Macranomics: Advanced Alternative Payment Models

Environmental exposures and human disease
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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Dr. Ivanova is a fellowship-trained, board-certified cardiologist with specialty expertise in noninvasive cardiology, cardiovascular disease, echocardiography, cardiac imaging, nuclear stress cardiology, aortic disease, heart valvular disease, arrhythmias, atrial fibrillation, hypertension, carotid artery disease and peripheral vascular disease. She diagnoses and treats adult patients with cardiovascular disease.

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Dr. Ivanova has medical staff privileges at Allegheny General Hospital and is welcoming new patients.

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412.359.5822

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Control

Deval (Reshma) Paranjpe, MD, FACS
Medical Editor

Let us go then, you and I,
When the evening is spread out against the sky
Like a patient etherized upon a table;  
-T.S. Eliot,
The Love Song of J. Alfred Prufrock

“I really love you,” said the patient to the anesthesiologist, as she fell under the spell of IV sedation, while her husband looked on and cracked up.

Another patient, mid-cataract surgery and completely agitated under IV sedation, begged the question: “What’s wrong? What’s the matter?”

“WHERE’S MY DOG?!?!”
“He’s at home. He’s safe.”
“Oh,” she said, and went to sleep.

I also remember a Jekyll-and-Hyde VA patient who was as polite and kind as could be, until the IV sedation started. Then, he became verbally abusive and hurled every horrid racial slur he could find at all of the OR staff – and all the OR nurses were African-American, and his two surgeons were Indian-American. On waking, he remembered nothing, smiled benignly, and asked: “How did I do?”

Anesthesia, like alcohol, has a lovely way of loosening inhibitions and revealing a person’s hidden nature and carefully guarded secrets. It is truth serum, and it is freedom. It is liberation, and it is escape. It is a surrender at once necessary and dangerous. Many’s the patient who stays up all night worrying about the procedure, to then sleep like a baby through the entire thing, blissfully sedated. Some even enter the OR looking forward to “finally getting a good night’s sleep.” “Waking them up is the tricky part,” say the anesthesiologists.

There are other patients whose stories hit closer to home. The elderly OR nurse, who drowsily insists on knowing if the instruments have been sterilized, and how. And the physician, who watches and critiques every aspect of the experience like a hawk … or who sits there on the gurney in pre-op, stoic and yet quietly terrified.

We are so accustomed to being in control that we violently fear losing that control. Control is relative; while contemplating surgery, we all shuffle through our internal rolodex of myriad simple little problems or mistakes in either anesthesia or surgery, any one of which could make it all go needlessly bad. Ignorance, in many ways, is bliss.

“If I am in control, at least I know that things will be done right. I will watch out for the things I know can go wrong ….” And yet it is the things that we cannot control that we fear most. Surgeons universally fear going under anesthesia; I’m guessing that many anesthesiologists also may fear undergoing surgery. Both have seen bad things happen on both sides of the IV tubing for no good reason and without warning. The X factor, as one surgeon friend calls it, is the thing we cannot control and the thing we cannot predict – the thing that we fear the most. The Bogeyman. The ghost in the machine.

Control is central to our identity as physicians. We chose the profession of medicine not only just to help our fellow human beings. On a personal level, consciously or subconsciously, we gravitated toward this field because it offered us a sense of some control over illness, disease, disability and death. We may not always win, but medical training has at least given us the knowledge and the skills to recognize these scourges and fight them. Medicine is a way for us not to feel helpless and a way to ensure others are not helpless.

Control is a good thing. It is why we do pre-op planning: measure twice, cut once. Control is why some of us worry about physicians who did their training after the work hour rules were in place. Will they have the same experience as we do? The same stamina? The same discipline and devotion and determined mindset? The common punchline is: “And these are the people who are going to be taking care of us.” (Hopefully, they will be control freaks just like we are.)

Control is essential to good medicine. It is why we resent and argue with administrators telling us what to do without adequate knowledge or experience of the clinical situations. It is why we resist the legislation of medical care by those who have never prac-
ticed medicine. It is why we have protested quacks and charlatans and snake oil salesmen for centuries. Control over the integrity of the practice of medicine – resisting the influence of business and legislators and the almighty dollar – is key to our identity as physicians.

Organizing physicians is indeed like herding cats sometimes – our personalities are independent and autonomy is our oxygen. We like high perches and a good vantage point. Some of us have a degree of beneficial OCD and all of us, in some way, are control freaks – mostly in a good way. If we can simply figure out ways to channel that need for control that unify all of us into the national voice of medicine, we will be fortunate indeed.

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

Joseph C. Paviglianiti, MD
Associate Editor

My wife of 20 years secretly rejoiced when the Pittsburgh Tribune-Review stopped publishing their hard copy version Nov. 30, 2016 (another end of an era, I told my kids), in favor of an online-only edition. Whenever she feels I may not be listening or paying attention to what she is saying, she usually finds my nose buried in the daily paper, pretty much reading it cover to cover (sports first … this is Pittsburgh, for Pete’s sake). She knows I love her with all my heart, but the idea of having to share my limited physical and emotional support presence, not only with our kids, but with a newspaper, sometimes irks her. We had just gotten rid of cable four months earlier, the process of which I could write a separate, multi-volume, stand-alone editorial series about. Suffice it to say that it may be “easier for a camel to go through the eye of a needle than for a rich man to enter the kingdom of God,” (Matthew 19:23-26), but downsizing cable may be even more difficult, if even unattainable.

While I have not missed the talking heads and political spin, after two months of news deprivation, and craning my neck to catch glimpses of the presidential inauguration on my patients’ hospital room televisions, we relented and are back to a hard copy of the newspaper. Unfortunately, the news has not improved during our self-imposed media blackout. Until today.

I have been searching for some inspiration to write my first editorial for the Bulletin for weeks. I knew I wanted to write about the idea of trying to elevate ourselves; to become the extraordinary people that we were intended to become. That has been an idea that has occupied a lot of our family’s free time over the last few months, as my oldest child labored through his Common Application for college. Who knew that essays counted so much toward one’s future? Describe in 500 words how you have been a leader in the community. In 450 words, describe three things you can do right now to make the world a better place. In 750 words, what makes you “extraordinary?”

Now, my 18-year-old son is a good kid, but I do not think he has had much time to develop into a leader, much less even scratch the surface of being extraordinary. But what about me? I have logged well over 50 years on this planet and am on the downward slope of life. Am I “a leader?” Am I “extraordinary?” Am I the total person that God (or whatever your faith perspective is) wanted me to become? Most importantly, what do I need to do in my remaining years here on Earth to fulfill “my mission” to have made this world a much better place than I found it?

Lately, I have been asking myself that a lot, not always pleased with my own self-review.

I finally found my inspiration, both in the looming deadline for this editorial and in today’s sports page of the Post-Gazette. I was just paging through when I was greeted with an old photo of a very young Sidney Crosby signing a yellow plastic duck for a pediatric patient at a charity event. I know the photo well because a copy of it also has hung in our office for many years. My eyes then moved to a much more moving photo of Mr. Crosby, with some of his Penguins teammates, at the bedside of an obviously ill patient at Children’s Hospital. Smiles are on everyone’s faces, but the biggest grin, actually a look of total glee, is on Crosby himself (great photo, Google it if you get a chance). Sure, many sports stars visit Children’s Hospital annually, and that is a really good thing. They don’t have to, but they do a world of good in a child’s life by turning some of their athletic star power into healing power.

I imagine these “visits” as 20-minute meet and greets to try to cheer up a sick child, and then the athletes get back to their own glamorous lives.

www.acms.org
In “The Unseen Sidney Crosby” article, we are treated to the secret healing life of what Mr. Crosby does afterward: On many occasions, he goes back, after the cameras and journalists have left, and just visits with the child and family. Sometimes, he brings some toys or video games and they just play without the cameras watching. Just him, a sick child, and a very worn out family. No cameras. No obligations. No media spin. No political gain. Just time. Just caring and an immediate love given from his heart to a sick kid. Mr. Crosby is a popular request in the Make-a-Wish world, and he reportedly goes above and beyond when interacting with those who want to meet him, sometimes forging a lifetime friendship. Sometimes, there are multiple visits to the same patient – later, unannounced, in private.

