University School of Medicine, St. Louis, Mo., complete the list of exceptional guest faculty for this year’s conference.

Dr. Hill

POS meets at ACMS

The Pittsburgh Ophthalmology Society met Jan. 5 at the ACMS building. From left are Joseph Rizzo, III, MD (presenter); POS member Ellen Mitchell, MD; Thierry Verstraeten, MD, president; and POS members John Charley, MD; and Gabrielle Bonhomme, MD. At the meeting, David Buerger, MD, was confirmed as POS president-elect.

Dr. Shah has published more than 100 articles in ophthalmologic peer-reviewed journals, along with five book chapters. He has presented at the annual meeting of the American Academy of Ophthalmology, the American Society of Retina Specialists, the Retina Society, the Canadian Ophthalmology Society and the Association for Research in Vision and Ophthalmology. He also has lectured on various topics at several meetings both inside and outside the United States. He has received numerous awards, including the Heed Foundation Award, the Vitreous Society Honor Award, the American Academy of Ophthalmology Achievement Award and the American Society of Retina Specialists Senior Honor Award. He has been or is currently an investigator in 30 clinical trials dealing with macular degeneration, diabetic retinopathy, uveitis and AIDS. He serves as a reviewer for Archives of Ophthalmology, British Journal of Ophthalmology, Ophthalmic Surgery and Lasers, Retina, Graefe’s Arch for Clinical and Experimental Ophthalmology, American Journal of Ophthalmology, and Ophthalmology, and also is an examiner for the American Board of Ophthalmology.

Continued on Page 54
Welcoming
Peter F. Stracci, DO, FACC
Cardiology

Dr. Stracci is a fellowship-trained, board-certified, cardiologist with 25 years of experience caring for patients with cardiovascular disease and also a graduate of Pittsburgh School of Pharmacy. He has clinical expertise in valvular heart disease, carotid artery disease, peripheral vascular disease, congestive heart failure, atrial fibrillation, hypertension, coronary artery disease, myocardial infarction, nuclear stress cardiology, lipid disorders and echocardiography.

He received his medical degree at West Virginia School of Osteopathic Medicine in Lewisburg, W.Va., and completed his internship at Doctors Hospital in Columbus, Ohio. He completed his residency and cardiac fellowship at Allegheny General Hospital in Pittsburgh, Pa.

Dr. Stracci is certified by the American Board of Internal Medicine and Cardiovascular Disease and is a Fellow of the American College of Cardiology. He holds memberships with several professional organizations including the American College of Chest Physicians and the Western Pennsylvania Heart Association, the Pennsylvania Osteopathic Medical Association and the American College of Cardiology.

He has medical staff privileges at Allegheny General Hospital, Clarion Hospital, and the Peters Township Health + Wellness Pavilion.

As always, new patients are welcome. Most major insurances are accepted.
Dr. Sheybani has presented research internationally and is currently involved in device design aiming to make glaucoma surgery safer amongst many other endeavors. His areas of specialty include glaucoma and surgical management of the anterior chamber (front of the eye). Dr. Sheybani completed his medical degree at Washington University School of Medicine in St. Louis, followed by residency at Washington University in St. Louis, where he was selected to remain on faculty as chief resident. During that year, Dr. Sheybani was responsible for ophthalmologic trauma and emergencies as well as all adult inpatient ophthalmology consultations at Barnes Jewish Hospital. He then completed his fellowship with Dr. Ike Ahmed in Glaucoma and Advanced Anterior Segment Surgery in Toronto, Canada.

Registration and conference details can be found on the society website at www.pghoph.org or by contacting Nadine Popovich, administrator, at npopovich@acms.org or (412) 321-5030.

Annual Meeting for Ophthalmic Personnel set

Running concurrently with the POS Annual Meeting is the 38th Annual Meeting for Ophthalmic Personnel. More than 200 ophthalmic technicians, assistants, coders, photographers and front office staff are expected to attend this year’s meeting at the Pittsburgh Marriott City Center.

This well-respected annual program is designed for ophthalmic technicians and administrative personnel to provide clinical updates as well as relevant and key technical sessions.

Planned by co-chairs Pamela Rath, MD, and Laurie Roba, MD, this year’s program is broken into four segments to allow attendees to select the program they are most interested in and for which they may obtain credits. Credits are only granted following approval by the JCAHPO with the formal application for the 2017 conference under consideration.

Highlights for the 2017 program include clinical sessions on: Pediatrics, Cornea (infectious diseases), Glaucoma, Neuro-Ophthalmology, Oculoplastics and Uveitis. Risk management session offerings include: chart audit, coding, cross-training staff and work-up protocol. The program will once again feature the popular workshop sessions.

Registration and course information can be found by visiting www.pghoph.org.

For questions, please contact Nadine Popovich, administrator, at npopovich@acms.org or (412) 321-5030.

2017 Clinical Update in Geriatric Medicine slated

The 25th annual Clinical Update in Geriatric Medicine conference, jointly provided by the Pennsylvania Geriatrics Society – Western Division (PAGS-WD), UPMC/University of Pittsburgh Institute on Aging, University of Pittsburgh School of Nursing and University of Pittsburgh School of Medicine Center for Continuing Education in the Health Sciences, will be held April 6-8 at the Pittsburgh Marriott City Center.

The fastest-growing segment of the population comprises individuals above the age of 85 years. The purpose of the conference is to provide an evidence-based approach to help clinicians take exceptional care of these often-frail individuals. Designed by course directors Shuja Hassan, MD; Judith Black, MD; and Neil Resnick, MD, along with the PAGS-WD planning committee, this award-winning course is designed for family practitioners, internists, geriatricians and other health care professionals who provide care to older adults.

Speakers are selected by a multidisciplinary committee of academic and practicing clinicians; selection is based on two criteria: (1) expertise – nationally recognized and often responsible for advances relative to practice, and (2) ability – to share it in a practical, succinct and entertaining way to facilitate its easy incorporation into a practice.

