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Wash your hands early and often, my friends. There’s been a huge surge in viral conjunctivitis cases lately. As any ophthalmologist will tell you, there’s no treatment for viral conjunctivitis other than supportive measures in most cases. Exceptions are certain dastardly viral strains which cause an entity known as epidemic keratoconjunctivitis (EKC). This can cause conjunctival membranes which must be debrided daily – a bloody and painful process. EKC can impair vision, and its sequelae can take months to treat and resolve. The treatment for this horror is judicious use of topical steroid to prevent scarring when membranes occur, and should be given only by an ophthalmologist who can closely follow the patient, lest the diagnosis be something else (herpes simplex virus, etc.) that is disastrously worsened by steroids.

EKC is awful, and can masquerade as entities far worse. I’ve seen referrals for orbital or preseptal cellulitis turn out to be EKC. I’ve seen referrals for scleritis turn out to be EKC. I wash my hands, and my writing instruments, and get the entire exam room and anything the patient contacted scrubbed down immediately after seeing any patient with EKC (or any infectious conjunctivitis). Gloves are de rigueur. As soon as I get home, I do two loads of laundry – I throw my clothes and then my lab coat in the washer (with bleach), and take a shower and wash my hair. (Perhaps I have OCD. Perhaps. But I saw a fellow resident succumb to EKC during training and that was enough for me.)

To tell a patient with viral conjunctivitis that there’s nothing you can do for him beyond artificial tears and cold compresses is to invite a look of abject disappointment and severe frustration, as well as the occasional audible profanity. “You mean there’s nothing you can give me to fix this?” The “antibiotics won’t work for this because it’s a virus” speech is often received poorly, with a response reminiscent of a bear growling. Any of you who treat the common cold/viral upper respiratory infection will be able to identify this look instantly.

But perhaps there is no sight quite as pathetic (pun intended) as an ophthalmologist who has contracted viral conjunctivitis. We’ve done everything possible to avoid it, and picked it up anyway. Perhaps it has something to do with having to keep one’s face two inches from each patient’s face while examining them in the slit-lamp while some of them feel free to cough, sneeze, or even chatter away. I can imagine the little viral particles flying around in every microscopic droplet. Even if you wear a mask, your eyes are still exposed. It’s like being a pediatrician, or a school teacher, or a parent … but at extremely close quarters with your sick charges for the entire day.

But what to do? You have viral conjunctivitis. Desperation sets in. You certainly don’t want to spread it to anyone, and you need to be rid of it – quickly. You have a full OR schedule next week. There is an urban legend that has been circulating for decades among ophthalmologists about the off-label use of Betadine ophthalmic solution (5 percent) to reduce the viral load and speed recovery. (This solution is normally used as a preoperative antiseptic in the OR before eye surgery.) The Betadine cure is ridiculously simple. It’s brilliant. It makes perfect sense in theory. And it’s cheap.

Everyone knows someone who knows someone who has done the Betadine cure. No one remembers exactly how long it took to get better but everyone knows both someone who swears it worked and someone who scoffs at it. Some have even used it as an off-label Hail Mary treatment for their patients with severe EKC, and studies are underway in adults and children.

Everyone, however, agrees on one thing: It hurts like the dickens. The cure is far worse than the disease, and results in hours of agony even if you pretreat the eyes with topical
anesthetic. (IV sedation makes all the difference for the patients undergoing surgery who have a Betadine ophthalmic prep.) I remember driving a friend home from clinic in training because he hadn’t considered the possibility that he couldn’t drive after self-treating with Betadine. (It worked in his case.) The Hail Mary treatments that I saw helped somewhat, but universally left the patients screaming in agony. It’s the sort of treatment that makes you wish they had been given a swig of whiskey and a bullet to bite. It’s the closest we come to the Wild West.

I bring this up not to suggest that you entertain giving yourself (or your worst enemy) a Betadine prep if you contract conjunctivitis, but to discuss human nature. If we are willing to resort to such a painful anecdotal remedy in our desperation for a quick cure so we can return to function as physicians, how can we blame our patients for turning to the Internet for help with their ailments when what we can offer them for their disease beyond a point is only supportive therapy? After all, they’re looking for off-label uses of common ingestibles and treatments, just like we might in desperation. They seek a return to function, and preservation of health.

From the beginning of human history, people have sought out healers in search of a tangible cure — something that they can hold in their hands and believe in their hearts will work. While that tangible cure may have evolved from a handful of herbs and a magical amulet to one produced to more ordered and scientific systems of medicine, human nature hasn’t changed. Even in the age of Western allopathic medicine, people still unconsciously want something that they can walk away holding, even if they know it’s only a placebo. It’s the primal need for a feeling of control over one’s illness. “Give me a pill for this, doctor.” This is what naturopaths do, and why patients love them — they walk into the naturopath’s office and walk out with a concrete “solution” when the allopathic doctor denies them an antibiotic pill.

But what if that “placebo” actually worked in terms of supportive therapy? What if you could placate the legions of irate virus-afflicted antibiotic-seekers with a pill which would contain evidence-based supportive therapy but no prescription antibiotic? Or better yet, an antiviral? (The antiviral pill makers would certainly like this scenario. Patients would love this scenario if supportive pills were over the counter and cheap. Who wouldn’t?)

If we start to view alternative medicines — everything from turmeric to garcinia cambogia to arnica — as off-label use of common foods and herbs, what a change in thinking it might be. Studies can be done and these can be incorporated, if deserving, into evidence-based medicine. This also would quell the cries of that annoying person you may know who insists that everything “natural” is good for you and anything you prescribe is bad because it has “chemicals” in it. (And to whom you may reply drily: “Well, arsenic is natural.…”)

Imagine a pill which will not only satisfy your patient’s primal need for a Thing to Help Them, but which actually would help them — and help you better treat disease, and advance medical knowledge.

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.

There are currently two openings on the Bulletin Editorial Board for ASSOCIATE EDITOR. The position requires an interest and flair for writing and the willingness to contribute an editorial column of 500-900 words twice per year. Associate editor terms are for two years; they may serve three consecutive terms. Selection of the final candidate will be made by the Editorial Board and the ACMS Board of Directors. Please email or fax a short letter and a writing sample to Bulletin Managing Editor Meagan Welling at mwelling@acms.org, or fax (412) 321-5323.
We are living in an era of disaffection; a time filled with fear, anger and resentment. Sixty-five years ago, in the wake of World War II, Eric Hoffer published his classic book “The True Believer: Thoughts on the Nature of Mass Movements.” Hoffer, a long-shoreman turned social philosopher, wrote: “Though the disaffected are found in all walks of life, they are most frequent in the following categories: (a) the poor, (b) misfits, (c) outcasts, (d) minorities, (e) adolescent youth, (f) the ambitious (whether facing insurmountable obstacles or unlimited opportunities), (g) those in the grip of some vice or obsession, (h) the impotent (in body or mind), (i) the inordinately selfish, (j) the bored, (k) the sinners.” Do you see yourself in one of these categories, or do you think they only describe others?