We read of a little Amish boy that Mr. Crosby has taken a particular interest in, but when he returns to visit the child several weeks after their initial encounter, just because he liked him and wanted to visit him again, he discovers that the boy has passed away from cancer. I am sure Mr. Crosby felt a true sense of loss, and my heart aches for him while reading about it.

Throughout the article, we are given myriad examples of when Sidney Crosby actually strikes up friendships with those who can do nothing for him, but he gives of his time, and his heart, quite generously. In private. When no one else is watching. This is the “unseen” Sidney Crosby. Quite remarkable for a 29-year-old guy without children himself.

How can I be more like him? Well, if you ever have seen me skate, you know that won’t be the answer. But, I have been blessed in my own life – differently, but still abundantly. Faith. Family. Freedom. Happiness. Love. I can grow a real beard. All the ingredients are there. It is up to me to continue to try to give back, unceasingly. There are many injustices in this world that need me. That need all of us. How can I be better? How can we as physicians be better citizens of our communities and this nation? While always trying to improve our world one act at a time, we need look no further than our Pittsburgh ice rink. He shoots. He scores. He gives from his heart. Extraordinary!

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Reference
Our region recently was struck by two violent tragedies in less than a week. In Canonsburg, an officer was senselessly gunned down in the line of duty and his partner critically injured while responding to a call during an act of domestic violence. As we have learned from police, the suspect in this case attempted to hurt more individuals by using a failed propane improvised explosive device (IED) hidden in his car. Just 22 miles away in Homestead, a man injured five people at a mental health facility during a mass knife stabbing.

These are just two more incidents added to the growing list of recent local intentional mass injury events (IMIEs) Western Pennsylvania has witnessed. The events are familiar to all of us: the Franklin Regional High School stabbings, the LA Fitness Shootings, the Western Psychiatric Institute and Clinics shootings. Earlier this year, five family members were murdered during a shooting spree in Wilkinsburg.

As of November, our country has experienced 427 mass shootings (where four or more people are injured by a firearm during a single episode) which have claimed 540 lives in the current year. Data from the FBI demonstrates that these incidents are increasing in both their frequency and their lethality. These IMIEs cannot be predicted. There is no predilection for either urban or rural settings. Most troubling is that there is an increasing trend toward the use of weapons other than firearms in the commission of these crimes, such as large vehicles driven into crowds and IEDs, which further complicate how public safety agencies manage these events.

After the tragic shootings on Dec. 14, 2012, at Sandy Hook Elementary School in Newtown, Conn., where 20 children and 6 adults were murdered, a group of high level stakeholders from federal and state government, all sectors of public safety (EMS, law enforcement, fire) and physicians met in Hartford, Conn., and held the first of three meetings on how to improve survivability during mass shooting events. This first meeting of the Joint Committee to Create a National Policy to Enhance Survivability from Mass Casualty Shooting Events (more commonly referred to as the Hartford Consensus) reviewed data from mass shootings from around the country looking for what, if any factors, could be impacted or applied to positively influence survivability. They reviewed data which included law enforcement response time, time to threat suppression, time to EMS arrival and autopsy results. Conclusions drawn from this data contributed to a body of consensus recommendations which was first released in 2013.

The Hartford Consensus identified evidence that there was, in most instances, a delay in hemorrhage control at nearly all mass shooting scenes.
As health professionals know well, a person can bleed to death in less than five minutes. Their conclusion was simple: Early hemorrhage control is critical. The most novel of these recommendations was to actively engage the immediate responders, the uninjured lay public bystanders, who may be in the immediate vicinity of the event and train them in simple bleeding control techniques so that they can be used as a multiplying force to save more lives.

Through the leadership of Lenworth Jacobs, MD, a trauma surgeon at Hartford Hospital in Connecticut near where the Sandy Hook shootings occurred, this work came to the attention of the White House. Subsequently, the initiative evolved into the Stop the Bleed campaign, which was launched from the White House in the fall of last year (https://www.whitehouse.gov/blog/2015/10/06/stop-bleed).

Stop the Bleed aims to educate and train the public to both recognize when life-threatening bleeding is occurring and then how to control it through compression and tourniquet application. Images which have emerged from both the Pulse nightclub shooting in Orlando and the Boston Marathon bombing demonstrate clearly how non-medically trained bystanders applied homemade tourniquets and dressings to injured and severed limbs to effect control of life-threatening bleeding. These actions demonstrate the willingness of the public to engage when the need arises.

Coordinated through the partnership of all trauma centers in our region through the Charles Copeland Regional Trauma Council, and in conjunction with hospitals and emergency medical services across Western Pennsylvania, Ohio and West Virginia, UPMC is helping to lead the delivery of programming that teaches the lay public as well as our law enforcement community these simple and most basic skills. However, training in bleeding control is not enough. The right tools must be positioned strategically so that they

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are available when needed. To fill that need, UPMC has donated $1.3 million dollars over the next three years to place “Bleeding Control Kits” which are packed with topical hemostatic agents, tourniquets and gauze in every public school building and a tourniquet on the belt of every law enforcement officer in Western Pennsylvania. The Jewish Health Care Foundation also has generously committed $100,000 to this important initiative. Our vision is to have these bleeding control kits positioned in publically accessible locations in the same way automated external defibrillators have been. The overall goal of the initiative is to make bleeding control techniques as common a skill as cardiopulmonary resuscitation (CPR), and to promote the mantra of the Stop the Bleed campaign that “everyone can save a life.” No one should die a preventable death from bleeding, and Stop the Bleed is making this goal a reality.

As physicians and health care professionals, we have a responsibility to innovate and lead discussions which result in meaningful public health policy. The problem of IMIEs is a national public health crisis and physician engagement to influence elected leaders toward meaningful legislation designed to enhance the public safety from IMIEs, train first responders and the public in basic bleeding control techniques is essential. Support the Stop the Bleed campaign in Western Pennsylvania. To learn more, visit www.stopthebleedtoday.com. Requests for training and information about implementation in your community are available on the site. Together, we can insure that everyone has the skills to save a life.

The authors are members of the UPMC Stop the Bleed Steering Committee.

Dr. Neal is an assistant professor of Surgery and Critical Care Medicine at the University of Pittsburgh School of Medicine and an attending trauma and general surgeon in the Division of Trauma and Acute Care Surgery at UPMC.

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Mr. Bertoty has a clinical background in emergency nursing and is the clinical director of Emergency and Trauma Services at UPMC Presbyterian Hospital.

Dr. Peitzman is the Mark M. Ravitch Professor of Surgery at the University of Pittsburgh School of Medicine. He is also the past president of the American Association for the Surgery of Trauma and past president of the Panamerican Trauma Society.

*Editor’s Note: Other local hospitals also are participating in the Stop the Bleed initiative, including Forbes Regional Hospital and Allegheny General Hospital.

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Pre-Exposure Prophylaxis (PrEP): A Viable Option to Prevent HIV Infection

Have you talked with your patients about PrEP yet?

PrEP, short for Pre-Exposure Prophylaxis, is a daily regimen of Truvada® (300 mg of tenofovir disoproxil fumarate and 200 mg of emtricitabine) that can reduce a patient’s risk of human immunodeficiency virus (HIV) infection by more than 90%, when taken as prescribed.

Truvada® has been found to be highly protective against HIV and is currently the only FDA-approved medication for PrEP. The Centers for Disease Control and Prevention (CDC) recommends PrEP and has developed guidelines for healthcare providers electing to provide PrEP for the prevention of HIV infection in individuals who have significant risk for acquisition of HIV.

Here are some frequently asked questions that may be helpful as you move forward with prescribing PrEP to your patients:

How do we know PrEP works?
Several studies have shown that PrEP is effective in reducing the risk of HIV:

iPrEx – a randomized, double-blind, placebo-controlled, multinational, clinical trial, evaluated Truvada® versus placebo in 2,499 HIV-negative men and transgender women who have sex with men. iPrEx showed that the protection conferred by Truvada® was 92% in individuals who had detectable drug levels in blood.