Conference highlights include:

- Evidence-based evaluation and treatment of multiple common clinical problems seen in the office, hospital and long-term care
- Symposium on neurodegenerative diseases including Parkinson’s disease and Alzheimer’s
- Symposium covering the latest updates for common cardiovascular conditions, including hypertension and acute MI in the elderly
- Ask the Expert sessions, allowing participants to get answers to their most vexing questions. This year’s sessions focus on Infectious Disease, Cardiology and Psychiatry.
- Multiple breakout sessions including: Prognostication in Chronic Disease; Decision Making Capacity; Billing Code Primer; Using Antipsychotics in Long Term Care; and Foot Problems

This year’s distinguished guest faculty includes: William B. Applegate, MD, MPH, MACP, professor of gerontology and geriatric medicine, Wake Forest Baptist Health, Winston-Salem,
Members of the PAGS-WD receive a discount when registering for the conference! To inquire about becoming a member or current membership status, contact Nadine Popovich at 412-321-5035, ext. 110, or npopovich@acms.org. Apply for membership on the Society website at www.pagswd.org.

**PUA meeting announced**

The Pittsburgh Urological Association will meet at 6 p.m. March 30 at Eddie Merlot’s, 444 Liberty Ave., Pittsburgh.

The guest speaker will be David Albala, MD, medical director and co-director of Research Associated Medical Professionals and chief of urology, Crouse Hospital, Syracuse, N.Y. Dr. Albala will present “Clinical Utility of the Oncotyle DX Prostate Cancer Assay in Early State Prostate Cancer Treatment.”

Reservations are required by March 24. To register or for more information, please contact Amy Stromberg, administrator, at astromberg@acms.org or (412) 321-5030.

**PAMED offers medical student scholarships**

The Pennsylvania Medical Society (PAMED) Alliance, in conjunction with the Foundation of the Pennsylvania Medical Society, is offering multiple $2,500 scholarships to Pennsylvania residents attending an accredited Pennsylvania medical school full-time as a second- or third-year student. Applications must be postmarked by Feb. 28.

In addition to completing an application, candidates must submit two reference letters; verification of medical school enrollment on school letterhead; an essay describing the applicant’s vision for the future of Pennsylvania medicine; and membership with PAMED and county medical society (membership is free).

The PAMED Alliance established the Alliance Medical Education Scholarship fund in April 2000. These scholarship awards are possible thanks to Alliance fundraising events and contributions from its members.

The Pennsylvania Medical Society Alliance is an organization of physician spouses from the Commonwealth of Pennsylvania who are improving the health and quality of life for all people.

The Foundation of the Pennsylvania Medical Society, which administers the Alliance Medical Education Scholarship, sustains the future of medicine in Pennsylvania by providing programs that support medical education, physician health and excellence in practice. It has been helping to finance medical education for more than 60 years.

For an application, contact the Foundation at (717) 558-7852, or visit Student Financial Services at www.foundationpamedsoc.org.

**ACMS Practice Administrators Forum: 2017 calendar set**

ACMS recognizes the important role practice administrators play in the medical community and continues to assist administrators and their staff by offering educational programs throughout the year through the Practice Administrators Forum. The forum is dedicated to providing a strong professional network for health care management.
professionals. Our mission: help practice administrator members become more effective in their daily professional responsibilities and enhance productivity and efficiency through increased knowledge of basic health care management principles.

This year’s programs include presentations on: MIPS, Labor Law Regulations, Legal Update and Medical Record review. Attendees receive valuable practice support along with the opportunity to network with their peers in order to find solutions to their practice challenges. Meetings are held at the Allegheny County Medical Society facility, with registration at 8 a.m. and programs beginning at 8:30 a.m. (unless otherwise indicated). The complete list of program dates and topics can be viewed by visiting www.acms.org/events.

Sponsorship opportunities also are available. For further information on sponsorship, or becoming a member of the Practice Administrators Forum, please contact Nadine Popovich, administrator, at npopovich@acms.org or (412) 321-5030.

Community Notes

JHF accepting applications for 2017 Fine Awards

The Jewish Healthcare Foundation (JHF) has issued a request for applications for the 2017 Fine Awards for Teamwork Excellence in Health Care. The 2017 Fine Awards will recognize teams of professionals in western Pennsylvania who provide innovative, quality improvement-centered treatment for mental health and substance use problems. Three winning teams, selected by a panel of judges, will each receive a $20,000 award.

The deadline to apply for the Fine Awards is March 1. Interested teams from Allegheny, Beaver, Butler, Washington and Westmoreland counties can apply by completing an online application on the JHF website, www.jhf.org.
Alliance News

HEADS UP
MARK YOUR CALENDAR
ACMS ALLIANCE GOVERNING BOARD MEETING
Tuesday, March 14, 2017 at 10:30 a.m.
ACMS Building at 713 Ridge Ave. (Parking Available)
RSVP information for Membership, call 412-321-5030

Governing Board will attend and Alliance members are warmly welcome to join us for a planning session of remaining business, Alliance Year 2016-17. Agenda is under development at this time but will include leadership 2017-18, treasury decisions for year-end distributions/disbursements, details of Annual Meeting and more. Governing Board Meeting reminder and RSVP information to be sent soon. Thanks for your interest in and support of our ACMS Alliance.

CONTENT AND TEXT BY KATHLEEN JENNINGS RESHMI

DOCTOR’S DAY
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MARCH 30, 2017

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ALLEGHENY COUNTY MEDICAL SOCIETY ALLIANCE

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Perspective

Activities & Accolades

ACMS member giving Grand Rounds

ACMS member Nicole Vélez, MD, director of Surgical Dermatology, Allegheny Health Network, will be giving Grand Rounds: “Updates in Skin Cancer Management: Cases from the first year of the AGH Mohs Clinic,” April 26 from noon to 1 p.m. at Magovern Auditorium, Allegheny General Hospital. Dr. Vélez is a dermatologist and Mohs surgeon.

Cyril Wecht, MD, receives humanitarian award

Cyril Wecht, MD, nationally noted forensic pathologist, attorney, University of Pittsburgh clinical professor in Pathology, University of Pittsburgh adjunct professor, School of Public Health, research professor in Law at Duquesne University, instructor adjunct professor University of Pittsburgh Law School and previous appointee (twice) to the role of coroner in Pittsburgh, was honored Jan. 7 as a 2017 Western Pennsylvania Humanitarian Award winner.

The Annual Western Pennsylvania Humanitarian Awards were created by Achieving Greatness Inc. to recognize and honor individuals who have worked tirelessly and gone above and beyond the call of duty to make the world a better place, their commitment to Western Pennsylvania being most important.