Hoffer’s interest was to understand and describe the psychological motivations of individuals that coalesce around fanatical or extremist cultural movements. Hilary Hinton Ziglar, better known as “Zig,” worked as a salesman before becoming famous as a motivational speaker. He also understood the psychology of the individual. As a true believer in human potential, Ziglar’s interest was to motivate others to get what they want in life. In his first book, “See You at the Top,” he wrote: “Life is an echo. What you send out comes back. What you sow, you reap. What you give, you get. What you see in others, exists in you.”

The right-leaning lobbyist Ed Rogers, who once worked in the White House, made the following comments in an opinion piece written for The Washington Post last December: “The war on terror could define our times, yet the Republicans are off-message because of the Trump idiocy. Republicans need to remind voters of the danger Obama has put us in and of how Hillary Clinton and other Democrats on the ballot have been complicit in creating America’s new vulnerabilities.”

Pollsters would call me an independent – unaffiliated by political party. Neither am I held sway by the gravitational pull from the planetary systems of left-wing or right-wing ideology. I would say to Rogers that terrorism has already defined our times in myriad ways. Republicans are not off-message because of Trump or his idiocy. They are off-message because they have no idea themselves what to do. Republicans are off-message because they, too, have been complicit in creating the world of disaffection we live in. They are off-message because they share the simplistic ways of thinking that characterize politicians running for office.

From my perspective as an independent observer, there does not appear to be a deficiency of effort devoted to reminding voters of the dangers Obama has put upon us or of the harmful complicity of Clinton and other Democrats on the ballot. Indeed, Republicans and Republican-leaning media have incessantly blamed Obama, Clinton and the Democrats for the ills of the world and the dangers they believe we face. I would say that incessant blaming serves no useful purpose for public discourse or educating voters. Incessant blaming is a transparent effort to win an election through emotional appeals. Incessant blaming also masks an underlying emptiness of thought and reason. No one is above criticism, but critics should put themselves in the position of those they criticize. What you see in others, exists in you.

Rogers also invoked the specter of the late Lee Atwater, a political consultant known for his harsh and aggressive tactics to win elections. “Where’s Lee Atwater when you need him?” Rogers asked. “Every other GOP candidate needs to come out against Trump with both fists. If they are afraid to do so, they shouldn’t even be in the race.” Within the current crop of presidential wannabes, too many of these aspirants are pungent examples of what Richard Hofstadter called the paranoid style in American politics, running for office by fueling fear, anger, and resentment. Atwater was part of that ugly historical legacy, which he later admitted to and apologized for:

“My illness helped me to see that what was missing in society is what was missing in me: a little heart, a lot of brotherhood. The ’80s were about acquiring – acquiring wealth, power, prestige. I know. I acquired more wealth, power, and prestige than most. But you can acquire all you want and still feel empty. What power wouldn’t
I trade for a little more time with my family? What price wouldn't I pay for an evening with friends? It took a deadly illness to put me eye to eye with that truth, but it is a truth that the country, caught up in its ruthless ambitions and moral decay, can learn on my dime. I don't know who will lead us through the '90s, but they must be made to speak to this spiritual vacuum at the heart of American society, this tumor of the soul."

The humanist, novelist and philosopher Aldous Huxley died the day President Kennedy was assassinated. Earlier that year, he wrote "Culture and the Individual" for *Playboy* magazine:

“Between culture and the individual the relationship is, and always has been, strangely ambivalent. We are at once the beneficiaries of our culture and its victims. Without culture, and without that precondition of all culture, language, man would be no more than another species of baboon. It is to language and culture that we owe our humanity.... Working on the twelve or thirteen billion neurons of a human brain, language and culture have given us law, science, ethics, philosophy; have made possible all the achievements of talent and of sanctity. They have also given us fanaticism, superstition and dogmatic bumptiousness; nationalistic idolatry and mass murder in the name of God; rabble-rousing propaganda and organized lying.... Thanks to language and culture, human behavior can be incomparably more intelligent, more original, creative and flexible than the behavior of animals, whose brains are too small to accommodate the number of neurons necessary for the invention of language and the transmission of accumulated knowledge. But, thanks again to language and culture, human beings often behave with a stupidity, a lack of realism, a total inappropriateness, of which animals are incapable.”

What do you and I have in common with Democrats, Republicans and the disaffected? We are humans, not animals. And what you see in others, exists in you.

*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 Plain People (Amish and Mennonite) are descendants of Anabaptist immigrants who settled in Pennsylvania in the mid-1800s. Because of the limited founder population, they have a unique spectrum of genetic diseases that has garnered much attention, mostly in the Lancaster Amish. Medical care for patients with rare disorders within the Plain Communities has been expanding since the Clinic for Special Children was established in Strasburg, Pa., by Dr. D. Holmes Morton and members of the local Amish community 25 years ago. There are now similar programs at two centers in Ohio, in Indiana and in Wisconsin, as well as a new adult-focused program, the Central Pennsylvania Clinic for Special Needs Children & Adults, in Kish Valley, Belleville, Pa., supported in part by Children’s Hospital of Pittsburgh of UPMC (CHP).

However, many Plain Community members in Western Pennsylvania who are in need of specialty care, including diagnosis and management of genetic conditions, still need to travel to Pittsburgh, often at great expense. In an effort to alleviate this burden, CHP has established a Plain Communities Translational Medicine Program that includes the clinic in Belleville, improved coordination of care at CHP, and outreach Medical Genetics care at the UPMC Horizon Womancare Center in Hermitage, Pa. Patients seen through the Plain Communities Translational Medicine Program receive culturally sensitive care at a significant reduction in cost.

Challenges facing medical care in the Plain Communities in Western Pennsylvania are exemplified by the case of an adolescent Amish girl who presented to CHP with an apparent stroke. She was underweight and small for her age. Family history at that time included migraines, hearing loss, diabetes and multiple miscarriages in various maternal relatives. Her assessment was remarkable for pronounced lactic acidosis and an MRI scan of the brain suspicious for a metabolic stroke. Genetic testing led to a diagnosis of MELAS syndrome (mitochondrial encephalopathy, lactic acidosis and stroke-like episodes), and institution of medical management with carnitine, ubiquinol and arginine has improved her condition and slowed the progression of her disease (El-hattab, et al.). Subsequent family studies performed through an outreach project in the family’s home identified that 13 of her close family members also were affected by the condition. In spite of the fact that many of these individuals have been treated for multiple symptoms consistent with MELAS syndrome, including hearing loss, stroke risk and end-stage renal disease as a complication of diabetes, none had been evaluated for this disorder.

Our experience with this family clearly demonstrated the need for broader access for genetic disease evaluation and the opportunity for management within the community closer to the concentration of Amish and Mennonite families, and directly triggered the establishment of the Plain Communities Translational Medicine Program.