Partners PrEP – a randomized, double-blind, placebo controlled trial that looked at the safety and efficacy of Truvada® versus Viread (tenofovir disoproxil fumarate) in serodiscordant couples (one person HIV positive and one person HIV negative). Truvada® reduced the rate of new HIV infections by 75% and Viread reduced HIV infections by 67%. There was no significant difference between Truvada and Viread. Better protective efficacy was achieved with better rates of adherence.

For information on additional clinical trials on PrEP, please visit Project Inform.

Who is eligible for PrEP?
Any individual who is at substantial, ongoing, high risk for acquiring HIV infection either through sexual contact or intravenous drug use. This may include certain gay and bisexual men, transgender persons, sex workers, persons who inject drugs, individuals in a sero-discordant relationship, or anyone who wants an extra level of security when having sex.

What needs to be done before initiating PrEP?
1. Have your patient take an HIV test.
2. Test for acute HIV infection if your patient has symptoms consistent with acute HIV infection
3. Screen for Hepatitis B infection – treat if active infection exists. Truvada® has activity against Hepatitis B infection. Caution should be used prior to discontinuation of Truvada® in individuals with chronic Hepatitis B.
4. Screen and treat as needed for STDs.

Patients must have a documented negative HIV antibody test and a calculated creatinine clearance rate of ≥60 mL per minute (via Cockcroft-Gault formula).

What needs to be done while a patient is on PrEP?
- Every 1-3 months - re-test for HIV, document a negative test result
- After the first 3 months on PrEP – check blood urea nitrogen and serum creatinine. Repeat every six months from that point on.
- If applicable, pregnancy testing every 3 months
- Evaluate and support PrEP medication adherence at follow-up visits
- Every 6 months – test for STDs even if the patient is asymptomatic. Higher risk individuals may require more frequent testing.

What is the cost of PrEP?
Being on PrEP entails costs of medication and follow-up physician visits and lab work. Truvada® is a brand-name drug and, and no generic version is currently available.

Costs for the medication vary depending on a patient’s insurer’s standard copay/coinsurance associated with brand-name drugs. For patients who are uninsured, Truvada® can cost as much as $1,800 per month.

Payment assistance programs can help cover the cost of Truvada®, if the patient is eligible. Please refer patients who do not have health insurance coverage to the Partnership for Prescription Assistance program (1-888-447-2669 or www.pparx.org), or to Gilead’s Medication Assistance Program for PrEP (1-855-330-5479 or www.truvada.com). For patients who have health insurance, please refer them to Gilead’s Co-Payment Assistance Program (CAP) (1-877-505-6986 or www.truvada.com).

To learn more about providing PrEP or referring a patient for PrEP services, please visit www.aidsfreepittsburgh.org or www.preppgh.com (PrEP provider directory)
One of the most enjoyable aspects of an academic medical career is the interaction one has with medical students, residents and fellows. I was always impressed with the enthusiasm of these bright young physicians in training. Further, I frequently found their questions a stimulus for further learning on my part. One day, a student, who was doing a radiology rotation with me, asked about a spine trauma issue on which I recently had published a paper. I invited her back to my office to get her a reprint. I pulled open a long file drawer where I kept the reprints of my publications, and as I began looking for the paper in question, she asked, “Are those all your papers?”

“Yes,” I replied.

“How many have you had published?”

“Oh, somewhere around 150.”

She paused for a few seconds and then asked, “Of all of those, how many really made a difference?”

Her question took me by surprise. I would have liked to have said that they all did, but instead, I dug further down in the file and produced a pair of papers on CT of the esophagus. What made these papers unique was the fact that they were the first reports in the medical literature about using computed tomography (CT) for evaluating patients with esophageal carcinoma. As a result, as I explained to my student, they changed the management of that dread disease.

In 1979, there were few treatment options for patients with esophageal carcinoma – surgery or radiation therapy. Unfortunately, at that time, surgery had a reported 47 percent mortality associated with it! When my colleagues and I wrote the papers, I was practicing at the Veterans Administration Hospital in Durham, N.C. We had a large population of esophageal cancer patients due to the prevalence of alcohol and tobacco abuse in their medical histories. Dr. Robert Postlethwait, chief of surgery at the VA, was conducting a study comparing surgical results with those of radiation, and was alternating patients undergoing the treatments. I convinced Dr. Postlethwait to operate on the next 10 patients after they had undergone a thoraco-abdominal CT exam. We found perfect correlation with the CT findings and the operative findings which showed evidence of mediastinal and nodal spread of the carcinoma. With that success, we studied an additional 20 patients. Overall, when compared with operative, bronchoscopic and/or autopsy data, CT correctly identified the extent of mediastinal spread in 27 patients as well as the presence of intra-abdominal metastases in 22.

Making a difference

RICHARD H. DAFFNER, MD, FACR

How did it make a difference? The spread of esophageal carcinoma is facilitated by three anatomic factors. First, the esophagus is devoid of a serosal layer except at the esophagogastric junction. The absence of serosa allows tumors to extend from the mucosa through the muscular layer and infiltrate the deeper mediastinal tissues. Second, there is a rich network of draining lymphatics, resulting in antegrade and retrograde nodal spread. And third is the presence of thin fascial bands between the esophagus and the trachea that facilitates spread at that level. All of these allow early local spread, which often is found when the patients first become symptomatic.

We had validated CT of the esophagus as a reliable and accurate method of staging esophageal carcinoma and determining whether operative treatment was indicated. While, at the time, the overall survival averaged six months following diagnosis, we were able to prevent surgeries that may have hastened the patients’ demise, thus allowing the patients some degree of comfort in their last days.

Those of us who chose careers in academic medicine are well aware of the “Publish or Perish” atmosphere that determines advancement. Research is important for discovery of newer diagnostic methods, newer treatments,
problem solving, or simply improving on which diagnostic or therapeutic methods are used in state-of-the-art medicine. Furthermore, research is needed as the basis for evidence-based decisions physicians must make for their patients. In my career, I have been fortunate to have served as a manuscript reviewer as well as a member of the Editorial Boards of several major radiology journals. I have seen many excellent papers as well as many poor ones. And with each paper submitted for my review, I have always asked the following questions: Is this work original? Is this good science? What new information have the authors provided? And, most importantly, what difference will the information in this paper make? As mentioned previously, I would like to think that all of my publications made a difference, certainly in adding to medical/radiologic knowledge. However, of all my publications, these two papers directly affected patients by changing management, and hopefully, made a difference in their lives.

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.
Dear Editor:

Re: “A Better Model for Healthcare in America” (ACMS Bulletin, February 2017), I agree with much of what Rep. Murphy has to say: i.e., that we have to “lower the cost of healthcare,” that we should “enable physicians to deliver better-coordinated, patient-centered care integrating physical and behavioral medicine,” and that we should “enable more coordinated and integrated care for all our citizens, rich and poor, young and old.”

While it is always nice to hear in general terms from members of Congress about what health care reform should accomplish, what we need is proposed legislation in the form of a bill, along with a credible explanation, with specifics, of how the proposed legislation will accomplish the stated goals. While there are numerous proposals out there, most are likely to make an already too fragmented and complex system even more complex without achieving the touted cost savings or better access to care. For instance, just talking about “choice” and competition among health care insurance companies does not justify an assumption that access and quality of care will be improved as a result. Controlling health care costs and ensuring quality and access for all is complex, and all options should be considered and discussed.

A recent article on single-payer is worth a read. But incredibly, in 2014, the American Medical Association (AMA) rejected a proposal that U.S. physicians be polled as to their views on single-payer, despite solid evidence that the majority of Americans want a single-payer system, and evidence that more and more physicians do as well. The Medical Student Section (a significant segment of the physicians of tomorrow) of the AMA subsequently adopted a resolution to support “innovative state legislation to achieve universal health care, including but not limited to single-payer health insurance.”

