Updates from ACHD

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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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Eclipses have long been heralded as wondrous and fearful events. Ancient legends point to the sun or moon being eaten by a dragon, or other mythical beast. Some superstitions celebrate the eclipse, while others forbid going out or eating during an eclipse for fear of the harmful effects of abnormally powerful cosmic rays. We must assume that cultures learned the hard way not to look directly at a solar eclipse, with lingering tales of eclipse victims regaling the young with how they came to have an eclipse-shaped blind spot in their vision. This unfortunately still happens today.

At some point long ago, mathematicians and astronomers deduced logical relationships regarding the orbits of the celestial spheres and started predicting eclipses with reasonable certainty. This knowledge spread to certain parts of the world; the Egyptians, Babylonians, Greeks and Indians certainly calculated eclipse occurrences. Other cultures which may not have predicted or calculated eclipse phenomena recorded and chronicled them.

Eclipses were astrologically associated with the ascent or downfall of kings and other momentous political events, and before the science of prediction was well-accepted, they were regarded with terror. The advent of scientific prediction quelled those fears, but not completely for some cultures. We now know when a solar eclipse will be, and that knowledge sends some people out sun-gazing with eclipse glasses or paying astronomical hotel room fees to experience totality, while others are simply happy to now know exactly when to take shelter in their houses and avoid the windows for fear of cosmic rays.

Science and superstition intertwine inexorably. Some of what was considered science in past ages has been debunked; some things long considered as superstition have had some roots in truth. Scientists have used eclipses to study the sun’s corona and better understand the nature of the universe, debunking both previous “science” and superstition and gathering new knowledge.

If nothing else, the phenomenon of the eclipse should remind us that there are things beyond our control. The sudden eerie darkening of the sky in our area, even with only 88 percent of the sun eclipsed, was a powerful sight to those who were able to catch a glimpse. Birds stopped chattering, and the bright blue sky was dampened with a strange purple-grey tint. The temperature dropped. Something felt primally amiss.

In the path of totality, the sky became dark and the stars came out, and day briefly turned into night. Adults wept at the magnificent experience and wondered if they would ever see it again. Children didn’t understand the significance, having lived so few years. Pets thought it was morning and wanted to be fed again.

To a human being without an explanation, it would have been terrifying. Would the sun ever return, or would the earth be plunged into total darkness? We no longer fear these things. But the experience is undeniably weird, and unsettling to the core.

In medicine, we have our own eclipses. There are things we can predict but not explain; things we can explain but not understand. There are things we can predict, explain and understand but that still leave us with an uneasy, unsettled feeling. And finally, there are things we cannot predict. Why does one patient get better while another one with the same profile gets worse? Logic and reason take us so far, but medicine is not engineering. Ultimately, the body is part of the natural world.

There is so much in the medical universe that we still do not understand, and so much knowledge still to be discovered and absorbed. Let us take a
moment to realize that we are part of something so much larger than we can fathom. Despite every scientific advance made today, we can see why human nature turns to superstition and the rejection of science to quell that uneasy feeling (see also anti-vaxxers, people who check out against medical advice or are afraid of hospitals, etc.). That is a shortcoming of human nature. But another shortcoming is myopia; we often are so shortsighted and self-centered that for centuries some humans insisted on pain of death to naysayers that the sun revolved around the Earth. How arrogant is mankind! But how humble is the Earth!

Think of what a tiny dot our Earth is in the universe. Think of how little we truly know about the human body. Our knowledge is but the tiniest tip of the iceberg. How much less do we know about the universe, and how humble and earnest we should be in our studies of both!

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.

VOTE for the 2017 ACMS Bulletin Photo Contest!

Log on to www.acms.org and vote for 12 of your favorite photos. Voting is open until Friday, Oct. 6.

Winners will be announced after that date via email, on the ACMS website, and in the October issue of the Bulletin.
Ask your doctor if deprescribing medication is right for you

ROBERT H. HOWLAND, MD
ASSOCIATE EDITOR

The modern version of the Hippocratic Oath requires physicians to swear that they “will apply, for the benefit of the sick, all measures [that] are required, avoiding those twin traps of overtreatment and therapeutic nihilism.” Neither overtreatment nor therapeutic nihilism ever comes to mind, however, when watching a prescription drug product television commercial. These slickly produced ads portray a Panglossian world of healthier and happier lives by taking medication. This message is mindful of the 1998 film “Pleasantville,” which explores the ancient theme of utopia from the modern perspective of cable-TV nostalgia. “Pleasantville” (circa 1950s) appears to be idyllic – it never rains, the highs and lows rest at 72 degrees, the fire department exists only to rescue treed cats and the basketball team never misses the hoop. But the town represents a false hope. The faith that prescription medications are a risk-free solution to life’s health-related problems is based on a similarly false hope.

Buried in the fine print of drug product labels are adverse drug reactions, which are rapidly scrolled on television. Most adverse drug reactions are mild to moderate in severity, but some can be quite serious and even fatal. Data from the U.S. Centers for Disease Control and Prevention (CDC) tell us that unintentional falls were the leading cause of nonfatal injury during the period 2001-15. During the same era, unintentional poisoning (including medications) was the ninth leading cause of nonfatal injury. Unintentional injury was the fifth leading cause of death during 1999-2015. Among these unintentional injuries, poisonings (23.5 percent) and falls (19 percent) were surpassed only by motor vehicle/traffic injuries (32.9 percent) as a cause of death.

Polypharmacotherapy, the therapeutic use of multiple concurrently prescribed medications, obviously occurs in patients treated for multiple co-existing conditions. Polypharmacotherapy is not without risks, however, especially among older patients. “Polypharmacy” is a more commonly used term that has a negative connotation encompassing the risks or potential inappropriateness of combining medications. Polypharmacy is associated with an increased risk of adverse effects, drug-drug interactions, morbidity and mortality. Because medication use is a potentially modifiable risk factor for falls and poisonings, deprescribing medication is an important clinical strategy to consider for patient safety.

The term “deprescribing” was first coined by Australian researchers in 2003, and various definitions have appeared in the literature since then. Deprescribing can be defined as the process of withdrawal of an inappropriate medication, supervised by a health care professional, with the goal of managing polypharmacy and improving outcomes. This definition specifies the withdrawal of an inappropriate medication, but deprescribing also may appropriately involve reducing the dose of a suspect medication, switching to a potentially safer alternative medication, or eliminating an unnecessary medication. Physicians also know that many patients self-deprescribe medications without supervision by reducing doses, tapering, or abruptly stopping medication on their own. Patients do this for various reasons: adverse drug effects; perception that medication is not helping; desire to test the waters without medication; burden of taking too many pills; medication costs; medication fears derived from family comments or media reports; and a preference to pursue non-pharmacological therapies.