The goals of the Plain Communities Translational Medicine Program are to bring clinical care closer to Plain Populations in need; provide outreach.
education services to the medical and lay care providers in the region; and develop a research platform to improve our knowledge of the genetic risks faced by this unique population. It is essential that local providers, who already provide a significant amount of medical service to the Plain Community, have a high level of suspicion when an unusual constellation of symptoms is seen in an individual or within a number of close family members. Referral to the CHP Medical Genetics Clinic in Hermitage will allow for initial diagnostic evaluation by a metabolic specialist, a neurologist and a genetic counselor close to the individual’s home. The clinic can see both children and adults. If a diagnosis is confirmed, treatment and routine screening can be initiated and coordinated locally, with the intent to limit the need for routine and urgent trips to Pittsburgh for more intensive care.

Genetic counseling also is available on-site to help identify at-risk family members and arrange evaluations when needed. Given the community-based system of health care cost coverage practiced by the Plain communities, this program will benefit the whole community by decreasing overall health care costs, as has been demonstrated at the Strasburg clinic and elsewhere (Strauss, et al.).

The Children’s Hospital of UPMC Outreach Medical Genetics Clinic at the UPMC Horizon Womancare facility has been designed to address local community needs. We are available to evaluate patients who have a suspected hereditary disorder, or who have a constellation of findings that might be related to a single underlying etiology on the first Tuesday of each month. Appointments can be made by calling (412) 692-5070.

Ms. Walsh Vockley is a senior genetic counselor at Children’s Hospital of Pittsburgh of UPMC and coordinates the UPMC Horizon Womancare Outreach Genetics Clinic for the Plain Communities of Mercer County. Ms. Walsh Vockley also is involved in natural history studies about inborn errors of metabolism, and in newborn screening policy and practice.

Dr. Goldstein is a child neurologist at the Children’s Hospital of Pittsburgh of UPMC, where she is the director of Neurogenetics and co-director of the Neurofibromatosis Clinic, and is assistant professor of Pediatrics at the University of Pittsburgh School of Medicine. She is the current president of the Mitochondrial Medicine Society. Her current interests are in conducting clinical trials for patients with genetically confirmed mitochondrial disorders.

Dr. Gonzalez is board certified in Internal Medicine, Clinical Genetics and Medical Biochemical Genetics. She is a research assistant professor at University of Pittsburgh in the division of Medical Genetics in the department of Pediatrics at Children’s Hospital of Pittsburgh of UPMC. Her research interests include study of the genetic disorders in the Amish population and the use of next generation sequencing technologies as a method to characterize rare genetic disorders in this population.

Dr. Jerry Vockley is chief, Division of Medical Genetics, director, Center for Rare Disease Therapy, Children’s Hospital of Pittsburgh of UPMC; professor of Pediatrics, University of Pittsburgh School of Medicine; and professor of Human Genetics, University of Pittsburgh Graduate School of Public Health.

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Pittsburgh is a great city: The three rivers provide an optimal location for tourism and for many area businesses; our neighborhoods are unique and offer various flavors of our past heritage; and our sports fans are some of the most dedicated aficionados in the country. We have repetitively been ranked as one of the top livable cities in the United States, and our culinary scene is now gaining national recognition for its quality and variety. We are known as the city where French fries come on everything.

While the notoriety is respectable and we have much to hold in high esteem, those living in Allegheny County, and Pennsylvania, for that matter, struggle in certain areas that cross over into our realm of public health. In addition to the heroin epidemic, we struggle with rising rates of chronic disease. Per information published by The State of Obesity through the Trust for America’s Health, as of 2014, our state ranked 13th and 16th in our prevalence of diabetes and hypertension, respectively.¹ Our overall rate of obesity (BMI greater than 30) among our adult population is greater than 30 percent. It doesn’t help that, for our corner of the state, we are bordered by Ohio and West Virginia, both of which have similar rates of obesity.

As practitioners, we are all well aware of the importance of weight loss in our obese patients. Studies have shown that a single pound of weight loss translates to approximately a four-pound load reduction on knees and could improve joint pain associated with osteoarthritis.² Various improvements in hypertension are cited with weight loss, where losing 10 to 20 pounds can reduce systolic pressure anywhere from 4.5 to 20 mmHg.² Likewise, although mixed values are reported, fasting capillary blood glucose levels in type II diabetics decrease by 8-15 mg/dL after approximately a 10 percent loss in body weight by following diet and exercise recommendations.³ While the above mentions merely a few of the conditions affected by obesity, it’s easy to see how losing a few pounds may improve a patient’s chronic disease state. The most common modalities we turn to in this instance are dietary modifications and exercise recommendations.

In recent years, there has been a push for “exercise prescription,” and this is emphasized by groups such as Exercise is Medicine, Motivate 2 Move, and even the Centers of Disease Control and Prevention (CDC). These organizations provide an abundance of online resources for practitioners to better provide counseling to various types of patients and cater exercise regimens for specific chronic or acute disease states.⁵,⁶,⁷ They encourage use of the FITT principle of exercise prescription, which stands for frequency of activity, intensity, type of activity catered to the patient’s physical ability, and time or duration of said activity. CDC guidelines suggest that adults aim for a minimum of 150 minutes of moderate-intensity aerobic activity every week with at least two days of muscle strengthening, while children under 18 years old should perform at least one hour of aerobic activity daily, with three days per week of muscle strengthening.⁷ Different recommendations apply to pregnant and postpartum women to protect the gravid state; however, the general recommendation of 150 minutes of aerobic activity in a week still applies.

When we even consider exercise prescription, our minds quickly turn to our obese patients with comorbidities, when we also should consider other patient populations who would benefit from exercise for other reasons. Bone health and balance can be improved in our elderly patients with a proper exercise regimen and potentially decrease the risk of falling. In patients with fibromyalgia or mental health diagnoses, aerobic exercise and stretching activities may have a therapeutic effect both physically and through the release of favorable neurotransmitters. There are even benefits for those in the midst

Why not write a prescription for exercise?

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Megan Ferderber, MD
of chemotherapy or radiation treatment for various malignancies, as an exercise regimen may provide increased energy and be an adjuvant to other analgesic therapies.

Bottom line: There is a lot we, as primary care physicians, are expected to cover with our patients within an allotted time frame, and it is becoming increasingly difficult to fulfill all that is required of us in a single visit. Acknowledging the time dilemma, it may prove beneficial with certain patients to provide a prescription for exercise, both for weight management and for its multiple secondary benefits. Having something tangible and customized to a patient’s individual needs, such as a prescription, may help emphasize the importance of the intervention, overcome doctor-patient communication challenges and aid in after-visit recall. Try as we might, we may not be able to wrestle those coleslaw and fry-laden sandwiches from the clutches of our patients (or out of our own hands, for that matter), but perhaps prescribing an exercise regimen is what our patients require to begin pursuing overall health and wellness.

Dr. Ferderber is a third-year family medicine resident at UPMC St. Margaret and will be a UPMC Primary Care Sports Medicine fellow for the 2016-17 academic year; her interests include sports medicine, global health and public health. She can be reached at ferderberml@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.