Single-payer may not be the only answer, but it behooves us all to develop a system that is simple and efficient. The foundation of such a system should start with the assumption that health care is a human right, and not first of all looking to protect the current profit structure that benefits insurers, health IT vendors and the pharmaceutical industry, to name three.

Instead of repeating the broad generalities of an ideal health care system, Mr. Murphy and others in Congress who wish to reform health care could, for example, study Taiwan’s health care system, and discuss the remarkable history of its development with their constituents.

– Bruce L. Wilder, MD, MPH, JD

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What does ACMS membership do for me?
PAGS-WD announces award recipients

The Pennsylvania Geriatrics Society - Western Division is pleased to announce the 2017 Geriatrics Teacher of the Year Award recipients.

Debra K. Weiner, MD, FACP, is the 2017 Geriatrics Teacher of the Year Award recipient, which recognizes a physician who has made significant contributions to the education and training of learners in geriatrics and to the progress of geriatrics education across the health professions.

Dr. Weiner brings a highly developed, quintessentially geriatric approach to care through all of her educational efforts. She is involved in precepting, lecturing and curriculum design in many settings. She has coached, mentored and taught patients, caregivers and health professionals in a multitude of disciplines.

Dr. Weiner has developed case studies and questions for modules for the American Board of Internal Medicine and lectures extensively at many local, national and international forums. She has authored or co-authored numerous publications throughout her career, including a recent 12-part series on chronic low back pain in the respected journal Pain Medicine that was developed in collaboration with approximately 40 colleagues across the country.

Dr. Weiner currently serves as program director, Geriatric Medicine Fellowship Training Program, and professor of Medicine, Psychiatry, and Anesthesiology at the University of Pittsburgh. She is on staff at the Geriatric Research Education and Clinical Center at the VA Pittsburgh Healthcare System and serves on many of its committees.

Pamela E. Toto, PhD, OTR/L, BCG, FAOTA, is the 2017 recipient of the Healthcare Professional Geriatrics Teacher of the Year Award, which

POS meets at ACMS

The Pittsburgh Ophthalmology Society met Feb. 8 at the ACMS building. From left are POS President Thierry Verstraeten, MD, and guest speaker Dean Elliot, MD. Dr. Elliot presented Current Management of Ocular Trauma and Hemorrhagic Occlusive Retinal Vasculitis After Cataract Surgery.
recognizes a health care professional who has made significant contributions to the education and training of learners in geriatrics and to the progress of geriatrics education across the health professions.

Dr. Toto is a nationally recognized educator, practitioner and leader in geriatric occupational therapy. Throughout her career, she has taught and interacted with countless students, practitioners, health care professionals, and consumers with the goal of promoting and advancing evidence-based strategies to promote health and well-being in older adults.

Dr. Toto has presented numerous national and regional peer-reviewed presentations on geriatric topics ranging from best practice physical activity strategies for older adults to client-centered goal setting for older adult well-being.

Dr. Toto was one of the first occupational therapists in the United States to become board certified in gerontology by the American Occupational Therapy Association in 2000.

She has served as assistant professor, Department of Occupational Therapy, School of Health and Rehabilitation Sciences, University of Pittsburgh, since 2011, and has been the program director for the Clinical Science Doctorate in Occupational Therapy Program since 2015. Dr. Toto also is a geriatric clinical consultant, UPMC Centers for Rehab Services in McKeesport.

Vincent Balestrino, MD, is the 2017 Lifetime Achievement Award recipient, which recognizes and honors a...
physician who has made significant contributions to the education and training of learners in geriatrics education, with the utmost dedication, commitment and teaching excellence spanning their professional career.

Dr. Balestrino has made significant contributions to the growth of geriatrics education in the Pittsburgh region and has inspired numerous learners to be passionate about the specialty.

He has been a clinical assistant professor of family medicine at the University of Pittsburgh School of Medicine since 1997 and served as the director of the Geriatric Fellowship program at UPMC St. Margaret from 2004 to June 2012, a role that he recently resumed on an interim basis after the departure of the fellowship director. Dr. Balestrino currently serves as associate director of the Family Practice Residency program at UPMC St. Margaret Hospital.

Dr. Balestrino is director, Geriatric Services, UPMC St. Margaret. His experience and leadership also extend to long-term and palliative care with particular areas of interest in end-of-life care and wound care. In April 2015, he took on a new role as senior medical director at Presbyterian SeniorCare.

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.

Greater Pittsburgh Diabetes Club to meet

The Greater Pittsburgh Diabetes Club will host “Talking to Patients about Risk,” presented by Richard A. Jackson, MD, at 6 p.m. April 5 at the ACMS building.

Dr. Jackson is executive director, Grass Roots Diabetes; president, Health Analytics Solutions; assistant professor of Medicine, Harvard Medical School; and adjunct investigator, Joslin Diabetes Center. He has contributed to diabetes research and treatment for more than 35 years.

Attendees will learn to identify recent trends in diabetes-related outcomes; discuss differences in patient concerns vs. provider concerns; and explain new approaches to discussing risk with diabetes patients.

To register, visit https://gpdc040517.eventbrite.com. For more information, contact Amy Stromberg at astromberg@acms.org or (412) 321-5030.
Free concussion program offered to physicians

In 2011, the Safety in Youth Sports Act (Pennsylvania’s Concussion law) passed and officially began July 1, 2012. In the Act, language was included for an “appropriate medical professional” trained in the evaluation and management of concussions; however, no specific requirements were delineated.

In 2014, the Pennsylvania Department of Health (DOH) partnered with the Pennsylvania Athletic Trainers’ Society (PATS) to utilize a four-year Traumatic Brain Injury (TBI) grant awarded by the Health Resources and Services Administration (HRSA). Next PATS, in collaboration with the Sports Safety International (SSI) and the Pennsylvania Medical Society (PAMED), worked collaboratively to increase the current knowledge of the medical community, specifically primary care physicians and emergency room physicians, about TBI and available TBI resources in Pennsylvania.

The ConcussionWise program for doctors, titled ConcussionWise™ DR, is an education initiative to ensure that physicians across the Commonwealth are knowledgeable on the topic of TBI and are trained in current peer-reviewed research about the management of concussions. Continuing Medical Education units (CMEs) are provided to physicians who take the course as well as a “Recognition Database” that is searchable to the public in order to find a local physician with the most up-to-date training in the evaluation and management of concussions. The clinical content of the ConcussionWise™ DR has been peer-reviewed and approved by the Pennsylvania Academy of Family Physicians, Pennsylvania Chapter of American Academy of Pediatrics, Pennsylvania College of Emergency Physicians, Pennsylvania Neurological Society, Pennsylvania Orthopaedic Society and the Pennsylvania Psychiatric Society. Content includes the newest information with regard to clinical diagnosis and treatment including: identifying signs and symptoms, clinical trajectories, treatment and return-to-play protocols.

The ConcussionWise™ DR program is normally $59; however, the grant received from the DOH has made it possible to offer this online course for free to the first few hundred Pennsylvania physicians who sign up. Pennsylvanian physicians interested in the training course can go to http://www.concussionwise.com/pa-physician.

All of the ConcussionWise Pennsylvania online programs can be found at http://www.concussionwise.com/pennsylvania. Additionally, PATS has developed a helpful “Concussion Resource Center” on its website, http://www.gopats.org/, to assist individuals looking for information and resources about concussions.

For more information regarding this topic or to speak with PATS President Guy Sanchioli, MS, LAT, ATC, PES, please contact Linda Mazzoli, MS, LAT, ATC, PATS executive director, at patsexecutivedirector@gopats.org.

Statement released on recent mental health legislation

The office of Congressman Tim Murphy has released a statement regarding the Helping Families in Mental Health Crisis Act, signed into law in December 2016:

“The Helping Families in Mental Health Crisis Act, signed into law in December, brings research, treatments and cures into the 21st Century and finally starts to break down the wall between physical health and mental health. With this new law, federal agencies will be moving from vague feel-good programs to ones that emphasize evidence-based care for those at the highest risk. For the first time, there will be an Assistant Secretary for Mental Health and Substance Use who will lead the way, evaluating and improving the system.