The goals of deprescribing medication are to decrease the incidence and prevalence of adverse events, decrease the risks or consequences associated with drug-drug interactions, simplify medication regimens to enhance treatment adherence and re-
duce the direct and indirect costs associated with medication use, while maintaining or improving clinical outcomes. Simply decreasing the number of drugs may not necessarily result in functional improvements, however, and can conceivably be associated with adverse outcomes.

In a systematic review of studies on the feasibility and effect of deprescribing medication in older adults, 134 studies demonstrated that deprescribing reduced the number of medications and the number of potentially inappropriate medications. The nonrandomized studies that were reviewed found that deprescribing was significantly associated with decreased mortality, but there was no significant effect on mortality in randomized studies. Among the studies where general educational deprescribing interventions were compared to patient-specific interventions (which identified target medications to deprescribe), mortality was significantly reduced when patient-specific interventions were applied. Deprescribing was not significantly associated with increased adverse drug withdrawal events, and did not change the incidence of adverse events, change quality of life, or change cognitive function. Deprescribing also did not improve the risk of falls, although those patients who fell had fewer falls.

Another comprehensive review also evaluated deprescribing trials and their impact on prescribing and clinical outcomes. Clinical controlled studies to reduce medication exposure found that medication use can be reduced, but that the impact of medication reduction on outcomes (such as hospitalizations, falls and mortality) was not assessed in most studies. Randomized clinical trials of interventions to reduce medication exposure had mixed results on prescribing and on outcomes, which often were not even assessed. Although various interventions decreased medication exposure in older patients, data on the effectiveness of deprescribing on clinical outcomes was conflicted or lacking.

A general deprescribing medication protocol includes five steps: 1) ascertaining all current medications and the reasons for each drug; 2) considering the overall risk of drug-induced harm in individual patients to determine the required intensity of a deprescribing intervention; 3) assessing each medication regarding its current or future benefit versus harm potential; 4) prioritizing medications for discontinuation based on their benefit-harm ratio, the likelihood of adverse withdrawal reactions, or disease rebound risk; and 5) discussing and implementing a discontinuation plan while closely monitoring patients during follow-up.

Deprescribing medication is a good idea in theory, but may be difficult to implement if there is no communication or collaboration among different prescribers. In addition, studies of groups of patients suggest that deprescribing is feasible and safe, but reported outcomes do not consistently demonstrate general benefits such as fewer falls, better functioning, or not dying, either because the studies do not assess these outcomes or because the outcomes did not consistently differ from treatment as usual. Moreover, a limitation of making clinical decisions based on group data is that group data do not tell us anything about individual patients. Nonetheless, whether deprescribing medication is right for your patient should always be a consideration, and should be assessed on a case-by-case basis and from visit to subsequent visit.

Dr. Howland is a psychiatrist and associate editor of the ACMS Bulletin. He can be reached at howlandrh@upmc.edu.

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 World Health Organization defines self-care as “the activities individuals, families and communities undertake with the intention of enhancing health, preventing disease, limiting illness and restoring health.” Self-care can be traced back among blacks before their arrival in the United States to their native cultures in Africa. Although self-care is not viewed as a legitimate area of health inquiry among most health professionals, in rural South Carolina, the sea island slaves and their descendants (Gullah) passed on West African spiritual traditions intertwined with Christianity. The results were individuals who were either herbalists dispensing ointments and potions to maintain health or conjurers casting spells for luck, love, health, prosperity and protection from enemies or evil spirits. These were called “root doctors” who practiced white or black magic. The term “root” was descriptive because they carried cloth sacks filled in secret with various ingredients, mostly special herbs and roots.

Self-care coping mechanisms practiced by African Americans, for example, had teas and specific plant leaves, stems and roots for internal use curing specific sicknesses and controlling some chronic illnesses; externally using Epsom salts to treat other chronic illnesses, inflammation and arthritis; and garlic to ward off evil spells. The use of self-care blossomed among the black communities and was essential to survival in the South under Jim Crow and in northern ghettos where professional medical care was extremely limited. I grew up in rural South Carolina in the 1950s where access to professional medical care was reserved for the near dead or dying. Everything else was taken care of with fervent prayer, herbs and specific plant leaves boiled into a noxious drink or applied on pieces of cloth or big leaves and wrapped on the area as a poultice home remedy. Kirkland, Mathews, Sullivan and Baldwin edited a book on “Herbal and Magical Medicine” in 2002. Dr. Mathews wrote a chapter called, “Doctors and Root Doctors: Patients Who Use Both.”

Data on self-care are not readily available so I went to a place I suspected it could still be practiced. I spent a week in South Carolina on the border islands where I grew up. I talked to the old and elderly about home remedies and herbal cures from Africa that they still use in lieu of professional health care. I discovered that techniques, plants and herbs found in West Africa weren’t available in South Carolina, so new plants and different techniques, some from the American Indians, had to be incorporated. Most people

**Increasing health coverage and health care access among blacks could improve health outcomes.**

**Is there a role for self-care in the absence of professional health care?**

I talked with used non-biomedical healing traditions when they were children; however, with the advent of modern medical care, few continue to use traditional self-care practices and techniques. Formulas have never been written down, passed on or formalized for future generations. Only minor remnants of these practices remain.

The issues of disparities in medicine and lack of access in modern times have not gone away. According to the Kaiser Family Foundation in 2011, 37 million individuals living in the United States identify as black or African American (12 percent). This group is the third-largest racial or ethnic group in the United States after non-Hispanic whites (65 percent) and Hispanics (17 percent). Forty percent of all blacks are under the age of 26 compared to 35 percent of non-Hispanic whites, and fewer than 10 percent of blacks are over 65 years old compared to 17
percent of non-Hispanic whites. This makes the black population notably younger compared to non-Hispanic whites. Nationwide, in 2013, just over one in five (21 percent) of blacks do not have health insurance. Blacks comprise the largest share of the uninsured in the District of Columbia (52 percent), Mississippi (48 percent) and Louisiana (42 percent).