ACMS member represents Foundation of ACS at meeting

ACMS member Christopher J. Daly, MD, FACS, represented the Foundation of the American College of Surgeons at the winter meeting of the Regents of the College in Chicago Feb. 9-12.

In Memoriam

Richard E. Easler, MD, 85, of Pittsburgh, formerly of Brownsville, died Sunday, March 27, 2016.

Dr. Easler received his undergraduate degree from Washington & Jefferson College and graduated in medicine from Jefferson Medical College, where he performed his residency.

Dr. Easler served three years in the U.S. Navy in the Bethesda Naval Hospital’s pathology department under James J. Humes. He was honorably discharged as a lieutenant commander in 1964 and served six more years in the U.S. Naval Reserves.

After five years at Canton Hospital in Ohio, Dr. Easler returned to western Pennsylvania and joined Western Pennsylvania Hospital’s Pathology Department in 1969, where he remained until his retirement in 1995.

He was preceded in death by his wife of 52 years, Gyorgyi. Surviving are two sons, Richard and David; and four grandchildren, Matthew, Jackson, Benjamin and Adelaide. Services were private.

***

George H. Gray Jr., MD, 94, of Pittsburgh, died Friday, December 30, 2016.

Dr. Gray graduated in medicine from the University of Pittsburgh and served his internship at Mercy Hospital. He also served his residency at Mercy Hospital and was a research fellow in neurology at Massachusetts General Hospital.

He was a veteran of the U.S. Army, having served two years in Japan. He was tapped as chief pathologist at the 19th Station Hospital in Osaka.

Dr. Gray established the first electro-encephalographic laboratory in Pittsburgh and served as its director for 25 years.

He served as chief of the Division of Neurological Surgery at Mercy Hospital; South Side Hospital; and St. Clair Hospital, also serving as chief of staff at all three hospitals. Dr. Gray was a member of several medical organizations and previously served as director of the Allegheny County Medical Society.

Dr. Gray was preceded in death by his wife, Marjorie Hickey Gray; and a son, Robert W. Gray.

Surviving are four children, Richard H. (Nancy) Gray, Linda (Eric Bee) Perri, Deborah S. Worden and William A. (Monica) Gray; eight grandchildren; and four great-grandchildren.

Services were held Tuesday, January 3, 2017, in William Slater Funeral Service, Scott Township.

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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

What does
ACMS membership
do for me?

Member Resources
BMI Charts, Healthy Lifestyle Posters, Where-to-Turn cards
Allegheny County Medical Society
412.321.5030
acms@acms.org
Carl M. Kaplan, MD, 87, of Boca Raton, Fla., formerly of Mt. Lebanon, died Monday, January 2, 2017.

Dr. Kaplan graduated in medicine from State University of New York Medical School. He completed his residency at the University of Pennsylvania.

He was a veteran of the U.S. Air Force, serving as chief radiologist and captain at the 4737th U.S. Air Force Hospital in St. John’s, Newfoundland.

Dr. Kaplan worked as a radiologist and then exclusively as a radiation therapist at Mercy Hospital for 31 years. He retired as the director of Radiation Therapy at Mercy Hospital in 1991.

His wife of more than 47 years, Roslyn, is deceased.

Surviving are sons Rich (Diane) Kaplan, MD, Jeff (Lisbeth) Kaplan, MD, and Jon (Nancy) Kaplan; eight grandchildren, Jessica, Lauren, Daniel, Rachel, Kristen, Zoe, Ben and Hanne; and his companion, Barbara Geenberg.

Services were held Sunday, January 8, 2017, in Mt. Lebanon Cemetery.

***

Richard A. Wilson, MD, 85, of Oakmont, longtime resident of Sarver, died Monday, January 2, 2017.

Dr. Wilson graduated in medicine from the University of Pittsburgh.

He served with the U.S. Public Health Services; had a family practice in Freeport; and served as director of Rehab Services at Allegheny Valley Hospital, Natrona Heights, for 36 years, retiring in 2001. He also served as president of the Armstrong County Medical Society.

Surviving are his wife of 63 years, Betty Jean Reiter Wilson; two sons, twins David M. (Linda) Wilson and Bruce E. (Tracey LeBlance) Wilson; two daughters, Barbara Jean (John Mrozek) and Brenda Sue Wilson; five grandchildren, Nicholas (Caroline) Wilson, Jennifer (Greg) Buzzell, Blake (Brianna) Wilson, Glen (Lyndsay) Wilson and LeAnna (Stephen) Schneider; great-grandchildren Jack G. Wilson, Atticus J. Buzzell, Amelia Rose Wilson and Ansel J. Buzzell; a brother, Donald E. (Marianna) Wilson; and a nephew, Johan Wilson.

Services were held Saturday, January 7, 2017, at Longwood of Oakmont, Verona, Pa.

***

William W. Lander, MD, 92, of Villanova, died Friday, January 6, 2017.

Dr. Lander graduated in medicine from the University of Pennsylvania and served his residency in internal medicine at Bryn Mawr Hospital.

He was a veteran of the U.S. Navy, having been stationed as a lieutenant with the First Marine Division on the front line at the Chosin Reservoir during the Korean conflict.

Dr. Lander maintained a family practice from 1953 until his death. He was to have seen patients the Monday after his death.

His titles at Bryn Mawr Hospital included chief of family practice, staff president, hospital representative to the American Medical Association and a member of the hospital's executive committee.

Dr. Lander was active with the Montgomery County Medical Society since 1954 and served as president of the Pennsylvania Medical Society in 1990.

He was preceded in death by his wife of 63 years, Nancy Bomberger Lander.

Surviving are sons John B. Lander, William P. Lander and David W. Lander; 13 grandchildren; and five great-grandchildren.

Services were held Thursday, January 12, at Church of the Good Shepherd, Bryn Mawr.

***

Richard Lawrence Wechsler, MD, 93, died Friday, January 13, 2017.

Dr. Wechsler graduated in medicine from the University of Pittsburgh. After finishing medical school, he turned down a chance to work with Dr. Jonas Salk and instead worked with pioneering transplant surgeon Dr. Thomas Starzl.