References
Pittsburgh Ophthalmology Society meets at ACMS

The Pittsburgh Ophthalmology Society (POS) welcomed Prem S. Subramanian, MD, PhD, as guest presenter for the Feb. 4 meeting. Dr. Subramanian is professor of Ophthalmology, Neurology, and Neurosurgery; vice chair for Academic Affairs, Ophthalmology; division chief, Neuro-Ophthalmology University of Colorado School of Medicine. John Charley, MD, invited Dr. Subramanian and provided formal introductions along with Thierry Verstraeten, MD, POS president.

Dr. Subramanian presented, “Evaluation of Diplopia,” and “Pseudo Tumor Cerebri: Is It Still Idiopathic?” to a robust crowd. February’s meeting serves as the final monthly meeting, with the Annual Meeting scheduled for March 18. Monthly meetings will resume in September. Members should check the POS website periodically after June 2016 for the confirmed meeting schedule (www.pghoph.org).

2016 Clinical Update in Geriatric Medicine set

The Clinical Update in Geriatric Medicine will be held April 7-9 at the Marriott Pittsburgh City Center. This award-winning course has been a popular and respected resource for more than 24 years. It is jointly sponsored by the Pennsylvania Geriatrics Society – Western Division (PAGS-WD), UPMC/University of Pittsburgh Institute on Aging, University of Pittsburgh School of Nursing, and University of Pittsburgh School of Medicine Center for Continuing Education in the Health Sciences. The program is designed by course directors Shuja Hassan, MD; Judith Black, MD; and Neil Resnick, MD; along with the PAGS-WD planning committee.

As our population continues to age, the number of elderly persons in our area hospitals, clinics and nursing homes has grown significantly. The fastest-growing segment of the population are those above the age of 85 years. The conference aims to provide an evidence-based approach to help clinicians take exceptional care of these often frail individuals.

Highlights of the three-day conference include:

- Geriatric Pharmacology – helpful tips on managing medications in your complex older patients
- Acute Care of the Elderly – clinical pearls from a national expert on inpatient care of the older adult
- Symposium on Geriatric Syndromes – updated, evidence-based information on falls, delirium, osteoporosis, incontinence and depression
- Geriatric Cardiology – updated information on hypertension specific to the older patient, atrial fibrillation management along with using novel oral anticoagulants, and chronic heart failure
- Appropriate prescribing of antibiotics for older adults
- Symposium focusing on patient care at the end of life, and living with hospice care
- Advanced Practice Providers session

The conference continually attracts distinguished guest faculty. This year’s exceptional guest presenters include: Daniel G. Blazer, MD, MPH, PhD, vice chair for Academic Affairs, Ophthalmology; division chief, Neuro-Ophthalmology University of Colorado School of Medicine.
New, luxury standard features

chair of Psychiatry, Duke University, Durham, N.C.; Sharon K. Inouye, MD, MPH, director of the Aging Brain Center at the Institute for Aging Research, Hebrew SeniorLife, Boston, Mass.; Lewis A. Lipsitz, MD, director, Institute for Aging Research, Hebrew SeniorLife, Boston, Mass.; Barbara Messinger-Rapport, MD, PhD, FACP, CMD, chief medical officer/Hospice Care at Hospice of the Western Reserve, Cleveland, Ohio; and Robert M. Palmer, MD, MPH, director, Glennan Center for Geriatrics and Gerontology, John Franklin Chair and professor, Internal Medicine, Eastern Virginia Medical School, Norfolk, Va. Local expert faculty, most of whom also are nationally renowned, will further enhance the program with key, evidence-based sessions.

To register, visit https://ccehs.upmc.com/liveFormalCourses.jsf. For additional information, contact (412) 647-8232 or email ccehsconfmgmt101@upmc.edu.

Members of the PAGS-WD receive a discount when registering for the conference! To inquire about becoming a member or current membership status, contact Nadine Popovich, administrator, (412) 321-5035, ext. 110, or email npopovich@acms.org. Apply for membership on the Society website at www.pagswd.org.

14th International HELP conference slated in Pittsburgh

The International Hospital Elder Life Program (HELP) conference will be held in conjunction with the Clinical Update conference April 7-8 at the Marriot Pittsburgh City Center. Designed by course directors Sharon Inouye, MD, MPH; Fred Rubin, MD; and Shin-Yi Lao, MPH, BSN, RN, this two-day international conference educates HELP teams regarding strategies for delirium prevention, using HELP to improve hospital-wide care of the elderly, and

Continued on Page 104
creating a climate of change.

Expert clinicians and experienced members of the HELP sites will share evidence-based information and clinical insights on selected topics regarding the influence of HELP, delirium updates and the larger policy implications of care for the elderly. Updates on collaborative papers, expansion of the program and innovative site projects also will be presented.

For more information, please contact Krystal Golacinski, UPMC Center for Continuing Education in the Health Sciences, at (412) 647-7050 or email ccehsconfmgmt101@upmc.edu.

Geriatrics Teacher of the Year Award recipients announced

The Pennsylvania Geriatrics Society Western Division (PAGS-WD) is pleased to announce the 2016 Geriatrics Teacher of the Year Award recipients: Daniel DiCola, MD (Physician Awardee), and Betty Robison, MSN, RN-BC (Healthcare Professional Awardee).

The award is presented to two outstanding teachers for their dedication and commitment to geriatric education. Dr. DiCola and Ms. Robison exemplify geriatrics teaching excellence and made significant contributions to the education and training of learners in geriatrics and to the progress of geriatrics education across the health professions.

Dr. DiCola is director of Geriatrics Education, Latrobe Area Hospital Family Medicine Residency Program; associate professor of Family Medicine, Jefferson Medical College/Sidney Kimmel Medical College; and medical director, IHS Mountain View Nursing Home. His commitment is evident at the hospital, health system and community levels, and despite the time involved in all of his clinical and teaching endeavors, he is invariably generous in sharing his time and knowledge with the community.

Michael Semelka, DO, FAAFP, who submitted the nomination for Dr. DiCola, along with Courtney Floyd, MD, wrote, “Dr. DiCola represents our profession in the most positive light and serves as an outstanding role model for our residents, faculty and the entire medical staff. Dan has also won numerous teacher of the year awards by residents, is actively involved in teaching third-year medical students from Jefferson Medical College, and runs our morning reports every day. If there were such a position in a residency program as ‘Designated Teacher,’ Dan would be it.

“Our geriatrics curriculum is longitudinal, involving regular lectures, weekly nursing home rounds, journal clubs, board review questions, and patient cases — all of which Dan attends and leads. Dan is also present at every resident conference, often giving input from a geriatrician’s perspective on whatever is discussed. Due to the robust geriatric education our residents receive (under Dan’s guidance), many of our graduates work in nursing homes. Dan has even recently inspired some of our recent graduates to pursue fellowships in geriatrics.”

Ms. Robison, MSN, RN-BC, is gerontology educator, Aging Institute (AI) of UPMC Senior Services, Adjunct Faculty, Chatham University.