Coverage for blacks under the Affordable Care Act (ACA) Coverage Expansion was intended to correct this issue of lack of coverage; however, this became problematic because 70 percent of nonelderly blacks are employed in blue collar jobs that typically provide low wages and are less likely to offer health insurance coverage. Most states have expanded coverage for children with Medicaid and CHIP covering over half of the black children (51 percent), but it plays a much smaller role in adults’ coverage, leaving more than a quarter (26 percent) uninsured. Because of the low income of blacks, 94 percent would be in an income range to qualify for Medicaid Expansion or Premium Tax Credits. While ACA intended for Medicaid expansion to occur nationwide, the June 2012 decision of the Supreme Court on ACA made this expansion a state option. Many of the states, particularly in the South where blacks are in large numbers, are some of the same states that chose not to expand Medicaid, leaving six in 10 blacks uninsured. Blacks with incomes below the Medicaid Expansion limit without a new coverage option for insurance remain uninsured.

Even with ACA, blacks are more likely than whites to be uninsured because of the lack of employer-sponsored insurance and many cannot afford to purchase private insurance on the individual market. More research by the Kaiser Foundation shows that the uninsured individual experience worsens with less access to care and poorer health outcomes. This is evident by the significantly higher mortality rate. Black infants and black males of all ages have the shortest life expectancy compared to all other groups. Also, chronic diseases like diabetes or obesity affect a greater percentage of blacks than Hispanics or whites. Increasing health coverage and health care access among blacks could improve health outcomes. Is there a role for self-care in the absence of professional health care?

Today, self-care has gone through yet another evolution. The modern-day version of self-care is achieving psychological and physiological wellness through some modern medications with inspired movement from yoga and Tai-Chi, self-encouraging mantras and Christian prayer. This latest version of self-care has been studied by Duke University regarding the effectiveness of yoga for treatment of depression, schizophrenia, ADHD and sleep disturbances. Harvard’s Mental Health Letters discuss yoga’s ability to reduce heart rate, lower blood pressure and ease breathing problems. Marcus Lorenzo Penn MD, CYT, is the founder and CEO of Self Care Reform Wellness Consultancy. He teaches self-care practices using relaxed breathing, gentle yoga, Tai-Chi, qi-gong, diet and deep self-inquiry to achieve wellness in lieu of traditional medicines. Researchers at the Walter Reed Army Medical Center in Washington, D.C., are offering yoga methods of deep relaxation to veterans returning from combat in hopes that these techniques will be more acceptable and less stigmatizing to the soldiers than traditional psychotherapy.

Millennials have shown a recent obsession with self-care combined with self-awareness to create a generation striving for emotional intelligence. Although self-care in some form can be traced back to the ancient Greeks, the Millennials, creator of the concept of “Me Time,” have developed their own spin on self-care fueled by their constant exposure to the Internet. Millennials have created a $10 billion industry on self-care. In 2015, the Pew Research Center reported that Millennials spent twice as much as Boomers on self-care essentials such as workout regiments, diet plans, life coaching, therapists, apps and Twitter bots to improve their personal well-being.

This constantly evolving self-care remains important for African Americans of this generation as well. In the midst of advocacy, African Americans are affected on an emotional, mental and physical level by issues around race, violence and discrimination. With self-care, when we feel like victims, we can repair ourselves from our lost dignity and constant exposure to dark feelings and use our gained knowledge to live as awakened beings aware of our history, but not defined by it.

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

The Pittsburgh Ophthalmology Society (POS) sponsored an Ophthalmology Community Wet Lab: Pars Plana Vitrectomy for the Anterior Segment Surgeon. Sessions were held at the UPMC Eye Center – Eye and Ear Institute May 30 and June 13, and due to the overwhelming response, a third session was added June 14. Ryan Vaughn, representative from Alcon, and Robert Nelson, representative from Bausch and Lomb, were instrumental in providing equipment, support staff, consumables and teaching assistance for the 2-1/2 hour course.

A maximum of nine physicians attended each session where they learned and practiced Pars Plana Vitrectomy for the anterior segment surgeon. Each work space included standard infrastructure such as a microscope, phaco machine, head model, all disposable ophthalmic products, instruments and fresh pig eyes. One station was set up with a camera and monitor to allow demonstration and observation. Both 23 and 25 gauge systems and trocars were available for practice.

Sharon Taylor, MD, and Ian Conner, MD, PhD, served as course directors and initiated this program offering. A special thank you to the following POS members who served as faculty: Garry Condon, MD, Deepinder Dhaliwal, MD, Joseph Martel, MD, and Thierry Verstraeten, MD, with didactic support from Andrew Eller, MD. Each shared their expertise and pearls of wisdom with colleagues. We also thank UPMC Eye and Ear for use of the wet lab for this worthwhile endeavor.

Comments from participants were stellar, and the Society looks forward to offering sessions in 2018. We welcome suggestions for future wet lab topics or for other educational sessions you would like to see offered. Submit suggestions to Nadine Popovich at npopovich@acms.org.

POS announces speaker for October meeting

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

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

Geriatrics Teacher of the Year Award nominations open Oct. 1

The Pennsylvania Geriatrics Society – Western Division (PAGS-WD) is seeking nominations for the Geriatrics Teacher of the Year Award beginning
Oct. 1. The award will be presented to two outstanding teachers for their dedication and commitment to geriatrics education.

The annual award will recognize and honor both a physician and a professional from another health care discipline including nursing, advanced practice, physical therapy, pharmacy, occupational therapy, dentistry, audiology, speech-language, pathology and social work who have made significant contributions to the education and training of learners in geriatrics and to the progress of geriatrics education across the health professions. Members and non-members of the Pennsylvania Geriatrics Society will be considered.

Eligible nominees will have demonstrated leadership and inspired learners to better the care of older adults and will have contributed to the growth of geriatrics in their professions. Teaching expertise and/or education program development are valued in the selection of the recipient for this honor.

Award eligibility and criteria, along with the nomination form, will be available on the society’s website, www.pagswd.org, Oct. 1. Nominations must be received before Jan. 4, 2018. Questions regarding the awards or nomination process can be directed to Nadine Popovich, administrator, at npopovich@acms.org or (412) 321-5030, ext. 110.

Awardees will be recognized at the dinner symposium held in conjunction with the 2018 Clinical Update in Geriatric Medicine scheduled Thursday, April 5, 2018, at the Pittsburgh Marriott City Center. Recipients will be honored with a plaque and receive complimentary membership in the society for one year.

PAGS-WD Fall Program set

The PAGS-WD Annual Fall Program will be held from 6 to 8:30 p.m. Nov. 9 at the University Club, Pittsburgh.

Toren Finkel, MD, PhD, professor of medicine, University of Pittsburgh School of Medicine, and director, Aging Institute of UPMC Senior Services at the University of Pittsburgh, will present “Geroscience and the Promise of Eternal Youth.”