Dr. Wechsler practiced internal medicine and gastroenterology and was the first local doctor to perform endoscopies. He also was an early adopter of performing regular cancer screenings.

He was preceded in death by his wife, Marjorie Wayne Wechsler.


Services were held Monday, January 16, 2017, at Ralph Schugar Chapel Inc., Shadyside.
Medical Review Officer Training
(Special CME Programs)

Comprehensive MRO Training including Hair, Sweat, Oral Fluid, Alcohol Testing, and AAMRO Certification Exam (Friday–Sunday)
21.75 CMEs provided by AAFP, AMA Category 1 credits

Washington, DC April 7–9, 2017

NEW! Advanced Comprehensive MRO Training and Certification Exam (1.5 Day Program—Certified MROs only) (Saturday–Sunday)
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Washington, DC April 8–9, 2017

Thank you for your membership in the Allegheny County Medical Society

The ACMS Membership Committee appreciates your support. Your membership strengthens the society and helps protect our patients.

Please make your medical society stronger by encouraging your colleagues to become members of the ACMS. For information, call the membership department at (412) 321-5030, ext. 110, or email membership@acms.org.
Meet your 2017 ACMS president: David J. Deitrick, DO

David J. Deitrick, DO, will be recognized as the 152nd president of the Allegheny County Medical Society (ACMS) at the ACMS Foundation Gala Saturday, March 4, at Heinz Field East Club.

Dr. Deitrick’s father, the late Richard E. Deitrick, MD, served as ACMS president in 1988. This is the first time in ACMS history that two generations have served as president of the society, creating a family legacy of physicians dedicated to organized medicine.

Dr. Deitrick grew up in Scott Township. He played football at Canevin High School for four years and graduated as the fifth leading wide receiver in school history. Dr. Deitrick received his undergraduate degree from Villanova University and graduated from the Kansas City University of Medicine and Biosciences in Kansas City, Mo., in 1993. He completed an internship at St. Francis Hospital in Pittsburgh and his residency at Bridgeport Hospital in Bridgeport, Conn., before returning to Pittsburgh in 1997.

Dr. Deitrick previously served as the division director for University of Pittsburgh Physicians Women’s Health in the Department of Obstetrics, Gynecology and Reproductive Sciences at UPMC Mercy Hospital and was chairman of the Department of OB/GYN at UPMC Mercy. He is currently a member of Jefferson Women’s Health and is on the staff of Jefferson Hospital of Allegheny Health Network.

Dr. Deitrick recently talked about what inspired him to become a physician and the influential role his father played in his life and shared an inside look at his own hobbies and family.

Dr. Deitrick, what inspired you to become a physician and why did you choose the specialty of obstetrics and gynecology?

My dad inspired me to pursue a career in medicine. He was my hero and a man that I looked up to my entire life. When I was in medical school I thought I wanted to pursue neurosurgery, but after I fulfilled a month of my obstetrics rotation I realized how awesome the specialty was and understood why my dad enjoyed it so much. He was an inspiration to me, not only to become a physician, but also to become an obstetrician/gynecologist.

You had the opportunity to practice with your father for many years. What was that experience like?

When I was finishing my residency in Connecticut, I was offered a position, but I never considered staying there. I always knew I wanted to return to Pittsburgh to practice medicine. I had the good fortune of practicing with my dad and being his partner for 12 years before he retired. He became my mentor on so many levels.

Your father was a past president of the ACMS, and you continue that family legacy by serving as the 152nd president of the society. What does organized medicine mean to you?

I was in college when my father became president of ACMS, but I knew that I wanted to go to medical school. I remember being at his inauguration ceremony and thinking to myself that this was a pretty important thing for physicians to be a part of. Back in those days everybody was in private practice and you really needed the camaraderie within and outside of your specialty that organized medicine provided.

It was evident to me that organized medicine was very essential and important in the everyday life of physicians years ago. It was inbred into me that you have to be active in organized medicine, and I knew that it was going to be a big part of my professional career.

I joined ACMS when I was a first-year medical student and became introduced to the House of Delegates shortly after I moved back to Pittsburgh to practice in the late 1990s.

You were a member of the Pennsylvania Medical Society Political Action Committee (PAMPAC) Board of Directors for five years. Please tell our readers what it was like to serve in that capacity.

Participating on the PAMPAC Board was probably the single most import-
ant role that I have ever had within organized medicine up until this point. I was thrust into that position due to the unfortunate and untimely passing of Dr. Richard Harris, who had two years left on his term as a PAMPAC Board member. His passing was a huge loss for the medical community and organized medicine because he was such an energetic and dynamic force.

I was relatively new to ACMS and was getting involved with the House of Delegates at the time when I was nominated to finish serving out his term. I was then re-elected to serve my own three-year term on the PAMPAC Board.

Fulfilling that position helped me to connect with a lot of people within the medical community, and made me realize how important the society is at helping to shape policy, especially at the legislative level. Serving on the PAMPAC Board was a lot of fun and a huge learning experience.

You have integrated your involvement with organized medicine within the roles that you have filled at the hospital level over the years. How have you accomplished that?

I had the privilege of serving as chairman of the Department of OB/GYN at UPMC Mercy, as well as division director for University of Pittsburgh Physicians Women’s Health in the Department of Obstetrics, Gynecology and Reproductive Sciences at UPMC Mercy before transitioning to Jefferson Hospital.

During my time at Mercy, I always shared what was happening at the medical society during our department meetings. This was a practice that my father started when he was chairman of the department, and one that I continued after he retired.

There was always a spot on the agenda where we presented ACMS

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updates to attendees. It was a nice way to keep all physicians, members and non-members alike, informed and engaged. It was an opportunity to reinforce that the medical society works for all physicians, while encouraging non-members to join the society and become part of the united front.

What are some of the issues that you would like to address during your presidency?

My mantra this year as president is engagement and relevance. Our focus as a society is not only to attract young people, but also to keep them involved and engaged throughout their professional career.

The society does a good job of getting medical students, residents and fellows engaged and provides them with a platform to let their voices be heard, whether it is at the ACMS Board meetings or the House of Delegates meeting in Hershey. The challenge is to keep them engaged and involved in organized medicine as they get older. The other big challenge is engagement of employed physicians, and that is where the other part of my mantra comes in – relevance.