Through her leadership and support, Ms. Robison formed the Western Pennsylvania chapter of the National Gerontological Nursing Association (NGNA), one of only three NGNA chapters statewide. She has worked closely with staff at UPMC McKeesport, and through the contributions of her leadership, a core educational team was created at the hospital that worked to apply for and was awarded Nurses Improving Care for Healthsystem Elders (NICHE).

In her nomination letter of Ms. Robison, Taafoi Kamara, MPH, wrote, “I have had the privilege to work closely with Betty Robison and am wholly inspired regarding her commitment to the older adult and her commitment to ensuring that professional caregivers are provided with the opportunity to learn and advance their knowledge and skills. She seeks to take learning to the next level and is constantly searching for the unmet needs and new and innovative ways to educate the front line.”

Nominator Kelly Neal, DNP, CRNP-BC included, “Betty’s passion for geriatrics and education coupled with her natural leadership ability and creative methods of teaching shine through in this small sample of education projects

Continued on Page 106
Welcoming
Terrence D. Julien, MD
Neurological Surgery

Dr. Julien is a board-certified, fellowship-trained neurosurgeon with clinical expertise in neuro-oncology and spinal disorders, particularly minimally invasive spinal procedures. He joins the physicians of AGH Neurosurgery.

He is a graduate of Howard University, College of Medicine in Washington, D.C. He completed his general surgery residency at the Medical Center of Delaware in Wilmington Del. He went on to complete a neurosurgery clinical fellowship at New York University Medical Center and a neurosurgery residency at SUNY Health Science Center at Syracuse. He completed a research neurosurgical oncology fellowship at Memorial Sloan-Kettering Cancer Center in the Department of Neurological Surgery at Weill Medical School of Cornell University in New York. He also completed a clinical fellowship, and served as instructor in the Department of Surgery Neuro-Oncology Program at USF/H Lee Moffitt Cancer Center in Tampa, Fla.

Dr. Julien is certified, and a fellow of the American College of Surgeons. He holds professional memberships with the American Medical Association, the American Association of Neurological Surgeons and The Society for Neuro-Oncology.

He has published manuscripts and abstracts in medical journals and has presented to medical audiences locally and nationally. He most recently served as associate professor of Neurosurgery and vice chairman of the Department of Neurosurgery at Marshall University Joan C. Edwards School of Medicine in Huntington, W.Va.

Dr. Julien has medical staff privileges at Allegheny General Hospital, West Penn Hospital, Forbes Hospital and Allegheny Valley Hospital.

As always, new patients are welcome. Most major insurances are accepted.

For an appointment, please call

AGH Neurosurgery - Forbes
2580 Haymaker Road
Professional Office Building 2
Suite 106
Monroeville, PA 15146

320 East North Avenue
Suite 208
Pittsburgh, PA 15212

412.858.7766

AHN.org
ACMS members participate in Zika virus media call-in

Allegheny County Medical Society (ACMS) members Stephen Colodny, MD, and Ray Pontzer, MD, both infectious disease specialists, participated in a media call-in held by the Pennsylvania Medical Society (PAMED) Jan. 29 to help answer questions about the Zika virus.

In Memoriam

Clarence Mason Miller Jr., MD, 93, of Edgeworth, died Sunday, January 31, 2016.

Dr. Miller graduated in medicine from Jefferson Medical College in Philadelphia; served his internship at Jersey City Medical Center, N.J.; and served residencies at Sacred Heart Hospital in Allentown and the University of North Carolina Medical School.

He was a captain in the U.S. Army, having served in Korea and Japan.

Dr. Miller and his family settled in Sewickley, where he became chief pathologist at Sewickley Valley Hospital.

Deceased are his first wife, Eleonor Young Miller; and his oldest son, James Douglas Miller.

Surviving are his wife, Elizabeth Ann Miller; son Richard Miller (Marie); grandchildren Evan Miller, Mary Helen Montgomery (Heath) and Spencer Miller; daughter Alaine Miller (Kevin Milliken); grandchild Liam Milliken; and stepdaughter Leslie Wolke (Ziv Yoles).

Services were held in Edgeworth February 8, 2016.

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she has developed and/or facilitated during her tenure as the AI Gerontological Educator: Ageless Wisdom – an interactive and experiential geriatric sensitivity program which assists participants to identify and experience sensory, cognitive, psychological, functional and social changes of aging; (and) The Gerontological Nurse Certification Review – prepares nurses to sit for the Gerontological Nursing board certification.”

Dr. DiCola and Ms. Robison will be recognized at an award presentation to take place prior to the dinner symposium held in conjunction with the 2016 Clinical Update in Geriatric Medicine conference. The dinner symposium will be held April 7 at the Pittsburgh Marriott City Center. Awardees will be honored with a plaque and receive complimentary membership in the society for one year.

To learn more about the PAGS-WD, please visit www.pagswd.org.
ROYAL INSTITUTE OF BRITISH
ARCHITECTS
RECOGNIZES ACADEMIC WORK OF
ALLIANCE MEMBER
CHRISTOPHER PURPuRA

More than 350 universities in 65 countries participated in the Royal Institute of British Architects (RIBA) annual competition. The prestigious RIBA President’s Awards for Research promotes research that and researchers who contribute new knowledge and understanding to architecture and the practice of architecture. The RIBA organization highlights the need for knowledge and insight which nurtures innovation, quality, value and strategic thinking. Projects are judged by a distinguished panel of experts in four categories: University and Professional Research Organization; Practice (including practices with professional research divisions); PhD; and Master’s.

Christopher Purpura’s 2015 master’s thesis was nominated in July by the department head at Bartlett School of Architecture, University College London. His thesis was described as fascinating, compelling and elegant by RIBA. His nomination was shortlisted in September, and he received an email Nov. 13, inviting him to receive the RIBA Medal. With pride and joy, his parents, Dr. and Mrs. Lawrence Purpura, and family accompanied Christopher to London for the RIBA Presidential Awards Presentation Ceremony Dec. 2.

We fondly recall Christopher as a toddler among us as mom, Justina, ACMSA past president, attended Alliance meetings on Ridge Avenue. As a young adult ACMSA member, Christopher was a wonderful volunteer worker in Henry the Hand (international) as Dr. and Mrs. Purpura took time, expense and extraordinary effort to include the ACMSA community service project in their travels overseas and abroad. The Alliance is pleased to extend a collective, heartfelt congratulations to Christopher Purpura for the public recognition he has earned through intellectual focus, artistic brilliance and pragmatic ideas during his pursuit of excellence in understanding of architecture.

In Memoriam

Mrs. Roy Charles Monsour, Member, ACMSA

With family at her hospital bedside in Pittsburgh, Cicely Marie (Nicely) Monsour, of Greensburg, died Friday, December 18, 2015. Mrs. Monsour was the loving wife to the late Dr. Roy Charles Monsour, a family physician in Westmoreland County. Mrs. Monsour is survived by three daughters, Michel Monsour Franklin of Greensburg; Dr. Miroya Monsour Stabile of Shadyside; and Cicely Nafeli Monsour of Greensburg; along with three more generations of close family.