Online registration begins Sept. 27 on the Society’s website, www.pagswd.org. Registration is free for members; guests are welcome for a nominal fee.

For more information, contact Nadine Popovich, administrator, at npopovich@acms.org or (412) 321-5030, ext. 110.

PAMED Foundation offers medical student scholarships

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

“We recognize that medical students play a vital role in the future of medicine in Pennsylvania so we proudly administer scholarships to deserving students across the commonwealth,” said Executive Director Heather Wilson.

Additional scholarships are offered throughout the year and information can be found on the Foundation’s website at www.foundationpamedsoc.org. Applications are accepted through Sept. 30.

Allegheny County Medical Society Medical Student Scholarship

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

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

Scholarship for Students of South Asian Indian Heritage

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

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

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

Continued on Page 318
Medical Student Luncheon held at University of Pittsburgh

On Aug. 22, 150 medical students attended the University of Pittsburgh Medical Student Luncheon held at the Thomas E. Starzl Biomedical Science Tower on campus.

American Medical Association officers who planned the event were Perry Patton, Nicolas Zuniga-Penaranda, Gideon Nkrumah and David Osei-Hwedieh. Volunteers who also assisted were Stephen Canton and Waseem Lufti. All are second-year medical students at the University of Pittsburgh School of Medicine.

ACMS President David Deitrick, DO, spoke at the event.

Gateway Medical Society, ACMS hosting symposium

The Gateway Medical Society, in collaboration with the ACMS, will present “Reducing Racial Disparities in Cancer Outcomes” from 8 a.m. to 2 p.m. Saturday, Oct. 7, at the ACMS building.

The objectives of the symposium are to identify strategies for addressing social determinants to improve cancer health outcomes in racial and ethnic patients; identify strategies for increasing cancer screening in medically underserved communities; and understand risk factors for selected cancers and barriers to improved health outcomes for African American cancer patients.

Health care professionals from hospitals, health systems, clinics and medical groups as well as policymakers are invited to attend. The event is free and open to the public.

For more information or to register, visit www.gatewaymedicalsociety.org or call (412) 281-4086.

ACMS seeking physicians to participate in senior trail walks

ACMS is seeking physicians to participate in educational walks designed for senior citizens and led by an experienced guide from Venture Outdoors.

The program is part of the Senior Connections initiative started in 2016 by the Jewish Healthcare Foundation (JHF).
The walks are supported by the Allegheny County Parks Foundation and JHF.

Scheduled dates are:

- **Frick Park**: Wednesday, Nov. 15; 1-3 p.m. (Focus on diabetes and exercise)
- **South Park**: Wednesday, Oct. 11; 1-3 p.m. (Focus on heart health); Wednesday, Dec. 20; 1-3 p.m. (Focus on diabetes and exercise)

The Venture Outdoor Guide will lead the group and describe the natural surroundings.

Physician leaders will be asked to provide brief remarks at stopping points for seniors. The remarks can include comments related to your specialty, and will involve answering general questions from the participants.

Please respond to walkdoc@acms.org if you are interested in participating.

ACMS member physician Terence Starz, MD, center, is pictured with attendees at a senior trail walk held at South Park in July.

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**In Memoriam**

John S. Kennerdell, MD, 82, died Friday, August 11, 2017.

Dr. Kennerdell was chairman of the Department of Ophthalmology at Allegheny General Hospital prior to his retirement.

Surviving are his wife, Patricia Kennerdell; children Nancy Kennerdell Lawrence and Jeffrey Kennerdell; and siblings Edward Kennerdell, MD, and Margaret “Peggy” Kennerdell George.

A service was held Thursday, August 31, 2017, at the Magovern Conference Center, Allegheny General Hospital.
SUMMARY
ACMS ALLIANCE MEETING
Wrap-Up 2017 • Kick-Off 2018
Tuesday, June 20, 2017
AGENDA ITEMS ADDRESSED
MEETING MINUTES: 2016-17 were reviewed, discussed
TREASURY: Printed reports by Treasurer S. Da Costa and Assistant Treasurer B. Wible were presented
Subjects year-end and new year including:
• BUDGET 2016-17, reviewed
• DUES (2017-18), discussed
• YEAR END DISBURSEMENTS, 2016-17 decided
• PLANNED AUDIT 2016-17 AUDIT, addressed
• Reports and printed references were provided by ACMS Bookkeeper S. Brown.
LEADERSHIP CONFIRMATION:
Appointments conducted at Annual Meeting, May 23, 2017
MEMBERSHIP:
Insightful dialogue with Governing Board and Mr. Krah, ACMS executive director
BY-LAWS: Need for updating confirmed
CALENDAR: 2017-18: Confirmed
EVENTS: GENERAL MEETINGS (AUTUMN, HOLIDAY, ANNUAL):
Attendance, include ACMS Leadership, Officers and Directors
OTHER: GOVERNING BOARD MEETINGS: Name Moderator for each scheduled GOVERNING BOARD MEETING, to be printed on meeting notice.
THOMPSON AWARD, and AVANTI AWARD: dialogue to be continued
COMMUNICATIONS, BULLETIN, WEBSITE: Need timely content input and info confirmations from Membership; need custodian for website updates
OLD BUSINESS – STATE:
• PAMED Alliance regional/autumn and spring meetings, newsletter and Physician Family Magazine
• ACMSA Regional Director to keep up with PAMED Alliance, share with ACMS, vigilance for support of AMES Fund
NEW BUSINESS: Yearbook updates pending
Heartfelt appreciation to ACMSA Governing Board members and guests, Mr. Krah, and Honorary Member Janet Thompson for sharing thoughtful dialogue, insightful observations and comments. Appreciation to Mrs. LeRoy Wible for morning coffee and goodies. Thanks also for meeting set up, provided by Amy Stromberg, assistant to the executive director at ACMS. Thanks to KJ Reshmi for light gourmet lunch. Of course, recognition/thanks to Susan Brown, ACMS office for meeting materials, Treasury Report printouts, throughout the 2016-17 Alliance year.
NOTICE
Governing Board Meeting
Allegheny County Medical Society Alliance
Tuesday, Sept. 12, 2017
10:30 a.m.
Mrs. LeRoy Wible, Moderator

The meeting will be held at the Allegheny County Medical Society Building, 713 ACMS Ridge Ave., Pittsburgh. Ample on-site parking available. Please RSVP by Sept. 7 to KJ Reshmi at kjreshmi@aol.com or (412) 884-0657.