“Additionally, the law invests in services for the most difficult-to-treat cases and ensures that family members are a part of the care delivery team; trains people to recognize the signs and symptoms of mental illness, including law enforcement officers for how to best respond to a potentially violent situation; provides real resources to combat substance abuse, and specifically for the opioid crisis; addresses, head on, the number 10 killer in our nation – suicide, which disproportionately affects our veterans; expands our nation’s mental health workforce, because today, half the counties in America do not have a single psychologist or psychiatrist; and, for the first time ever, Congress is stepping in to help those with an eating disorder get access to real medical care.”

Allegheny County launches home visiting campaign

County Executive Rich Fitzgerald, Health Department Director Dr. Karen Hacker and Human Services Director Marc Cherna recently announced

Continued on Page 98
the launch of “Open Doors to Home Visiting,” a coordinated campaign to encourage families to enroll in one of the many free, voluntary home visiting programs offered in the county. The campaign encourages families, caregivers and the medical community to learn more about the county’s programs.

Home visiting programs offer parents and caregivers support and encouragement, providing them with the necessary tools and skills to raise healthy children. Additionally, the programs facilitate opportunities, school readiness and supports for children and their families.

There are currently 36 home visiting programs in the county, 26 of which are offered through the county’s network of family support centers. The Allegheny Link to Home Visiting Services, a collaboration between the Health Department and Human Services, is a central referral line for parents, physicians and caregivers to call who are interested in learning more about home visiting.

The Allegheny Link is available weekdays from 8 a.m. to 7 p.m. by calling 1-866-730-2368. Parents and caregivers who are interested in learning more about home visiting programs can call Allegheny Link, speak to their pediatrician, or visit alleghenylink.org.

Spanish-language program introduced for cancer survivors

Strength and Courage (Fuerza y Valienta), a nonprofit dedicated to providing exercise resources to breast cancer survivors so they can regain physical and emotional strength after treatment, has launched a new Spanish-language exercise program, specifically designed for women recovering from breast cancer.

Developed and introduced in 2008 by Dr. Sharon Cowden, a pediatrician and breast cancer survivor, and Janette Poppenberg, ACSM/ACS Certified Cancer Exercise Trainer, the English version has been distributed in every U.S. state and in 31 countries since its initial launch.

Breast cancer is the most commonly diagnosed cancer in Hispanic and Latina women, with close to 19,800 estimated new cases and 2,800 deaths in 2015, as reported by the American Cancer Society. Recognizing that a large portion of U.S. breast cancer survivors’ first language is Spanish – the second most widely spoken language in the world – it seemed a logical and inspiring next step to translate the program into Spanish.

Available in DVD or digital download, the program features specifically designed workouts including posture and post-op exercises, flexibility instructions, weight trainings and aerobic guidelines.

For more information on Strength and Courage (Fuerza y Valienta), visit http://www.strengthandcourage.net/?utm_source=PR&utm_medium=News_Release.


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Interested applicants should contact Denny Sabolick by email at ascjprc51@gmail.com or drjohnkslee@gmail.com or call (412) 885-5400, ext. 13.

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Mohinder Mohan Bahl, MD, died Friday, February 3, 2017.

Dr. Bahl attended medical school on scholarship in India. After working as a doctor in Nairobi, he moved to Pittsburgh in 1972. Dr. Bahl opened a practice in Penn Hills, serving his community for more than 35 years. He also mentored many young doctors.

Dr. Bahl recently was recognized by the Allegheny County Medical Society for his years of distinguished service. He was loved by his patients and respected by his peers.

Surviving are his wife, Saroj; children Ashish and Debora Bahl, Monish and Himani Bahl, Sachin and Rosie Bahl and Mala and Manish Maingi; brothers Dr. Vijay Bahl (Christine) and Dr. Madan Bahl (Pratibha); sister Priya Nischal (Hamesh); sister-in-law Devika Malhotra (wife of the late Ashok Malhotra); brother-in-law Bhushan Kaura; ten grandchildren; and numerous loved ones domestic and abroad.

Services were held Sunday, February 5, 2017, at Beinhauer Family Funeral Homes, Pittsburgh.
The pharmaceutical industry never takes a break when it comes to producing new types of medications for various disease states. Recently, a new class of medications known as biosimilars has entered the U.S. market. Biosimilars are similar to current biologics that are out on the market. In countries such as Australia and Japan, biosimilars have been on the market for more than seven years. Development of biologics provides treatment for complex diseases such as different types of cancer and autoimmune diseases. Treatment for complex diseases usually comes with a high price tag for patients. In many situations, patients may not be able to pay thousands of dollars for treatment of their disease. So, what can we do or create that solves the issue of accessibility? The answer to the question could possibly be the transition over to using biosimilars. The introduction of biosimilars into health care is projected to save as much as $25 billion in drug costs by 2018.² Biosimilars are expected to be discounted by 15 percent to 35 percent compared to the reference biologic.¹

What are biologics?

Biologics are medicines made from living cells through highly complex manufacturing processes.² They are composed of sugars, proteins, nucleic acids or a combination. These components can be isolated from humans, animals, or micro-organisms. Some examples include infliximab (Remicade®) and adalimumab (Humira®). Manufacturers submit a biologics licensing application (BLA) to the Food and Drug Administration (FDA) for review of their biologic medicine to be dispensed to the public. The BLA requires applicant information, product/manufacturing information, pre-clinical and clinical studies, and labeling.³ The clinical studies are required to provide information regarding safety and efficacy profiles for the biologic.

What are biosimilars?

Biosimilars are biological medicine proven to have high similarity to a reference biological medicine (RBM).⁴ The RBM is another name for the biologic in which the biosimilar was developed from and used in comparison. The amino acid sequence of the biosimilar is similar to the RBM with minor changes in the inactive components.⁴ Biosimilars have a more complex molecular structure compared to biologics and are produced using biotechnology techniques. The overall goal in the process of getting a biosimilar approved is to show similarity to the RBM. Clinical and analytical studies need to be performed to prove that
the biologic is similar to the reference product. At least one phase III trial may be necessary to provide the required clinical data.\(^1\) A lot of the safety and efficacy data are extrapolated from clinical results of the trials performed for the RBM. Biosimilars have the potential to include all indications as the RBM. Clinical trials do not need to be repeated for each indication that the RBM received FDA approval for. Figure 1 represents a comparison of the data that is involved for approval of each medication.

**Approval process of biosimilar**

Biologics follow a rigorous approval process through the BLA (also known as 351(a) pathway), which requires extensive clinical data. The FDA was given legal authority to approve biosimilars through Biosimilar License Application (also known as 351(k) pathway) created in the Biologics Price Competition and Innovation Act (BPCIA) which was part of the Patient Protection and Affordable Care Act (PPACA).\(^1\) The 351(k) pathway states that a biosimilar must demonstrate comparability by proving lack of clinical differences in purity, potency and safety.\(^1\) In essence, data presented for the biosimilar is required to be very similar to its respective reference biologic. Figure 2 outlines the two different approval pathways.

The approval of a biosimilar does not mean it is therapeutically equivalent to the RBM. The FDA can designate a biosimilar as “interchangeable,” which means it is considered to be therapeutically equivalent and can be substituted automatically for the RBM by the pharmacy unless the prescriber designates otherwise.\(^1,6\) This may not be the case in states that have more strict regulations. Pennsylvania has enacted a law that allows a pharmacist to substitute biologic products for a prescribed interchangeable biologic product (PA S 514).\(^6\)

The FDA released a draft guidance of considerations for demonstrating interchangeability in January 2017.\(^7\) It may take some time before manufacturers are able to provide the data required to demonstrate interchangeability. So how can we interchange biosimilars for RBM right now? The answer to that question is therapeutic interchange. Pharmacy and therapeutics committees can evaluate the safety and efficacy, approved indications, pharmacodynamics and pharmacokinetics of the biosimilar compared to the biologic and determine therapeutic interchange. The FDA Purple Book also can be used as guidance for therapeutic interchange.\(^8\) It lists licensed biological products including biosimilars and interchangeable biological products.