Mrs. Monsour was actively engaged over decades in several philanthropic, medical and cultural organizations in Ligonier, Greensburg and Pittsburgh. She had a long and strong commitment with the Monsour Medical Center and Auxiliary in dedication to her husband. As well, she gave important patronage to the Southwestern Pennsylvania Heart Association. She and her late husband were honored with the Heart of Westmoreland Award, given by the Western Pennsylvania Heart Association in 2000. Mrs. Monsour served as a board member of the Westmoreland...
Allegheny County Medical Society members:

The new world of Health Care ushered in by the Patient Protection and Affordable Care Act (ACA) has created uncertainty and confusion for most people. There are new regulations and requirements. Individual and employer mandates. Penalties for not purchasing coverage. On Exchange and Off Exchange access. As an Allegheny County Medical Society member, you have help.

Talk to USI Affinity, the ACMS’s endorsed insurance broker and partner. Our benefits specialists are experts in Health Care Reform. We can help you choose a health plan that provides the best coverage and value while ensuring you will be in compliance with complex new IRS and Department of Labor regulations. We’ll also provide you the kind of world class service and support you need to make sure you get the most out of your health care benefits after you buy.

You can also check out the NEW Allegheny County Medical Society Insurance Exchange, a convenient and secure online portal where you can find competitively priced insurance coverage for all your needs, including a wide variety of medical and dental plans.

To learn more, contact USI Affinity today!

Call 800.327.1550, or visit the ACMS Insurance Exchange at www.usiaffinityex.com/acms
Choral Society and also had significant leadership roles in the Pittsburgh Opera Association.

During World War II, Mrs. Monsour attended Margaret Morrison College, part of Carnegie Tech, now Carnegie Mellon University, and graduated in 1945. She was energetic in all things and a loved member of Kappa Kappa Gamma Sorority. Through the years, she shared sorority sisterhood with Rose Vachon Kunkel (the late Dr. William Kunkel) Roarty and the late Ollie Rau, (the late Dr. Raymond Rau,) all pillars in the ACMS Alliance and Allegheny County Medical Society. Mrs. Monsour was, along with her daughter, Michel Monsour Franklin, an active, visible member and generous supporter of our Alliance organization; daughter Dr. Miroya Monsour has participated in sponsorship of several Alliance events. Indeed, over her lifetime, Mrs. Monsour was highly respected and admired and was an inspiration to family, friends and associates. She was an influential and important part of medical, social and cultural fabrics in Westmoreland and Allegheny counties.

**Doctor’s Day**

**National Day of Recognition**

**March 30, 2016**

In tribute, we support our doctors with a contribution to the Allegheny County Medical Society Foundation with respect, appreciation and admiration from Allegheny County Medical Society Alliance

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Nowadays, when I rattle off the term ACP regularly as part of my day as a full-time hospice and palliative medicine physician, I am no longer referring to the American College of Physicians. I certainly was proud to achieve fellowship status in this storied organization at one point in my career, but I now take greater pride in initiating Advanced Care Planning (ACP) conversations with my patients.

Although most people are familiar with documents such as living wills and advance directives, the Centers for Medicare and Medicaid Services (CMS) generally has adhered to the “talk is cheap” mantra in regards to recognizing these physician-patient discussions. That is, until legislation in October 2015 allowed for reimbursement for evaluation and management (E/M) services for standalone ACP discussions between patients and their doctors. As the American College of Physicians continues to struggle with the public perception of what Internists do and launches campaigns such as marketing them as “Doctors for Adults,” palliative medicine subspecialists have quietly hijacked their longstanding acronym – ACP.

ACP continues to gain momentum at all levels of health care delivery models. Patients, providers and insurers all seem to be in agreement about ACP these days, and it is beginning to roll off everyone’s tongues. At the simplest level, this involves health care providers discussing end-of-life care with patients and documenting such in universal documents, like living wills, medical power of attorneys and Physician Orders for Life Sustaining Treatment (POLST). Even more important has been the coordinated effort to ensure that these sensitive edicts travel with the patient through all levels of health care delivery, void of class, race, or capacity.

Although there remains much work to be done, we do seem to be at the tip of the iceberg with ACP. A recent Kaiser Family Foundation survey paints the picture in sobering fashion. Despite the fact that 89 percent of adults feel their doctors should discuss end-of-life care issues with their patients, only 17 percent reported they actually had such a discussion with their doctor.

The motivation for patients to suggest or initiate this often challenging and dismal discussion remains a significant barrier. In addition, most health care providers are employed in a productivity model, which typically does not promote or incentivize doctor-patient discussions that take time. Although Medicare’s Self-Determination Act, enacted in 1991, required health care facilities to ask patients and acknowledge their Advance Directives, there has never really been any effort to value these discussions via a reimbursable model.

After many years of pressure from the American Medical Association, followed by the public relations disaster when the Affordable Care Act was introduced and the term “death panels” was coined in the context of ACP, CMS has finally saved the day. As of Jan. 1, CMS will now provide payments to a provider (physician, CRNP or PA) who submits claims for end-of-life discussions.

ACP services are allowable in both the outpatient and inpatient settings.

Advanced Care Planning 101

ACMS building
May 5, 2016
6 - 7:30 p.m.

* Sponsored by Family Hospice & Palliative Care

Join Board-Certified Hospice and Palliative Physicians Scott Miller, MD, and Keith Lagnese, MD, for an informal discussion of how to engage patients in simplistic end-of-life discussions and what CMS requires for documentation and reimbursement.

For more information, contact Linda Koval, (412)-572-8480, or lkoval@familyhospicepa.org.
Although patients often have these conversations with their PCPs, a subspecialist can provide these services. These ACP codes can be an add-on service or a standalone service. The latter is critical in validating the importance CMS places on these end-of-life conversations for our ballooning elderly population in the United States.

The specifics are as follows for Medicare reimbursement: CPT code 99497 provides for the first 30 minutes of face-to-face service with the patient, family member/surrogate; and code 99498 provides for each additional 30 minutes of ACP services. These codes must include the explanation and discussion of advance directive forms and usually the completion of such. These codes can be added to the Annual Medicare Wellness (AMW) exam with a -33 modifier, which should eliminate any associated co-payment.

Medicare assigning 1.5 relative value units (RVUs) for CPT code 99497 is both powerful and symbolic for medicine’s slow but steady evolution away from life-sustaining codes for emergent endotracheal intubation, which are valued at 2.33 RVUs. The gap between procedure-based vs. counseling services continues to narrow in the practice of medicine in the United States.

Although some physicians routinely have end-of-life discussions with their patients, and perhaps have taken advantage of coding for more traditional prolonged E/M services to procure payment, the advent of CPT codes for discrete ACP encounters is a monumental move by CMS. In my world, this short list of two new codes overshadows the long-delayed implementation of the voluminous ICD-10 coding revision that shared similar release dates by CMS in recent months.