HEADS UP REMINDER
Pennsylvania Medical Society Alliance Annual Meeting
The Alliance of the Pennsylvania Medical Society will be holding its Annual Meeting Oct. 14-15 at the Hershey Lodge in conjunction with the PAMED House of Delegates meeting. Plan now! PAMED Alliance membership is not required for the business elements of the Alliance’s Annual Meeting. PAMED Alliance members, spouses and guests are encouraged and welcome to participate in all events and social activities. Members, spouses and guests must register. For information on registration, visit: https://www.pamedsoc.org/annual-meeting/house-of-delegates/alliance-activities-for-families or call 717.558.7750 ext. 1503.

CONTENT AND TEXT BY KATHLEEN JENNINGS RESHMI
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Extended-release injectable naltrexone: A proactive approach to alcohol use disorders

Carlie Bodenschatz, PharmD Candidate

Introduction

According to the 2015 National Survey on Drug Use and Health, approximately 15 million adults in the United States live with an alcohol use disorder. Alcohol is ranked as the fourth leading preventable cause of death in the country, claiming the lives of approximately 88,000 Americans each year. In addition, an estimated $185 billion in health care costs, lost wages, and property damages result from alcohol use disorders each year in the United States. In the current practice guidelines for the treatment of alcohol use disorders, medication therapy is recommended to be utilized in addition to psychosocial therapy.

Terminology

With the release of the Diagnostic and Statistical Manual of Mental Disorders fifth edition (DSM-5) in May 2015, terminology used to classify alcohol use disorders was updated. The term alcohol use disorder replaces the two previous classifications, alcohol abuse and alcohol dependence. Now, alcohol use disorder encompasses all alcohol disorders and is broken down into three sub-classifications—mild, moderate, and severe. These sub-classifications are based on the number of diagnostic criteria that are met within the defined time period of one year. Diagnosis of alcohol use disorder requires patients to meet at least two of the eleven diagnostic criteria. Patients with two to three criteria are classified as mild, four to five are classified as moderate, and six or more are classified as severe. Previously, alcohol abuse and alcohol dependence each had separate diagnostic criteria which created confusion. Alcohol use was associated with patients meeting one or more of its four specific diagnostic criteria, and alcohol dependence was designated to patients meeting three or more of its seven specific diagnostic criteria. The updates provided in DSM-5 incorporated revised terminology, the inclusion of cravings as a diagnostic criterion, and the elimination of legal problems from the list of criteria. Overall, the restructuring and redefining of diagnostic terminology helped to create a simplified method of classifying patients with alcohol use disorders.

Vivitrol® (extended-release naltrexone)

Vivitrol® is an extended-release formulation of naltrexone approved for the indication of alcohol use disorders by the Food and Drug Administration in 2006. The extended-release formulation is an injectable suspension administered intramuscularly every four weeks. This product was developed with the intent to improve patient adherence and provide an alternative to daily oral naltrexone which was first approved for the indication in 1994. Its mechanism as a mu-opioid receptor antagonist involves blocking the effects of ethanol and sequentially blocking the pleasure one typically experiences after drinking alcohol. Through this mechanism, the medication has been shown to decrease both alcohol cravings and the amount of drinks consumed. Vivitrol® can help patients maintain abstinence and prevent relapse through its 30-day constant release formulation. It is well tolerated and associated with only mild side effects such as nausea, vomiting, fatigue, and injection site reactions.

To examine the efficacy of Vivitrol® in patients with alcohol use disorders, a multicenter, double-blind, placebo-controlled trial was organized in the United States. Patients were randomly assigned to either treatment or placebo groups, and all patients additionally received psychosocial counseling. The trial was a phase III efficacy trial in which patients from 24 different sites across the country received 24 weeks of monthly injections of Vivitrol®. Within the entire population studied, patients in the treatment group were reported to have a 25 percent decrease in heavy drinking days while on Vivitrol® compared to placebo. A subset of patients who remained abstinent for at least four days prior to initiation of treatment showed clinically significant improvement in outcomes compared to placebo. In the four-day abstinence subset of the treatment group, 24 percent of patients main-
tained abstinence for the six-month treatment period (11 percent with placebo) and 70 percent experienced no more than two heavy drinking days per month (30 percent with placebo). Additionally, the median number of days until consuming the first drink was three times greater in the treatment group compared to the placebo group. The median number of days until a heavy drinking experience was nine times greater with the treatment group compared to the placebo group. The drug’s effect on decreasing cravings and pleasure from drinking alcohol contributed to decreased alcohol intake and longer durations of abstinence in the treated patients.²

### Proactive approach

Since clinically significant benefits are shown to exist with Vivitrol® use, it is worth considering Vivitrol® for patients being discharged following an alcohol-related hospital admission. Throughout inpatient management of alcohol withdrawal, goals of therapy are focused on providing the patient with a safe and comfortable detoxification process while also managing symptoms. However, once the detoxification stage is complete, the next step is to help patients gain motivation to treat their alcohol use disorder, the underlying problem.³ Immediately following discharge, patients are at a high risk for relapsing. If patients were to receive Vivitrol® prior to discharge, the treatment could be beneficial during the transition from the hospital to their daily life. The proactive administration of a long-acting injection prior to discharge could help reduce cravings in these patients and increase their chances of maintaining abstinence until they begin other treatments such as psychosocial therapy.

The selection of the four-day abstinence period in the subset group in the study above was based on the median length of stay for patients being treated for detoxification in the United States.² Vivitrol® was shown to provide the best clinical outcomes in patients who were

Continued on Page 324
abstinent for a minimum of four days prior to initiation. Therefore, prior to discharge is an optimal time to initiate therapy. At this point in time, their abstinence in the days prior to initiation places them at an increased likelihood of experiencing beneficial outcomes of Vivitrol®.

Additionally, treating patients with Vivitrol® can lead to decreased health care related costs. One hospital system conducted a project to determine if administering Vivitrol® to homeless individuals with alcohol use disorders would result in cost savings. The idea for this project originated when the hospital identified this specific subpopulation as its most costly contributors. Some patients were identified to have had between 50 and 100 emergency room visits in a year. The hospital system was able to secure funding to provide Vivitrol®, costing about $1,500 a dose, to uninsured homeless individuals with the hope of providing a treatment that will increase positive outcomes. The project was coordinated with an outpatient clinic so that patients would receive a total of two to three months of Vivitrol® treatment. It was found that within the time period of this project, the rate of emergency room visits decreased to fewer than one per month for most patients, therefore decreasing hospital costs.