The more relevant we are within the physician community, the more significant we will be within the general community, too. The society needs to continue to be a trusted and familiar voice on issues that affect the health and well-being of people in our community, such as issues related to fracking, e-cigarettes, or the opioid epidemic. By staying relevant within our community, we continue to remain so among physicians, especially non-members of the society, and vice versa.

Tell me a little bit about your family.

My wife, Gretchen, and I grew up about a mile and a half from each other, but we did not meet each other until we were both freshmen at Canevin High School. We met at a freshmen mixer the first weekend of high school and eventually started dating.

We went to different colleges, but our relationship continued. Gretchen attended graduate school at the University of Pittsburgh while I was in medical school. We got married shortly after I finished medical school and then we moved to Connecticut while I completed my OB/GYN residency.

Gretchen and I currently reside in McMurray and have three sons, Adam, Nathaniel and Benjamin. Adam is 19 years old and is a sophomore at Allegheny College in Meadville. He is studying English with a focus in creative writing and a minor in economics. Nathan is 17 years old and is a senior at Peters Township High School. He will be attending Villanova University, my alma mater, in the fall and plans to major in astrophysics and planetary sciences. Our youngest son, Ben, is 14 years old and is in eighth grade at St. Louise de Marillac. He will be a freshman at Peters Township High School next year and is considering running track and playing football.

What are your interests or hobbies outside of medicine?

My big hobby is coaching football. I have been coaching football for about 10 years at St. Louise de Marillac and have been the head JV coach and offensive coordinator for the past several years. We have not lost a game in two years and have been JV Diocesan champions for two consecutive years. I also coached boys’ basketball at the school for several years. In addition to coaching, I enjoy music, especially from the Woodstock Era, and history.

Do you have a final message for the ACMS membership?

We need to continue to spread the message about the importance of being part of organized medicine to the non-members of the society and to continue to be relevant among the physician and patient community.

I am dedicated to continuing the work of my predecessor, Dr. Larry John, and to continue to make ACMS as visible as possible within the region via the local media outlets and through other avenues to help reinforce the fact that the medical society advocates for patients and physicians within Allegheny County every single day of the year.

Ms. Morton is a communications consultant. She can be reached at cmorton@acms.org.
I was accompanying a family member on an appointment and was sitting in the waiting room right next to the check-in window. Directly across from me, a woman was filling out forms and reviewing the medical history provided to her by the office when she arrived. Suddenly, she was at the window. And because I was sitting right there, I heard every word.

“I have a problem,” she said. “This isn’t me!”

The woman assigned to the front desk stared back at her but said nothing. The patient continued. …

“That’s my name and info, but there’s stuff listed on here that I’ve never had and that shouldn’t be here. Look … ‘anemia, advanced sexual dysfunction, hypertension …’ I’ve never been diagnosed with any of that stuff! This is all wrong.”

The employee at the window remained expressionless. She glanced at the print-out handed to her by the patient for just a moment then immediately handed it back to her. What she said next almost knocked me out of my seat.

“Well … that’s what’s in there.”

Then, nothing.

The patient was too upset to be appalled (as I was) at the employee’s total lack of empathy or concern. Instead, she pressed on. “OK, but how does stuff that’s not true end up in my medical record? That’s what I’m concerned about! Some kind of mistake has been made.”

“Well,” the employee monotonously replied, “just put a line through the stuff that’s not true before you turn it in.”

The patient’s shoulders fell. “OK,” she resigned.

I can say without hesitation that this employee should be removed from this role immediately. There are a variety of failures that occurred during this interaction. If this were simply a process issue – the employee didn’t know how to address the patient’s concern or answer her question – that can be fixed with training.

But there’s a bigger problem. This employee didn’t recognize the distress in the patient and didn’t hear her primary concern, which was that somehow her personal data had been corrupted. At no time did the patient’s concern trigger a moment of empathy or reflection on what it would feel like to have something like this happen to you … the fears it would provoke, the layers of concern it would trigger. She didn’t apologize, didn’t express equal concern and didn’t reassure the patient that she would look into the problem. In fact, the employee took no ownership of the problem whatsoever. There may be real data error in need of fixing that may or may not be called to anyone’s attention.

This is something that training cannot fix.

We have an obligation in health care to ensure that those men and women who sit in patient-facing roles are dedicated problem solvers who possess a service mindset. They also must possess the requisite affect and empathy to meet patients where they are, day in and day out.

Seeing this interaction play out reminded me of one of the great human resources adages that holds as true today as it ever has before:

Hire for personality. Teach skills.

Joe Mull, MEd, 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.
Preparing for the ‘repeal’ of Obamacare

BETH ANNE JACKSON, ESQ.

With repeal and replacement of the Affordable Care Act (ACA, f/k/a Obamacare) high on the agenda for President Trump’s administration and the Republican Party, physicians are once again thrown into a state of uncertainty for their practices and their patients. Despite the president’s call for quick action on the subject, it will likely take some time for a consensus on “repeal and replace” to develop, let alone actually pass as legislation that the president is willing to sign. Nevertheless, physicians can and should take steps now to prepare for the unknown:

• Don’t panic. Industry experts anticipate that any replacement could take two to four years to become fully implemented. Disruptions in health insurance markets could occur in the meantime, however, and if significant, preclude an orderly transition.
• Stay informed as the process unfolds. Understand proposals and amendments and assess how they could affect your practice and your patients.
• Don’t be silent. Let your U.S. senators (Sen. Casey and Sen. Toomey) and your representative in the House know what aspects of the ACA you think are important to maintain or repeal. Consider also writing to members of committees responsible for health care and sponsors of any proposed legislation.

1. Know and understand the formal positions of organizations that you belong to. Speak up if they’re not addressing your concerns and priorities.

On a more practical note, take these active steps to prepare and protect your practice:
• Continue to work toward compliance with MACRA (the Medicare Access and CHIP Reauthorization Act of 2015), the Medicare reform law that repealed the Sustainable Growth Rate (SGR) formula. MACRA is not on the table at this point, and little is known about the new administration’s policies on health information technology requirements.
• Review your policies and procedures for confirming benefits and co-payments now. Does your staff confirm coverage before a patient arrives at the office for services every time? Coverage may change quickly if the ACA marketplace fails, so confirmation of coverage (including any pre-existing condition exclusions, which could make a comeback) and the required co-payment and co-insurance for every visit will be essential.
• Assess your patient population: How many are on ACA plans? If they were unable to obtain comparable replacement coverage, what would the financial impact on your practice be? Review with your accountant and/or financial adviser your professional and personal expenditures and how they could be adjusted if the impact is potentially significant.
• If you and your staff are on ACA marketplace plans, explore your options for opportunities for group coverage (e.g., through professional organizations such as ACMS).