**Naming of biosimilars**

When deciding on how biosimilars would be classified, the question of whether the naming should be the same as RBM or have distinct names was left unanswered. Keeping the name the same would likely instill confidence and acceptance among prescribers and public. Using a new name may cause confusion and potentially resistance towards using a biosimilar. A recent survey of pharmacists who are members of the Academy of Managed Care Pharmacy, American Society of Health-System Pharmacists, or American Pharmacist Association indicated pharmacists would be more confident in substituting an interchangeable biosimilar for RBM if products shared the same name.\(^9\) BPCIA does not require biosimilars to have a new name. The World Health Organization stated a proposal for biosimilar naming. The proposal stated adding four characters to the end of the
RBM traditional nonproprietary name. The FDA later released a draft guidance document to biosimilar naming which included similar concepts. The FDA proposes adding a four-letter suffix to the end of the reference biologic’s name to be considered the name of its respective biosimilar. The four letters can be random or keyed to represent the manufacturer’s name.

**Future of medicine**

The concept of biosimilars is very interesting. It is yet another innovation that provides accessible treatment options for patients. This concept is fairly new in the United States, with only four biosimilars currently on the market. Table 1 lists biosimilars currently approved by the FDA. Recent release of draft guidance for manufacturers to demonstrate interchangeability will allow more confidence and acceptance for switching between the RBM and a biosimilar agent. Manufacturers will have to provide additional data and studies that demonstrate interchangeability. This development in medicine is very exciting and it gives us yet another option to treat complex conditions at a price that is more affordable for patients.

*At the time of this writing, Mr. Patel, a doctor of pharmacy candidate at Lake Erie College of Osteopathic Medicine, was on a clinical rotation in the Center for Pharmaceutical Care at Allegheny General Hospital. For any questions concerning this article, please contact Tucker Freedy, Pharm.D., BCPS, at the Allegheny Health Network, Allegheny General Hospital, Center for Pharmaceutical Care, Pittsburgh, Pa., (412) 359-3192, or email tucker.freedy@ahn.org.*

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**References**


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The third component of MACRA is advanced Alternative Payment Models (APMs). APM participation is ostensibly the ultimate goal of this current generation of “Pay for Performance.” Clinicians who take a further step toward care transformation – participating to a sufficient extent in Advanced APMs – would be exempt from MIPS payment adjustments and would qualify for a 5 percent Medicare Part B incentive payment. To qualify for incentive payments, clinicians would have to receive enough of their payments or see enough of their patients through Advanced APMs. The participation requirements are specified in statute and increase over time. If physicians receive 25 percent of Medicare payments or see 20 percent of their Medicare patients through an advanced APM in 2017, then they can earn a 5 percent incentive payment beginning in 2019.

Under the new law, Advanced APMs are the CMS Innovation Center models, Shared Savings Program tracks, or statutorily-required demonstrations where clinicians accept both risk and reward for providing coordinated, high-quality and efficient care. These models also must meet criteria for payment based on quality measurement and for the use of EHRs. The proposed rule lays out specific criteria for determining what would qualify as an Advanced APM. These include criteria designed to ensure that primary care physicians have opportunities to participate in Advanced APMs through medical home models.

Note that Alternative Payment Models are, for lack of a better word, a generic form of any payment method that is not “regular Medicare.” Advanced APMs are subsets of these generic APMs and are the only vehicle that qualifies for the 5 percent incentive payments. For example, Accountable Care Organizations (ACOs), which were created by the Medicare Shared Savings Program as established by the Accountable Care Act, are APMs, but not all ACOs are advanced APMs.

As of 2017, the following payment models qualify as advanced APMs:
- Comprehensive ESRD Care (CEC) – Two-Sided Risk (https://innovation.cms.gov/initiatives/comprehensive-esrd-care/
- Comprehensive Primary Care Plus (CPC+) (https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus)
- Next Generation ACO Model (https://innovation.cms.gov/initiatives/next-generation-aco-model/)
- Shared Savings Program – Track 2 (https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/shared-savingsprogram/index.html)
- Shared Savings Program – Track 3 (https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/shared-savingsprogram/index.html)
- Oncology Care Model (OCM) – Two-Sided Risk (https://innovation.cms.gov/initiatives/oncology-care/)
- Comprehensive Care for Joint Replacement (CJR) Payment Model (Track 1 – CEHRT) (https://innovation.cms.gov/initiatives/cjr)
- Vermont Medicare ACO Initiative (as part of the Vermont All-Payer ACO Model) (https://innovation.cms.gov/initiatives/vermont-all-payer-aco-model/)

At this time, the opportunity to participate in APMs is quite limited. The list of future approved advanced APMs is available at the CMS Quality Payment program website: http://qpp.cms.gov. Hopefully, these opportunities will be expanded in 2018 in order to earn the 5 percent incentive payments available in 2019.

Advanced APMs

To be considered an advanced APM, an APM must meet all three of the following criteria, as required under section 1833(z)(3)(D) of the Medicare Access and CHIP Reauthorization Act:
- The APM must require at least 75 percent of participants to use Certified EHR Technology (CEHRT);
• The APM must provide for payment for covered professional services based on quality measures comparable to those in the quality performance category under MIPS; and
• The APM must either require that participating APM Entities bear risk for monetary losses of more than a nominal amount under the APM, or be a Medical Home Model. The existing pilot Medical Home Models also are listed on the CMS website: https://innovation.cms.gov/Medicare-Demonstrations/Medicare-Medical-Home-Demonstration.html.

‘Other’ APMs

MACRA also enables “other” payer, i.e., Medicaid and commercial payers, to become “other APMs.” To be an “other” advanced APM, a payment arrangement with a payer must meet all three of the following criteria:
• The payment arrangement must require at least 75 percent of participants to use CEHRT;
• The payment arrangement must provide for payment for covered professional services based on quality measures comparable to those in the quality performance category under MIPS; and
• The payment arrangement must require participants to either bear more than nominal financial risk if actual aggregate expenditures exceed expected aggregate expenditures; or be a Medicaid Medical Home Model that meets criteria comparable to Medical Home Models expanded under section 1115A(c) of the Act.

This provision is targeted to be available in 2021, but it is not clear at this time how this will involve Medicare incentive payments to “other” payer models.

Physician-Focused Technical Advisory Committee

Congress also established a physician-led committee to explore new payment reform options. The Physician-Focused Payment Technical Advisory Committee (PTAC) is tasked with identifying future opportunities for APM participation. The law established PTAC to review and assess additional Physician-Focused Payment Models based on proposals submitted by stakeholders to the Committee. The Committee is scheduled to meet on a quarterly basis, and may meet more frequently as it starts to receive payment model proposals. The rule proposes criteria for the Committee to use in making comments and recommendations on proposed Physician-focused Payment Models. The criteria require that proposed Physician-Focused Payment Models further the goals outlined by the law, as well as reduce cost, improve care or both. This mechanism is intended to provide physicians with a unique opportunity for stakeholders to have a key role in the development of new models and to help determine priorities for the physician community. For more information, go to http://aspe.hhs.gov/ptac-physician-focused-payment-model-technical-advisory-committee.

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

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For many in the United States, Cuba calls to mind cigars, palm trees, revolution, classic cars and island life. Due to the travel restrictions and embargo that have dominated much of the news involving the United States and Cuba over that last five decades, public knowledge of the rich culture, lifestyle and day-to-day life of Cubans has been a mystery.

What many don’t know is that the Cuban health care system is one that has been described as “a model for the world.” Despite economic sanctions imposed by the United States, the Cuban system has managed to provide basic medical care to nearly its entire population. Described as “excellent and effective,” the Cuban system is largely based on a primary and preventative care model which, for a non-first world nation, has largely been successful.

However, the result of a focus on preventative care is the lapse of treatment for acute and chronic conditions. Procedures that require specialized training and equipment, such as joint replacement, are virtually non-existent. The lack of specialty care in these areas has resulted in a significant portion of the Cuban population left with limited mobility, some without the ability to walk. In a culture such as Cuba’s, walking is essential to everyday life. The average Cuban walks more than eight miles per day; being left immobile is oftentimes a heavy medical, psychological and social burden for Cubans of all ages.