**Summary**

Alcohol use disorders are highly prevalent in the United States and contribute to a significant amount of health care costs each year. The use of Vivitrol® has been shown to have clinically significant benefits in patients with alcohol use disorders who begin therapy after at least four days of abstinence. Vivitrol® also was shown to significantly decrease emergency room admissions related to alcohol use disorders when provided to uninsured, homeless individuals. Through taking a proactive approach and administering Vivitrol® prior to discharging vulnerable patients hospitalized for alcohol-related reasons, patients can have an increased likelihood of maintaining abstinence after discharge. By maintaining abstinence, patients are able to control and overcome alcohol use disorders and prevent future hospitalizations.

At the time of this writing, Ms. Bodenschatz, a doctor of pharmacy candidate at Duquesne University School of Pharmacy, 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, PharmD, BCPS, at Allegheny Health Network, Allegheny General Hospital, Center for Pharmaceutical Care, Pittsburgh, Pa., (412) 359-3192 or email tucker.freedy@ahn.org.

**References**


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Recent decision may change how physicians obtain informed consent

Lauren Rulli, Esq.

Physicians across the Commonwealth of Pennsylvania should be aware of a recent Pennsylvania Supreme Court decision that may change how informed consent is obtained from patients. In Shinal v. Toms, 162 A.3d 429 (Pa. 2017), the 4-3 Court ruled that only physicians, not members of their staff, may obtain informed consent from patients before performing major medical procedures.

The law regarding informed consent

Pennsylvania courts have long recognized that a physician must obtain informed consent from a patient before performing a surgical or an operative procedure. In doing so, courts fashioned the “informed consent doctrine” – binding case law that is created by the courts, rather than the legislature, commonly referred to as the “common law.” The informed consent doctrine was based on the theory that a procedure without informed consent is an unauthorized “touching” constituting an actionable battery under tort law.

Informed consent became statutory law on Nov. 26, 1996, when the Pennsylvania Legislature amended the Health Care Services Malpractice Act to codify the informed consent doctrine. This law, called the Medical Care Availability and Reduction of Error (MCARE) Act, 40 P.S. § 1303.504, not only incorporated the requirement that physicians obtain informed consent for surgeries, but it also expanded the informed consent doctrine to include non-surgical procedures. It reads, in pertinent part, as follows:

(a) Duty of physicians. Except in emergencies, a physician owes a duty to a patient to obtain the informed consent of the patient or the patient’s authorized representative prior to conducting the following procedures:

(1) Performing surgery, including the related administration of anesthesia.
(2) Administering radiation or chemotherapy.
(3) Administering a blood transfusion.
(4) Inserting a surgical device or appliance.
(5) Administering an experimental medication, using an experimental device or using an approved medication or device in an experimental manner.

(b) Description of procedure. Consent is informed if the patient has been given a description of a procedure set forth in subsection (a) and the risks and alternatives that a reasonably prudent patient would require to make an informed decision as to that procedure. The physician shall be entitled to present evidence of the description of that procedure and those risks and alternatives that a physician acting in accordance with accepted medical standards of medical practice would provide.

(d) Liability.

(1) A physician is liable for failure to obtain the informed consent only if the patient proves that receiving such information would have been a substantial factor in the patient’s decision whether to undergo a procedure set forth in subsection (a).

(2) A physician may be held liable for failure to seek a patient’s informed consent if the physician knowingly misrepresents to the patient his or her professional credentials, training or experience. (40 P.S. § 1303.504)

The MCARE Act has been interpreted narrowly by Pennsylvania courts to require informed consent only for the listed medical procedures: surgeries, radiation, chemotherapy, non-surgical related blood transfusions, inserting a medical device, and administering an

For fear of legal liability, physicians now must be involved with every aspect of informing their patients’ consent.
The plaintiff sued her physician for medical malpractice after a complicated brain surgery to remove a tumor went wrong. During a jury trial, the physician testified that, before the procedure, he met with the plaintiff to discuss the risks and different approaches to the surgery. He explained that there were two surgical approaches – a more risky one that had a better likelihood of long-term success, or a less risky one that was safer in the short term, but the tumor would more than likely grow back. By the end of the meeting, the physician understood that the plaintiff wanted to move forward with the surgery, but she had not decided whether she wanted the more risky or less risky approach.

Shortly thereafter, the plaintiff had a telephone call with the physician assistant about the surgery. The physician assistant answered the plaintiff’s questions about radiation, scarring and the incision. About a month later, the physician assistant met with the plaintiff in person. During this meeting, the physician assistant provided additional information about the procedure and obtained a signed informed consent form for the more risky surgical approach. Unfortunately, the surgery did not go as planned, resulting in stroke, brain injury and partial blindness.

The plaintiff sued the physician claiming that she was not informed of the risks associated with the surgery, and, if she had known, she would have chosen the less risky approach.

In court, it came down to a “he said, she said” scenario – the physician said that he properly obtained the plaintiff’s informed consent, but the plaintiff said that he did not. During trial, the judge instructed the members of the jury that, in deciding whether informed consent was properly obtained, it could consider the communications that the physician assistant had with the plaintiff. The jury returned a verdict in favor of the physician, and the plaintiff appealed.

**The Pennsylvania Supreme Court’s Decision and its impact**

The Pennsylvania Supreme Court reversed and held that the duty to obtain informed consent from a patient belonged solely to a physician who was performing the treatment and was non-delegable. In doing so, the Court explained that, under both the informed consent doctrine and MCARE Act, “a physician cannot rely upon a subordinate to disclose the information required to obtain informed consent.”

The Court stressed that “without direct dialogue and a two-way exchange between the physician and patient, the physician cannot be confident that the patient comprehends the risks, benefits, likelihood of success, and alternatives.”

This decision is now binding law across the Commonwealth of Pennsylvania, meaning that Pennsylvania physicians who rely on their staff to obtain informed consent from patients for medical procedures listed in the MCARE Act, including surgeries, will need to change their practice so that information relating to the procedure is communicated by the physician – not a qualified member of the staff – and patients are consenting to the physician who is performing the surgery.

Critics to the decision believe the Court placed unnecessary burdens on already overworked physicians. As the three justices who dissented from the majority noted, this “decision will have a far-reaching, negative impact on the manner in which physicians serve their patients. For fear of legal liability, physicians now must be involved with every aspect of informing their patients’ consent, thus delaying seriously ill patients’ access to physicians and the critical services that they provide.”