Now is not the time to sit back and hope that any repeal and replacement of the ACA will occur in an orderly manner without disrupting, at least to some degree, the health care and health insurance markets. Being informed, outspoken, proactive and prepared can help you weather any adverse effects that the upcoming legislation may have on your practice.

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Legal Summary

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

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

Reportable Diseases
Allegheny County Health Department
Quarterly (Q) Selected Reportable Diseases

<table>
<thead>
<tr>
<th>Disease*</th>
<th>2014 Q1-4</th>
<th>2015 Q1-4</th>
<th>2016 Q1-4**</th>
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*Case classifications reflect definitions utilized by CDC Morbidity and Mortality Weekly Report.
**These counts do not reflect official case counts since current year numbers are not yet finalized. Inaccuracies in working case counts may be due to reporting/investigation lag.
*** Seasonal flu seasons run from MMWR Week 40 to MMWR Week 39 in overlapping years; e.g., the 2015-16 flu season ran from Sunday, October 3, 2015 (Week 40) to Saturday, October 1, 2016 (Week 39).

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.
Pimavanserin (Nuplazid®) is the only FDA-approved atypical antipsychotic indicated for the treatment of hallucinations and delusions associated with Parkinson’s disease psychosis (PDP). It is known to act as an inverse agonist and antagonist of serotonin with high affinity for 5-HT$_{2A}$ receptors and low affinity for 5-HT$_{2C}$ receptors. The mechanism of action of pimavanserin is unique compared to other atypical antipsychotics because it does not bind directly to dopamine receptors and therefore is not associated with impaired motor function.1

Safety

Pimavanserin carries a Black Box Warning for increased all-cause mortality in older adults with dementia-related psychosis with the most common causes of death being cardiovascular or infectious in nature.1 This Black Box Warning exists as a class effect for all antipsychotics and was not specifically shown in the clinical trials for pimavanserin. As a result, pimavanserin is not approved for the treatment of patients with dementia-related psychosis unrelated to Parkinson’s disease.1

Pimavanserin carries a risk of QT interval prolongation with studies showing the maximum mean change from baseline of the QTc interval being roughly 5-8 msec in patients receiving therapeutic once-daily doses.2 This mean change in baseline is low in comparison to the average baseline changes of ziprasidone (10 msec) and iloperidone (9.1 msec) at therapeutic doses, which are the two atypical antipsychotics associated with the highest risk of prolonging QTc intervals.3,4 Clinical trials did not report any cases of Torsade de Pointes with pimavanserin, but it should still be used cautiously in patients with a history of underlying increased risk of QTc prolongation due to other medications or comorbid conditions to avoid sudden cardiac death.1,2

Pimavanserin is primarily metabolized by the enzyme CYP3A4 and therefore associated with numerous drug interactions. Concomitant use with strong CYP3A4 inhibitors, such as azole antifungals and macrolides, is associated with a 1.5-fold increase in maximum concentration (C$_{max}$) and 3-fold increase in overall drug exposure (AUC), which can increase the risk of experiencing adverse drug events.1

Use is not recommended in patients with severe renal impairment (CrCl < 30 mL/min) or hepatic impairment since these patient populations were not included in clinical trials.1,5,6 Avoiding use in severe renal impairment is unique to pimavanserin since the majority of atypical antipsychotics (except for luraside, paliperidone and risperidone) can be used regardless of renal function.

Efficacy

In a randomized, double-blind, placebo-controlled, phase 3 clinical trial, Cummings et al. studied patients aged ≥ 40 years old with PDP taking either pimavanserin (n=95) or placebo (n=90).5 The primary outcome was the change in total Parkinson’s disease-adapted Scale for Assessment of Positive Symptoms (SAPS-PD) score from baseline after 43 days of treatment. SAPS-PD is a tool used to assess changes of positive symptoms in patients with PDP, and a negative score indicates improvement. After the treatment period, the change in SAPS-PD score from baseline between the pimavanserin-treated group and placebo-treated group was -5.79 and -2.73, which equates to 37 percent versus 14 percent clinically significant improvement (CI -4.91 to -1.20; p-val-
In another randomized, double-blind, placebo-controlled phase 3 clinical trial, Meltzer et al. studied patients with PDP and a psychosis severity score of ≥ 4 as measured by the Neuropsychiatric Inventory (NPI) being treated with either pimavanserin (n=29) or placebo (n=31). After day 28, the SAPS-H (SAPS hallucination) score decreased from 10.8 to 7.6 in the pimavanserin-treated group compared to the placebo-treated group whose SAPS-H score decreased from 11.6 to 10.5, although the change was found to be insignificant. There was a significant decrease in both auditory and visual hallucinations in the pimavanserin-treated group compared to the placebo-treated group (LS mean difference -0.68 and -0.36; CI -1.75 to 0.67).

**Price**

A one-month supply (60 tablets) of pimavanserin costs roughly $2,000. Acadia-Pharm offers a payment assistance program, NUPLAZIDconnect, where patients can obtain a 30-day free trial at the initiation of therapy, depending on the patient’s insurance.

**Simplicity**

Pimavanserin is taken orally as two 17mg tablets once daily with or without food and does not require dose titration. Dose adjustments are not necessary for decreased renal function. Taking two tablets per dose could increase pill burden for patients, but once daily dosing is advantageous for compliance.

**Bottom line**

Pimavanserin is the first medication FDA-approved for the treatment of hallucinations and delusions associated with Parkinson’s disease psychosis taken as 34mg orally once daily. Its mechanism of action is very unique to all other antipsychotics because it does not bind to dopamine receptors and thus has not been shown to worsen motor symptoms in clinical trials. Although there is limited data assessing its safety and efficacy, current evidence shows that pimavanserin is generally well-tolerated and effectively decreases the frequency and/or severity of hallucinations and delusions in patients with PDP. Long-term studies are currently being conducted to assess the safety and efficacy of pimavanserin for extended use.