With the lift of the U.S. embargo in 2016, Operation Walk Pittsburgh was able to make its first ever trip to Cuba. It was a significant trip, as it marked the 20th anniversary of the very first Operation Walk mission trip, which also happened to be to the island nation of Cuba. Nationally, Operation Walk is a nonprofit organization that “seeks to enhance orthopedic surgical options for patients and orthopedic surgeons in developing countries.” The Operation Walk Pittsburgh team was thrilled to have continued the important work in Cuba that had begun decades before.

Throughout its 10 years of existence and eight medical mission trips, the Operation Walk Pittsburgh team has recognized that the ability to walk, to simply be mobile, is essential in ensuring the growth and prosperity of countries and cultures the world over. In the United States and much of the first world, citizens take for granted the access to medical care for serious but treatable diseases and ailments, joint problems, arthritis and bone deterioration. Even more, they can take for granted the access to mobility devices, wheelchairs, scooters, even walkers and crutches. Hundreds of thousands of joint replacements take place in the United States each year, mostly in older patients who are afflicted with degenerative arthritis. In countries such as Cuba, performing just a few hundred joint replacements, even on young patients who are born with debilitating deformities rather than with a degenerative disease, is rare.

Months of planning go into each Operation Walk Pittsburgh trip, organizing teams of doctors, medical personnel and volunteers, coordinating operational logistics with foreign governmental bodies and doing essential fundraising and supply collection. In 2016, 70 team members traveled to Cuba, each donating a full week of their time. In addition, the Operation Walk Pittsburgh team traveled with a full load of more than 8,000 pounds of cargo, bringing with them everything from band-aids...
and scalpels to crutches and the implants themselves. The trip was made possible by monetary and in-kind donations that totaled more than 1.2 million dollars. The generosity of the team was matched only by the generosity of each corporate and private donor who made the trip possible.

The goal of the Operation Walk Pittsburgh trip to Cuba was two-fold: to provide much-needed medical care to an overlooked population; and to foster a cultural exchange of specialized knowledge and experience, not just medically, but also socially. The rich blessings that came from the incredible cooperation between the United States and Cuban medical teams, which shared little in common other than the collective desire and drive to work tirelessly to help those who had no other chance of receiving treatment, enabled the replacement of 61 joints

Continued on Page 108
on 47 patients over just three days of surgery as part of a seven-day trip.

Patients who, weeks before, had been completely immobile, confined to wheelchairs and prevented from doing the activities they loved and the work needed to support their families, were able to stand for long periods without pain, walk up and down stairs and were even out of the hospital in just a few days. The overwhelming gratitude was heard in song and cries of joy, and seen in dancing and hugs and in an outpouring of handshakes, kisses and tears as patients were able to greet their families and return to their communities with a new lease on life.

Even though our trip for 2016 is complete, the work to fundraise, recruit volunteers and to collect supplies occurs year-round. To learn more about Operation Walk Pittsburgh, make a donation or get involved, please email Angela Devanney at angela@amd3.org.

Dr. DiGioia is the founder and co-medical director of Operation Walk Pittsburgh and the medical director of the Bone and Joint Center at Magee-Womens Hospital of the University of Pittsburgh Medical Center.

Dr. Weiss is a founding member of Tri Rivers Musculoskeletal Centers who does total hip and knee replacement surgery at UPMC-Passavant Hospital and is co-medical director for Operation Walk Pittsburgh.

Ms. O’Brien is a founding member of goShadow, a technology startup focused on end-user engagement, experiential redesign, process mapping and improvement. She has worked in digital production and marketing for more than 10 years. In healthcare, Ms. O’Brien was the marketing manager for MDNet Solutions, a digital patient connection tool, and was the lead digital marketing production manager at Highmark. She also has worked extensively in digital marketing and production for nonprofit organizations, including the Carnegie Library of Pittsburgh.

Ms. Devanney is a founding member of goShadow, a technology startup focused on end-user engagement, experiential redesign, process mapping and improvement. She first developed her process improvement skills in 2006 as a project manager at the Institute for Healthcare Improvement in Cambridge, Mass., where she provided consultation and technical knowledge to hospitals and organizations throughout the world. Ms. Devanney has been a team leader for Operation Walk Pittsburgh since 2008 and has led the team to Cuba, Panama, Honduras, Guatemala and Nicaragua to help hundreds of patients to receive joint replacements who do not have the means or access to receive specialty care.

The authors can be reached at bulletin@acms.org.
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“The most important modifiable risk factor for antibiotic resistance is inappropriate prescribing of antibiotics.” This statement was issued in the Core Elements of Outpatient Antibiotic Stewardship report published in the Morbidity and Mortality Weekly Report (MMWR) on Nov. 11, 2016. The problem of antibiotic resistance requires comprehensive planning and urgent action.

In 2014, the Centers for Disease Control and Prevention (CDC) published its Core Elements of Hospital Antibiotic Stewardship Programs, which recommended that all acute care hospitals implement an antibiotic stewardship program. This document outlined seven core elements for success. In 2015, CDC published the Core Elements of Antibiotic Stewardship for Nursing Homes, which adapted the Hospital Core Elements for a nursing home setting.

Now, Quality Insights, the Medicare Quality Innovation Network – Quality Improvement Organization (QIN-QIO) for Delaware, Louisiana, New Jersey, Pennsylvania, and West Virginia is under contract with the Centers for Medicaid & Medicare Services (CMS) for a new project promoting effective principles of antibiotic stewardship beyond the inpatient setting.

Quality Insights’ project goals are to recruit and collaborate with outpatient health care professionals in areas such as primary care clinics and clinicians, emergency departments and emergency medicine physicians, dialysis centers, nurse practitioners and physician assistants, outpatient specialty clinics and clinicians, retail health clinics and clinicians, ambulatory surgical centers, urgent care clinics and health care systems to develop and implement their own program for antibiotic stewardship utilizing the 2016 CDC Core Elements of Outpatient Antibiotic Stewardship.

Core Elements of Outpatient Antibiotic Stewardship

The four core elements of outpatient antibiotic stewardship are commitment, action for policy and practice, tracking and reporting, and education and expertise.

CDC recommends that outpatient clinicians take steps to commit to patient safety related to antibiotics through activities such as written displays or posters. In the Core Elements of Outpatient Antibiotic Stewardship appendix, a low-cost, successful intervention is for a clinician to display a poster with a public commitment to use antibiotics judiciously with the clinician signature displayed in examination rooms.

CDC recommends clinicians take at least one action to improve prescribing such as using evidence-based diagnostic criteria and treatment recommendations in concert with national or local pathogen susceptibilities. CDC also recommends tracking and reporting of at least one aspect of antibiotic prescribing that can lead to changes in prescribing practices, such as the percentage of all visits that lead to antibiotic prescriptions.

The last CDC core element is to provide multifaceted educational interventions for clinicians to address deficits in knowledge and the psychosocial pressures influencing antibiotic prescribing. Using effective communication strategies to educate patients and their families about when antibiotics are and are not needed combined with symptom management information may lead to increased patient and family satisfaction.

According to MMWR, the initial steps for antibiotic stewardship are to identify one or more high-priority conditions for improving antibiotic prescribing. These are conditions in which antibiotics are overprescribed, such as acute bronchitis, nonspecific upper respiratory infection or viral pharyngitis. Other interventions may be selecting the right agent, dose and duration, watchful waiting or delayed prescribing.