There is no doubt that the Shinal decision raises questions. For example, oftentimes, for more routine procedures, physicians rely on videos or pamphlets to educate a patient on the risks and benefits of a procedure before opening the floor for questions. However, under Shinal, this is no longer a proper way to obtain informed consent because the information is not coming from the physician. Another example is a situation in which one physician explains a procedure to a patient, but another physician performs the surgery. This also seems prohibited under Shinal, because the same doctor that obtains the informed consent is not performing the procedure.

We may need to wait for future lawsuits in which the courts clarify these situations. In the meantime, however, physicians should make it part of their practice to abide by the Shinal decision and obtain patients’ informed consent themselves.

Ms. Rulli is an associate at Tucker Arensberg and is a member of the firm’s Healthcare Practice Group. She can be reached at (412) 594-5510.
Tri Rivers Musculoskeletal Centers is proud to welcome Orthopaedic Foot and Ankle Surgeon Christopher T. Edwards, MD.

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Orthopaedic Foot & Ankle Surgeon

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Dr. Edwards is an orthopaedic foot and ankle surgeon at Tri Rivers Musculoskeletal Centers. He received his medical degree from the Pennsylvania State University College of Medicine in Hershey, Pa., and completed both his orthopaedic surgery residency and his orthopaedic foot and ankle fellowship at UPMC. Dr. Edwards provides the following clinical services:

- Reconstructive foot and ankle surgery
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Lyme disease surveillance in Allegheny County

Lyme disease is caused by the bacterium *Borrelia burgdorferi*, which is transmitted by the blacklegged tick *Ixodes scapularis* after attachment to the skin for more than 36 hours. Approximately 30,000 cases are reported nationally each year, but CDC estimates that the number of individuals diagnosed with Lyme disease is approximately 10 times higher. In endemic areas, the number of confirmed cases depends on the completeness of reporting and the capacity of the local health department to investigate laboratory reports.

From 2006 to 2016, the number of Lyme disease reports received by the Allegheny County Health Department (ACHD), mostly from laboratories, increased dramatically (Figure 1). In 2014, ACHD attempted to investigate all reports and classified 822 reports as confirmed or probable Lyme disease. In 2015 and 2016, ACHD investigated a 20 percent sample of reports and estimated cases to be 971 and 1285, respectively (Figure 2). All age groups and all areas of the county were affected (Figure 3).

Case counts based on laboratory reports alone underestimate the true burden of disease given that many cases are diagnosed and treated without testing. Therefore, ACHD asks providers to report cases of Lyme disease diagnosed based on erythema migrans (EM) rash to ACHD via PA-NEDSS. Current treatment recommendations for Lyme disease are outlined in the Clinical Practice Guidelines by the Infectious Diseases Society of America. ACHD recommends advising patients about the high incidence of Lyme disease in the county and the need for personal protective measures, such as using insect repellent, showering after being outdoors, checking for ticks and removing them promptly and clearing tick habitat in yards.

Continued on Page 330
Hepatitis C surveillance in Allegheny County

Reported cases of newly diagnosed hepatitis C continue to increase in Allegheny County (Figure 4). In 2016, ACHD received reports of 2,824 newly diagnosed chronic cases (formerly called “past/present” cases), classified on the basis of laboratory tests. The number of newly reported cases does not reflect current incidence or prevalence for several reasons: 1) for most reported cases, the time of infection is unknown; 2) some cases may no longer have the virus after clearing the infection or after treatment; and 3) many persons who are infected have never been tested, diagnosed or reported. Changes in case definition and case investigation practices may have affected the recent trend in case counts. The increase in Allegheny County, however, is suggestive of a growing burden of disease, an increase in testing, or most likely, both. To track new infections, ACHD strongly en-

Figure 3

Lyme disease case estimates by age group & sex Allegheny County, PA, 2016

Number of estimated cases

Age group


M  F
courages providers to report acute cases of hepatitis C, as these can be identified only if information on symptoms is provided. In 2016, there were only 11 cases of acute hepatitis C, which is far less than what we would expect. Intravenous drug use continues to be the most common risk factor for both acute and chronic cases.

Several new developments should increase the identification of hepatitis C cases and facilitate treatment:

1. The Pennsylvania Hepatitis Screening Act (Act 87 of 2016) went into effect on Sept. 18, 2016. The Act states that a hepatitis C test must be offered to all individuals born between 1945 and 1965 who receive health services as a hospital inpatient or who receive primary care in a health care provider’s office, health care facility or hospital outpatient department in the state of Pennsylvania.

2. The Pennsylvania Department of Human Services (DHS) announced a change to the state’s Medicaid Assistance policy to expand coverage of treatment of hepatitis C virus (HCV) to individuals who have liver function test scores of F1 or F0. Under the new policy, the Department will authorize the drugs for beneficiaries with test scores of F1 starting on July 1, 2017, and for those with scores of F0 starting on Jan. 1, 2018. Only infectious disease physicians and gastroenterologists are authorized to write prescriptions for HCV direct-acting antivirals for Medicaid patients.


References
Doctors across the country who want to preserve their independence are joining a fast-growing trade association that not only serves as their collective voice on the local and national stage, but also saves them money.

With nearly 1,000 members in 33 states across the country and chapters in California, Florida, South Carolina, New England and soon Pennsylvania, the Association of Independent Doctors (AID) speaks out on behalf of frustrated independent doctors who don’t have the time, resources or clout to fight the formidable forces facing them.

A national non-profit, AID also helps independent doctors by educating consumers, lawmakers, businesses and the media about why saving America’s independent doctors matters.

Since it began in 2013, AID has successfully and relentlessly pursued its goals of stopping health care consolidation, which drives up costs; fighting for price transparency; eliminating facility fees; promoting equal reimbursements for physicians whether they are independent or employed; and exposing the abuse of the tax-exempt status by nonprofit hospitals.

“If all these trends were reversed, independent doctors would enjoy healthier practice dynamics and Americans would save hundreds of billions in health care costs,” said Marni Jameson Carey, AID’s executive director.

Moreover, doctors who join AID enjoy other benefits, including a significant savings on medical malpractice insurance. Through a collaboration with Coverys, an A-rated provider of medical liability coverage, AID members receive a 15 percent discount off their med-mal premiums.

Doctor members also get a listing in the organization’s online directory, designed to help patients and referral sources find independent doctors, and can participate in AID-Save, a group savings program.

A state chapter is not far off. “We already have five members in Pennsylvania, and our footprint in the Keystone State is growing,” said Carey, who addressed the Pennsylvania Medical Society in August. “Individual membership is great, but chapters are even better. When we have a strong base of support in one area, we have more sway with lawmakers and media.”

Central Pennsylvania felt the impact of AID’s anti-trust efforts last summer when the association worked with the Federal Trade Commission to block the Penn State Hershey Medical Center and Pinnacle Health System merger.