Several reports indicate that local insurers likely will be waiving co-pays for these encounters when submitted as standalone visits, in hopes of encouraging patients to initiate these vital end-of-life conversations. Only time and insurance data will declare legitimacy and efficacy of ACP codes, but the priority of ACP discussions has been forever changed moving forward in our country’s health care delivery system.

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

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

Additional Advanced Care Planning resources

- VitalTalk, a nonprofit that provides advanced communication skills training to clinicians working in palliative care, is offering a “Delivering Serious News” course for five CME credits through the University of Pittsburgh School of Medicine. The course takes about five hours to complete. A preview of the course can be found at http://seriousnewspreview.vitaltalk.org/. For more information, visit www.vitaltalk.org/courses.
- UPMC Center for Continuing Education in the Health Sciences (CCEHS) offers an online Physician Orders for Life Sustaining Treatment (POLST) course. It is a 1.25 credit hour, three-part module. More information can be found at https://ccehs.upmc.com/onlineLearning.jsf.
- Ariadne Labs is a joint center between Brigham and Women’s Hospital and the Harvard T. H Chan School of Public Health, both nonprofits. Its mission is to “create scalable health care solutions that deliver better care at the most critical moments in people’s lives, everywhere.” The executive director is noted author and physician Dr. Atul Gawande. Ariadne Labs has developed a Serious Illness Conversation Guide, which can be found on page 112.
Serious Illness Conversation Guide

CLINICIAN STEPS

☐ Set up
Thinking in advance
Is this okay?
Hope for best, prepare for worst
Benefit for patient/family
No decisions necessary today

☐ Guide (right column)

☐ Act
Affirm commitment
Make recommendations about next steps
- Acknowledge medical realities
- Summarize key goals/priorities
- Describe treatment options that reflect both
Document conversation
Provide patient with Family Communication Guide

CONVERSATION GUIDE

Understanding
What is your understanding now of where you are with your illness?

Information Preferences
How much information about what is likely to be ahead with your illness would you like from me?

FOR EXAMPLE:
Some patients like to know about time, others like to know what to expect, others like to know both.

Prognosis
Share prognosis as a range, tailored to information preferences

Goals
If your health situation worsens, what are your most important goals?

Fears / Worries
What are your biggest fears and worries about the future with your health?

Function
What abilities are so critical to your life that you can’t imagine living without them?

Trade-offs
If you become sicker, how much are you willing to go through for the possibility of gaining more time?

Family
How much does your family know about your priorities and wishes?

(Suggest bringing family and/or health care agent to next visit to discuss together)
Multiple myeloma, a malignant neoplasm of plasma cells, remains incurable with a median survival of only five years. While the development of proteasome inhibitors and immunomodulatory drugs has shown improvement in survival, patients with relapsed or refractory disease continue to fail treatment and undergo many lines of therapy. Combination therapy with lenalidomide used in conjunction with dexamethasone is a commonly used treatment option for relapsed or refractory multiple myeloma but still only provides patients with modest survival benefit.

Recently, three-drug regimens have emerged using proteasome inhibitors such as bortezomib and carfilzomib in combination with lenalidomide and dexamethasone. While these agents are effective, patients are plagued by increased toxicities, most commonly neuropathic pain with bortezomib and cardiac and renal toxicities with carfilzomib. Because of this, there has been an increasing need for new targeted drug therapies that provide survival benefit without an increase in side effects. A major advancement occurred in December 2015 when elotuzumab received breakthrough therapy designation and gained expedited FDA approval.

**What it is**

Elotuzumab (Empliciti®) is a first-in-class immunomodulatory monoclonal antibody indicated for use with lenalidomide and dexamethasone in the treatment of relapsed or refractory multiple myeloma in patients who have received one to three prior therapies. ELOQUENT-2, a phase III trial, showed a 30 percent risk reduction in disease progression or death and a mean progression-free survival (PFS) of 19.7 months compared to 14.9 months with lenalidomide and dexamethasone alone, which supported its fast-track approval.

**How it works**

Elotuzumab has a novel mechanism of specifically targeting the signaling lymphocytic activation molecule F7 (SLAMF7) protein which is expressed on myeloma cells as well as Natural Killer cells. This directly activates Natural Killer cells and facilitates the interaction with myeloma cells to mediate the killing of myeloma cells by Natural Killer cells through antibody dependent cytotoxicity. Because SLAMF7 is not expressed on normal tissue cells, cell killing is specific for multiple myeloma cells. Preclinical trials showed that the combination of elotuzumab and lenalidomide resulted in enhanced activation of Natural Killer cells greater than the effects of either agent alone.

**Place in therapy**

Elotuzumab is currently indicated for use in combination with lenalidomide and dexamethasone for treatment of patients with active myeloma who have failed one to three prior therapies. At this time, it is not approved as mono-therapy nor is it approved as a first-line treatment option for newly diagnosed multiple myeloma.

**Dosage**

10 mg/kg administered intravenously in combination with lenalidomide and dexamethasone:
- Every week for the first 2 cycles (28-day cycles)
- Every 2 weeks thereafter (28-day cycles)

**How supplied**

Elotuzumab is available as 300mg and 400mg single-dose vials for reconstitution. Elotuzumab should be stored under refrigeration between 2°C to 8°C (36°F to 46°F). The final concentration of elotuzumab after reconstitution is 25 mg/mL. After dilution, the final product is stable for 24 hours refrigerated.

**Adverse effects/warnings**

The most common adverse effects seen with elotuzumab were fatigue, diarrhea, fever, constipation and cough. In the ELOQUENT-2 trial, serious adverse effects such as pneumonia, upper respiratory infections and anemia were more frequent in the elotuzumab arm compared with the control arm. However, the percentage of patients who discontinued treatment due to adverse reactions was similar for both treatment arms (6.0 percent for elotuzumab arm vs. 6.3 percent for control arm). Elevations in liver enzymes consistent with hepatotoxicity also were reported in patients treated.

Continued on Page 114
with elotuzumab. If elevations occur, elotuzumab should be stopped until levels return to baseline.5

In ELOQUENT-2, infusion-related reactions were reported in 10 percent of patients treated with elotuzumab. The most common symptoms reported included fever, chills and hypertension. In the trial, 5 percent of patients required interruption of treatment and 1 percent of patients required discontinuation of elotuzumab because of severity of reaction. Due to incidence of infusion reactions with elotuzumab, premedication with the following prior to infusion is required:1
• Dexamethasone 8 mg IV
• H1 antagonist: diphenhydramine 25-50 mg oral or IV (or equivalent H1 antagonist)
• H2 antagonist: ranitidine 50 mg IV or 150 mg oral (or equivalent H2 antagonist)
• Acetaminophen 650-1000 mg oral

Drug interactions5
At this time, no formal drug-drug interaction studies have been conducted with elotuzumab.5

Laboratory test interference1,5
Elotuzumab may be detected in serum protein electrophoresis (SPEP) and immunofixation assays used for multiple myeloma M-protein monitoring, therefore interfering with the analysis of complete response or disease progression in some patients.5 In the ELOQUENT-2 trial, the elotuzumab group had a lower number of complete responses than the control group. The authors believe that interference with multiple laboratory assays could have played a role in this finding.1