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Medication-assisted treatment (also called MAT) is defined by the Substance Abuse and Mental Health Services Administration (SAMHSA) of the U.S. Department of Health and Human Services as the use of pharmacological medications, in combination with counseling and behavioral therapies, to provide a “whole patient” approach to the treatment of substance use disorders. It is a standard of care for opioid use disorders. The amount of scientific evidence about the effectiveness of MAT is sufficient for SAMHSA to state that it reduces drug use and overdose rates and helps retain people in treatment longer, factors that are associated with better recovery outcomes. MAT also reduces criminal behaviors and infectious disease risks.

This position statement is designed to clearly communicate the position of the Allegheny County Department of Human Services (DHS), the Allegheny County Health Department (ACHD), Community Care Behavioral Health Organization (Community Care) and Allegheny HealthChoices, Inc. (AHCI) with regard to the use of medications to treat opioid use disorders. Currently, FDA-approved medications to treat opioid use disorders include methadone, buprenorphine (commonly combined with naloxone and known by its brand name, Suboxone®) and naltrexone (commonly known in its extended-release injectable brand-name form, Vivitrol®). Methadone and buprenorphine reduce cravings and withdrawal symptoms; naltrexone blocks the effects of opioids so that people will not get intoxicated/high or overdose if they use heroin or prescription opioids. When taken as prescribed, these medications do not cause the intoxication associated with opioid misuse and can help individuals improve their functioning in everyday life.

In keeping with our organizational missions and in the best interest of those seeking treatment and/or recovery, the following represents our key positions on MAT for opioid use disorders.

A person can initiate and sustain recovery using MAT.

The SAMHSA Principles of Recovery quite clearly state that there are many different pathways to recovery and that each individual has the right to determine his or her own way. We honor and adhere to these principles.

Treatments for opioid use disorder that do not include medication have worked for many, but not all, individuals over the years. Because of the growing body of science in recent years, there are more options available to individuals seeking treatment than ever before. There is a misconception among some providers, policymakers and members of the public, including people in recovery, that only treatments that avoid the use of medications, or “drug-free” treatments, are best. This belief is not supported by research and what is known to be effective. We do not believe that one must be free of all medications in order to initiate and sustain recovery.

Everyone who enters behavioral health treatment for an opioid use disorder should be informed of all available treatment approaches in a factual, objective manner.

Our goal is to have a network of mental health and substance use disorder treatment providers with shared values, including the belief that educating clients about MAT and actively assisting them to utilize MAT (when clinically appropriate) affords the best opportunity for sustained recovery. Providers may directly provide MAT or coordinate with those who do; either way, the ultimate goal is to assist the individual to choose the approach that offers the best path to recovery.

We recognize that there are valid reasons why people with an opioid use disorder may not choose a MAT approach. Not everyone may benefit from MAT, and even those who might benefit may choose not to pursue that option. But the decision to initiate MAT, the particular medication selected and the length of treatment are decisions most appropriately reached by individu-
als in consultation with their doctor and
treatment team, based upon clinical and medical history, needs and circumstances, and response to treatment.

The appropriate MAT approach and type of medication used will vary by individual, depending upon the individual’s clinical picture, life situation, and treatment and recovery goals. Each medication works differently, has different side effects and risks, and is delivered in different health service locations (e.g., daily clinic visits, weekly visit to a counseling center, routine medical appointments with a physician). Similarly, length of MAT treatment is dependent upon a number of factors (e.g., individual’s choice to continue or terminate treatment, severity of symptoms, complexity and comorbidity of physical and mental health conditions). Those with a less severe opioid use disorder may benefit from a shorter course of medication, while those whose opioid use disorder has progressed to a chronic condition may need to continue using medication for many years or even, as do those with other chronic diseases, for the rest of their lives.

Use of medication alone is not the same as use of medication in conjunction with counseling treatment.

There are significant differences between using these medications on one’s own, as prescribed under the care of a doctor who is concerned about an individual’s well-being and recovery, and as prescribed by a physician as part of a comprehensive treatment plan combined with counseling. While there are some who may benefit from the use of medication only, prescribed by a physician, we take the position that there is sufficient evidence to suggest that combining medications with counseling is the best initial approach to treating opioid use disorders.

Whereas it has become increasingly common for people to secure non-prescribed medications from a peer or on the street, this is illegal (even if intended to be used to treat the symptoms of withdrawal) and contraindicated by treatment standards and recovery approaches, and may contribute to the risk of a future overdose.

Treatment providers who do not offer MAT as an option cannot be considered evidence-based providers.

Every individual has the right to choose whether to use MAT, given full understanding of its potential risks and benefits. A provider who does not offer this treatment option, including a discussion of its potential benefits, is not offering quality, evidence-based treatment.

No limitations should be placed on the provision of medical care or human services because an individual is receiving MAT.

As recognition of opiate addiction has grown, so has the need to recognize opiate addiction as a disease, requiring specialized treatment and intervention. A continuum of clinical and non-clinical supports and services is available to individuals who are working to achieve recovery, including peer-based recovery support services. Unfortunately, a negative bias toward individuals receiving MAT may exist when it comes to provision of services such as housing, residential services and/or certain outpatient mental health treatment or support services. We maintain that an individual’s choice to use MAT should not limit his or her access to other services.

Nobody should be penalized or taken off MAT because of involvement with the criminal justice system.

The decision to initiate and sustain recovery using MAT, as well as the decision to discontinue using MAT, is a medical decision made by an individual, a clinical team and a doctor. Discontinuation requires careful planning to ensure adequate treatment and ensure adequate treatment with a focus on recovery, overdose prevention and risk reduction. Criminal justice professionals are entitled to information about the individual’s progress; however, it is never acceptable to order discontinuation of MAT as a condition of court supervision. Furthermore, federal funding for drug courts should be contingent upon the drug court utilizing MAT when clinically appropriate.