“We still have so much more to do,” said Carey.

To join the cause or learn more about AID, go to www.aid-us.org/join, or call (407) 571-9316. To find out more about the Coverys benefit, go to www.aid-us.org/coverys.
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  - Phone: 1.877.497.5065

If your practice has 16 or more MIPS-eligible clinicians:
- Visit the Quality Insights Quality Innovation Network (QIN) website: www.qualityinsights-qin.org
- QIN Contacts for PA
  - Lisa Sagwitz – email: lsagwitz@qualityinsights.org, ph: 1.800.642.8686, Ext. 7714
  - Joe Pinto – email: jpinto@qualityinsights.org, ph: 1.800.642.8686, Ext. 7817

About Quality Insights QPP Support Center

Quality Insights is the Quality Payment Program-Small Underserved and Rural Support (QPP-SURS) Center for Delaware, New Jersey, Pennsylvania and West Virginia under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The Quality Insights QPP Support Center is available to help MIPS Eligible Clinicians in small, underserved and rural practices successfully prepare for and participate in the QPP. To learn more about the Center, visit www.qppsupport.org.

About Quality Insights Quality Innovation Network

Quality Insights is the Quality Innovation Network-Quality Improvement Organization (QIN-QIO) for Delaware, Louisiana, New Jersey, Pennsylvania and West Virginia. Quality Insights collaborates with health care providers, patients and allied organizations across the network to bring about widespread, significant improvements in the quality of care they deliver. We are committed to reaching the Centers for Medicare & Medicaid Services’ goals of better care, smarter spending and healthier people. To learn more about the network, visit www.qualityinsights-qin.org.

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

Is it worth my time to attend? YES!
Some of the things past attendees say about these meetings:
- Invaluable
- Relevant to my job
- Always walk away with important updates

2017 Fall Meeting Schedule

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

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

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

Register online at www.pamedsoc.org/ManagerMeeting

* Live webcast is also available; call-in information will be provided prior to the meeting.

These meetings are available exclusively to PAMED members as a free member benefit.
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Nominating Committee Report
for Officers and Delegates
August 7, 2017

The Nominating Committee is pleased to recommend the following candidates for election to office in 2018. Nominations will remain open until October 1, 2017; additional nominations may be made until that date. Elections will take place the last week of October.

President
Robert C. Cicco, MD
(Automatically becomes president)

President-elect
Adele L. Towers, MD

Vice President
William K. Johnjulio, MD

Secretary
Patricia L. Bononi, MD

Treasurer
Peter G. Ellis, MD

Directors (Five to be elected)
Todd M. Hertzberg, MD
Lawrence R. John, MD
Abraham J. Kabazie, Jr., MD
Mohannad Kusti, MD
David A. Logan, MD
Ezz-Eldin Moukamal, MD
Matthew B. Straka, MD
Angela M. Stupi, MD
Marcela Böhm-Vélez, MD

Other Directors currently serving but not up for election this year:

Term Expires in 2018
David L. Blinn, MD
William F. Coppula, MD
Kevin O. Garrett, MD
Raymond E. Pontzer, MD
John P. Williams, MD

Term Expires in 2019
Thomas B. Campbell, MD
Michael B. Gaffney, MD
Keith T. Kanel, MD
Jason L. Lamb, MD
Maria J. Sunseri, MD

Peer Review Board
Term Expires in 2020
James W. Boyle, MD
Matthew A. Vasil, DO

Other members currently serving but not up for election:

Term Expires in 2018
Sharon L. Goldstein, MD
Bruce L. MacLeod, MD

Term Expires in 2019
Robert W. Bragdon, MD
Matthew B. Straka, MD
### Delegates (Eleven to be elected)  
[may serve three two-year terms]

- William F. Coppula, MD
- Patricia L. Dalby, MD
- M. Sabina Daroski, MD
- David J. Deitrick, DO
- Kevin O. Garrett, MD
- Mark A. Goodman, MD
- Jan W. Madison, MD
- Ralph Schmeltz, MD
- William Simmons, MD

### Other members currently serving but not up for election:

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### Alternate Delegates  
(Ten to be elected)  
[one-year term]

- Coleen A. Carignan, MD
- Robert C. Cicco, MD
- Amber Rae Elway, DO
- Sharon L. Goldstein, MD
- Richard B. Hoffmaster, MD
- Abraham J. Kabazie, Jr., MD
- Srinivas Kondapalli, MD
- Mohannad Kusti, MD
- Sanford Littwin, MD
- Barbara S. Nightingale, MD
- Deval M. Paranjpe, MD
- Joseph C. Paviglianiti, MD
- Lauren Sciullo, MS
- Matthew B. Straka, MD
- Adele L. Towers, MD
- Matthew A. Vasil, DO
- John P. Williams, MD

Respectfully submitted,

Matthew B. Straka, MD  
Chair, Nominating Committee

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2017 NOMINATING COMMITTEE

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<tr>
<th>Name</th>
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<td>David L. Blinn, MD</td>
<td>Michael B. Gaffney, MD</td>
<td>G. Alan Yeasted, MD</td>
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<td>James W. Boyle, MD</td>
<td>Matthew B. Straka, MD</td>
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<td>Niladri Das, MD</td>
<td>Matthew A. Vasil, DO</td>
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Poetry Corner


On the Neurobiology of Love

Love lights up in the longing brain
like a blush on the burning cheek,
deep amid the limbic pools of dopamine,
which even before the images were taken
lay stirring in the feral gardens
and primitive lairs of infatuation,
where Gabriel and Evangeline,
where Abelard and Heloise,
Tristan, Isolde and countless others
sighing and caving on their knees
were wont to secret and obsess;
hidden circles,
genius loci dispassionately named
the ventral tegmental and caudate nucleus
by Dr. Tom Willis who went there first
three and one half centuries ago,
unfolding the occipital lobes and guessing,
as he applied his probe, that passion lay within.
So now under the prying lens
of functional magnetic resonance
we see the very core of yearning
that consumes them
and map the pathway to distraction
over which a small group of lovesick volunteers
are driven on restless nights:
“My darling…My sweetheart…My joy…My pain.”
Love glows in the longing brain,
amid the stirring pools of dopamine
with an ardor that a thousand poets have mistaken
as a fondness of the heart,
and will again.

Michael Hepler-Smith, MD, is a pediatrician
and can be reached at bulletin@acms.org.
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The project is supported by the Pennsylvania Medical Society and our physician-led medical specialty partners.

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