Benefits of antibiotic stewardship programs include optimizing how infections are treated and reducing harmful effects of overuse. Other benefits include reducing Clostridium difficile infection cases, reduction of treatment failures, increased infection cure rates as well as cost savings. Quality Insights’ goals are based on Continued on Page 113
Introduction

The link between environmental exposures and human disease has been known for centuries. An example is childhood lead poisoning from household lead paint exposure, which was recognized more than a century ago. An early link between occupational exposure and cancer was documented in 1775 by an English surgeon who noted that young chimney sweeps exposed to soot subsequently developed scrotal cancer. In more recent decades, occupational and environmental exposure to air pollutants has been shown to cause a variety of respiratory, cardiovascular and neurological conditions. Current concerns about the impacts of global climate change have begun to focus on public health effects such as heat-related mortality, respiratory disease including asthma during periods of poor air quality, and psychosocial stress resulting from extreme weather events.

Pittsburgh-based researchers have made important contributions to the understanding of occupational and environmental exposures and human disease. In the 1970s, Drs. Carol Redmond and J. William Lloyd and their colleagues studied mortality in Allegheny County coke oven workers and found excess deaths due to lung cancer. This excess was more than five-fold in those who worked full-time in topside jobs in coke ovens where air toxicants were most concentrated. They also documented higher cancer rates in non-white coke oven workers that were explained by differential assignment to high-exposure jobs. Later, in the last two decades of the 20th century, University of Pittsburgh researcher Dr. Herbert Needleman and his colleagues deepened the scientific understanding of the long-term cognitive and neurobehavioral consequences of childhood lead poisoning. This led to landmark changes in public health policies resulting in dramatic reductions in human morbidity from lead exposure.

Environmental health in Pittsburgh and Southwest Pennsylvania

Despite some improvements in recent decades, there are several occupational and environmental health conditions that continue to contribute to disease and premature death in Pittsburgh and Southwest Pennsylvania residents. While the air appears cleaner due to declining industrial emissions of large-size particulate matter, air quality around point sources in certain census tracts in Allegheny County continues to confer some of the highest cancer risks in the United States. Similarly, diesel exhaust and small particle industrial emissions increase the risk of lung cancer, bladder cancer and respiratory diseases like asthma throughout the region. There are ongoing concerns about lead in paint as well as lead contamination of drinking water related to old water mains and infrastructure, and newly identified concerns about brominated drinking water contaminants potentially linked to Allegheny River Basin, coal-fired power plant emissions. Abundant health concerns have been raised regarding the profuse, heavy industrial development of shale gas in the Marcellus Shale gas patch in Southwest Pennsylvania. Fracking has been shown to result in prodigious emissions of air toxics such as particulate matter, volatile organic compounds, nitrogen oxides (the latter two combine in the presence of sunlight and heat to form harmful ozone) and methane – emissions which occur at all points along the chain of natural gas operations, from well pads, to pipelines and compressor stations, to processing and transportation facilities.
In addition to making residents who live in proximity to natural gas infrastructure sick, these emissions also contribute significantly to global climate change. Groundwater and surface water contamination resulting from leaks and spills of fracking chemicals and “flowback” also has occurred. The health implications of these activities are currently under study; however, the research literature abounds with examples that tell us that certain populations—fetuses, infants, pregnant mothers, the elderly, the poor—are at highest risk for harm.

Pittsburgh health researchers Drs. Evelyn Talbott and Deborah Gentile are conducting groundbreaking work identifying the association between air pollution and neurological, respiratory and immunological conditions in children. Other researchers at the University of Pittsburgh and Carnegie Mellon University are doing state-of-the-art modeling of outdoor air exposures that contribute to asthma prevalence in inner-city schoolchildren. In an effort to educate more health professionals about these important issues, we recently participated in a webinar that addressed the issue of childhood cancer and air pollutants (see https://www.uml.edu/Research/Lowell-Center/Cancer-Free-Economy/Preventing-Cancer/webinar.aspx). Future webinars and ACMS Bulletin topics will include more detailed discussions about the intersection of air pollution with women’s health, cardiovascular disease, cancer in children and adults, and asthma in Pittsburgh and the Southwest Pennsylvania area.

**Conclusion**

Allegheny County clinicians have much to contribute to address environmental health issues in their patients, beginning with paying attention to the emerging peer-reviewed literature being published. Awareness extends to the exam room by taking careful environmental health histories which can identify potential toxic exposures at the workplace, the schoolyard, and in and around the home. Knowing a patient’s zip code will allow consideration that their chief complaints may have environmental origins and lead to appropriate guidance given to patients about ways to reduce harmful exposures. They also can join with advocates and elected officials seeking area-wide reductions in toxic environmental exposures. Continuing Medical Education credits (free) for health professionals on several of these topics are available in an online resource at the Centers for Disease Control and Prevention: https://www.cdc.gov/features/story-of-health/.

*Dr. Clapp is professor emeritus at Boston University School of Public Health and adjunct professor at the Lowell Center for Sustainable Production. He formerly was the co-chair of Greater Boston Physicians for Social Responsibility.*

*Dr. Ketyer is a pediatrician who lives and works in Allegheny and Washington counties. He is a member of the AAP Council on Environmental Health, a board member of Physicians for Social Responsibility – Philadelphia, and edits Pediatric Alliance’s *The PediaBlog.*

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the 2016 CDC Core Elements of Outpatient Antibiotic Stewardship. These goals include formation of a multidisciplinary advisory group comprised of thought leaders who can provide advice to the QIN-QIO, recruitment of outpatient settings and providers, education and outreach on antimicrobial stewardship program development and implementation and integration of models of change to sustain success.

Quality Insights Quality Innovation Network can provide free education, resources and technical assistance to both clinicians and the community. Providers are signing up now to be a part of this important new project.

For more information, go to www.qualityinsights.org or contact Eve Esslinger at eesslinger@qualityinsights.org or Julie Sholtis at jsholtis@qualityinsights.org.
There’s no getting around it — providing constructive feedback can be a challenge. Pathway for Improvement, the Pennsylvania Medical Society’s (PAMED’s) new interactive tool can help!

Gain insight into your team and earn CME toward your patient safety and risk management requirement.

Go to www.pamedsoc.org/pathway to get started.

**Step One: Learn About Providing Constructive Feedback**

Start by reading four online articles that will prepare you to evaluate your practice environment.

**Step Two: Take the Physician Survey**

Then, you will review and rate statements about your group’s culture. You will also have a chance to share suggestions on how you could improve or change the situation, if needed.

The survey also offers group participation options. For information on how the physicians on your health care team can complete Pathway for Improvement as a group, contact PAMED’s Knowledge Center at 855-PAMED4U (855-726-3348) or KnowledgeCenter@pamedsoc.org.

This valuable tool is designed to help your organization:

- Recognize the skills needed to improve communication and provide feedback in a positive, constructive manner.
- Identify current gaps and provide input into the creation of solutions.
- Review responses to assess for opportunities to improving the organizational team.
- Support the process of becoming a better engaged team member.
# APPLICATION FOR MEMBERSHIP

**Preferred Method of Contact:**
- **Mail:** ________ (Office or Home)
- **E-mail:** ________
- **Fax:** ________

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**Within the last 5 years, have you been convicted of a felony crime?** □ Yes □ No. If yes, please provide full information.

**Within the last 5 years, has your license to practice medicine in any jurisdiction been limited, suspended or revoked?** □ Yes □ No. If yes, please provide full information.

**Within the last 5 years, have you been the subject of any disciplinary action by any medical organization or hospital staff?** □ Yes □ No. If yes, please provide full information.

If elected to membership, I agree to conduct myself professionally and personally according to the principles of medical ethics and to be governed by the Constitution and Bylaws of the Allegheny County Medical Society and the Pennsylvania Medical Society.

I hereby release, and hold harmless from any liability or loss, the Allegheny County Medical Society, the Pennsylvania Medical Society, their officers, agents, employees, and members, for acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications and hereby release from any liability any and all individuals and organizations, who, in good faith and without malice, provide information to the above named organizations, or to their authorized representatives, concerning my professional competence, ethical conduct, character and other qualifications for membership.

I also authorize the above named organizations, in the consideration of my application, to make inquiry of any of my references and institutions by which I have been employed or extended privileges, as to my qualifications. I further authorize any of the above persons or institutions to forward any and all information their records may contain and agree to hold them harmless for any actions by me for their acts.

**Date:__________________**

**Signature:__________________**
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