Organizations with position statements in favor of the use of MAT to treat opioid use disorder include:

• National Association for Drug and Mental Health Service Administration (SAMHSA): http://www.samhsa.gov/medication-assisted-treatment
• National Center on Addiction and Substance Abuse (CASA): http://www.centeronaddiction.org/newsroom/position-statements
• National Association for Drug Court Professionals (NADCP): http://www.nadcp.org/sites/default/files/nadcp/NADCP%20Board%20Statement%20on%20MAT.pdf

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• Broken No More (formed by families and friends of those suffering from addiction) http://broken-no-more.org/resources/treatment/
Other resources about MAT:
• NIATx: “Getting Started with Medication-assisted Treatment” http://www.niatx.net/PDF/NIATx-MAT-Toolkit.pdf
• Allegheny HealthChoices Inc. Medication-Assisted Treatment Service Locator: http://www.ahci.org/mat/

References

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The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) sunset the PQRS, Value-Based Modifier (VM) and Medicare EHR Incentive programs Dec. 31, 2016. The new Quality Payment Program includes two paths: the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs). Most Medicare clinicians will initially participate in the Quality Payment Program through MIPS.

As part of a contract with the Centers for Medicare & Medicaid Services (CMS), Quality Insights provides free support to MIPS eligible clinicians in the two tracks of the program: MIPS and APMs.

Participants in this Quality Insights initiative receive tips, tools, resources and up-to-the-minute information about the program. Additionally, Quality Insights provides education and resources as well as access to free MACRA/MIPS learning modules created by CMS that can be completed for CME/CEU credit.

Check out the new MACRA/MIPS Quality Payment Program initiative on the Quality Insights website (www.qualityinsights-qin.org) for resources, links and CMS materials designed to help clinicians, practice managers, administrators and other office staff transition to value-based payment. Webinar recordings and slide decks also are available in the Event section.

Learn more about how Quality Insights can help your practice transition to the new Quality Payment Program. Contact Lisa Sagwitz at lsagwitz@qualityinsights.org or call (412) 655-7356 to get started.

About Quality Insights

As the Quality Innovation Network-Quality Improvement Organization (QIN-QIO) for Pennsylvania, New Jersey, Delaware, West Virginia and Louisiana, Quality Insights is committed to collaborating with providers and the community on the Centers for Medicare & Medicaid Services’ goals of better health, smarter spending and healthier people. Our data-driven quality initiatives improve patient safety, reduce harm and improve clinical care locally and across the network. To learn about Quality Insights’ health care quality improvement initiatives, visit www.qualityinsights-qin.org.

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As this Republican Congress works with the President to tackle the issue of healthcare cost and coverage, it is important that we don’t repeat the mistakes from eight years ago. We must prioritize getting it right over getting it done quickly. If we want to lower the cost of health insurance for American families, we have to lower the cost of healthcare - this requires identifying the sources of the high cost. Consider: five percent of Medicaid patients account for 55% of all Medicaid costs; a Kaiser study found 10 percent of patients account for two-thirds of healthcare costs in our nation; recently, Maryland identified $37 million in healthcare dollars were spent on just 500 patients. Some of these patients have chronic complicated diseases, some have short-term needs such as a pregnancy. Ultimately, all need healthcare, but care doesn’t have to cost the patients, the government or employers as much as it does today.

Many patients are “over utilizers” in that they use a lot of expensive healthcare services because they have health conditions that could have been prevented or are complicated from poor-quality treatments. Merely increasing copays and deductibles, which occurred under the Affordable Care Act (ACA), won’t prevent a patient from being taken to an emergency room or be hospitalized for serious problems; in fact, higher copays and deductibles are often barriers for these patients to receive the care that would have prevented the emergency department visit.

Instead of charging patients more for treatment when they have health problems, we should pay healthcare providers to help patients stay healthy and manage their health problems more effectively. One major opportunity for doing that is to break down the payment walls between physical and behavioral medicine and enable physicians to deliver better-coordinated, patient-centered care integrating physical and behavioral medicine.

Seventy-four percent of patients with a mental illness have at least one chronic health condition, 50 percent have two or more. New evidence shows that schizophrenia alone, often in the absence of other known diabetes risk factors, is associated with a significant risk of diabetes. Thirty-three percent of heart attack patients will develop depression, and similar links have been found between depression and cancer, stroke, chronic pain, hypothyroidism, and arthritis. Failing to treat both depression and the physical problem in a coordinated way doubles the total cost of
care. Studies consistently show a savings that run between 20 and 50 percent for over utilizers under an integrated/coordinated model of care.

For example, rather than assuming a patient with diabetes needs help only from an endocrinologist, some primary care physicians proactively screen newly diagnosed patients for depression followed immediately with a referral to a mental health professional when appropriate. Additional complications (thus, additional costs) can be prevented and treatment compliance increased with this proactive, integrated approach to care. In like manner, doctors who treat patients with chronic back pain and diagnose alternative pain management strategies saw a 30 percent reduction in spine surgery.

There are many other examples around the country in which proactive care management has helped patients with asthma, cancer, heart disease, Inflammatory Bowel Disease, chronic migraine, and other conditions to receive better care at lower cost. To be effective, physicians, nurses, psychologists and other medical professionals need the flexibility to have phone, email and other communications between providers and patients to address patients’ questions on symptoms and medications as expeditiously as possible. Unfortunately, Medicare, Medicaid, and many health plans don’t pay for these high-value services, and they end up spending more to treat problems after they occur.

There are also federal policies that prevent sharing the information that could help ensure patients receive the treatments they need. For example, the opioid crisis in this country has taken too many lives. By law, a physician is often totally blind to any history of the patient’s addiction disorder or treatment because of federal regulations 42 CFR Part 2. While listing of drug allergies, for example, is allowed, the federal regulations prohibit opioid addiction data from the medical record without signed permission for each disclosure to each provider. The physician is often unaware and cannot coordinate care with the addiction counselor and a patient leading to errors such as prescribing of opioids that result in a relapse and in some cases death.

Access to health insurance coverage is a hollow promise if that insurance isn’t affordable. We need to make major changes in our current fee-for-service payment system and regulations that will enable more coordinated and integrated care for all of our citizens, rich and poor, young and old. Reforming healthcare payment and delivery, as well as insurance, will prevent many tragedies while also saving our nation’s health care system $500 billion dollars over the next decade.

Tim Murphy, a Republican, is a U.S. representative from Pennsylvania and a psychologist in the Navy Reserve Medical Service Corps.
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