Clinical efficacy
The safety and efficacy of elotuzumab was studied in ELOQUENT-2, a phase III trial that compared elotuzumab in combination with lenalidomide and dexamethasone with lenalidomide and dexamethasone alone. In the trial, a total of 646 eligible patients were randomized in a 1:1 fashion to the elotuzumab group or control group and received 28-day cycles of therapy until disease progression, unacceptable toxicity, or consented withdrawal. Patients in the elotuzumab group received:1
• Elotuzumab 10 mg/kg administered on days one, eight, 15 of first and second 28-day cycles and on days one and 15 for all subsequent cycles
• Lenalidomide 25 mg per day on days one-21
• Dexamethasone 8 mg IV and 28 mg orally on elotuzumab days
• Dexamethasone 40 mg orally during the weeks with no elotuzumab
Patients in the control group received:1
• Lenalidomide 25 mg per day on days one-21
• Dexamethasone 40 mg orally on days one, eight, 15, and 22

The primary study endpoints were PFS and overall response rate (ORR). The secondary endpoints were overall survival (OS) and the severity of pain or interference with daily life. At the time of analysis, the one-year rate of PFS was 68 percent in the elotuzumab group versus 57 percent in the control group, and the two-year rate of PFS was 42 percent and 27 percent, respectively. There was a significantly longer average PFS (19.7 months) with the elotuzumab group compared to the control group (14.9 months). The overall response rate was significantly higher in the elotuzumab group than with lenalidomide and dexamethasone alone (79 percent vs. 66 percent). In analyzing quality of life, there was no significant change in pain severity or pain interference between the two groups. It is important to note that the benefit of elotuzumab was consistent across study groups including patients with factors associated with poor prognosis, for example age greater than 65, patients with higher disease staging, those who failed stem cell transplant and patients with del(17p) considered “high-risk.” The results of ELOQUENT-2 concluded that patients with relapsed or refractory multiple myeloma treated with elotuzumab, lenalidomide and dexamethasone had improved PFS when compared with patients who received lenalidomide and dexamethasone alone.

At this time, there are no head-to-head trials comparing triple therapy with elotuzumab, lenalidomide and dexamethasone to other triple therapy treatment regimens. Until these studies are done, it may be reasonable to compare mean PFS results from previous studies assessing the efficacy of triple therapy with bortezomib and carfilzomib respectively to the results of ELOQUENT-2.

• The results of Richardson, Paul G., et al, a Phase II trial looking at the safety and efficacy of bortezomib, lenalidomide and dexamethasone in relapsed/refractory multiple myeloma, showed a median PFS of 9.5 months.3
• The results of the Phase III ASPIRE trial showed a mean PFS of 29.9 months with carfilzomib in combination with lenalidamide and dexamethasone compared with 17.6 months with lenalidamide and dexamethasone alone.4

Cost information
The approximate wholesale price
of elotuzumab is ~$2,100 for a 300 mg vial and ~$2,800 for a 400mg vial. For an 80 kg patient, a minimum of two 400mg vials will be needed per dose (~$5,600). However, for an overweight patient, ≥120kg, the average cost of elotuzumab would be close to $10,000 per dose.

Summary

Elotuzumab is indicated for use in combination with lenalidomide and dexamethasone to treat relapsed or refractory multiple myeloma in patients who failed one to three prior therapies. In the ELO-QUENT-2 trial, a significant relative risk reduction of 30 percent was shown in patients who received therapy with elotuzumab, lenalidomide and dexamethasone compared with lenalidomide and dexamethasone alone. The triple therapy also resulted in increased mean PFS by almost five months compared to the two-drug regimen.1 Head-to-head studies are needed to confirm elotuzumab’s benefit over bortezomib and carfilzomib. However, elotuzumab has shown survival benefit with the potential to be associated with less toxicity compared to existing three-drug regimens. The addition of elotuzumab was not detrimental to patient quality of life.1 Moving forward, this could support its use in patients who have experienced multiple treatment failures and cannot tolerate alternate agents.

Dr. LaMonaca is a pharmacy resident at Allegheny General Hospital, Allegheny Health Network. She can be reached at vlamonac@wpahs.org.

References


Recent articles, including several of mine, have criticized the current version of Medicare reform for lack of substance. Perhaps it would be more informative to actually summarize these developments.

**New Medicare reform**

The most recent Medicare reform is the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The basic tenants of MACRA are:

1. The sustainable growth rate (SGR) fix;
2. The establishment of the “new” Medicare payment theory, i.e., Merit Based Incentive Payment System (MIPS); and
3. The encouragement of physician participation in Alternate Payment Models (APM).

**SGR fix**

We all basically understand the SGR problem. SGR was a formulaic methodology embedded in the Medicare Resource Based Relative Value System (RB-RVS) which mandated decreases in the Medicare conversion factor (which is the dollar value for each relative value unit of a procedure) which in turn would automatically reduce Medicare physician payments if volume exceeded the budgetary prediction used to create the Medicare Physician Fee Schedule (PFS). Ironically, although SGR threatened PFS reduction, many times, it was overrid-den by Congress and the president in 17 of the last 18 years.

The MACRA SGR fix does repeal this annual threat and establish PFS stability, but at the cost of essentially eliminating any potential increase in the underlying Medicare physician fee schedule for the next 10 years.

- Physician fee schedule increases will be fixed at ½ of 1 percent (0.5 percent) annually for the five years following adoption, i.e., 2015, 2016, 2017, 2018 and 2019.
- Thereafter, there will be no increases for the years 2020-2025.

**MIPS**

Concern with this component of Medicare reform is that it is more theory than substance at this point; no actual program has been devised. Instead, Congress has directed the Centers for Medicare and Medicaid Services (CMS) to develop MIPS to begin implementation in 2019, at which time CMS will terminate three current incentive programs and design a new incentive program based upon four physician performance categories (https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-In-

The three programs that will be eliminated are:

- PQRS – Physician Quality Reporting System;
- Value Based Modifiers (VBM); and
- EHR meaningful use.

The new performance categories will be:

- Quality Performance;
- Resource Use (cost effectiveness);
- Clinical Practice Improvement Activities; and
- Meaningful Use of Certified EHR programs.

One cannot help being a little cynical when recognizing that the performance measurements being eliminated are, at least nominally, the same performance indicators that will be used. The financial impact is that these four performance categories will be used to either penalize or reward physicians by applying either the discounts or the bonuses to the already existing Medicare Physician Fee Schedule (PFS), using the following ranges:

- 2020: 4 percent reduction – 4 percent bonus
- 2021: 5 percent reduction – 5 percent bonus
- 2022: 7 percent reduction – 7 percent bonus
- 2023 and thereafter: 9 percent reduction – 9 percent bonus
Alternative Payment Model

Medicare reform is based on the transition by physicians from regular Medicare PFS payments to Medicare APM payments which, if successful, will exempt physicians from MIPS and make physicians eligible for a 5 percent bonus, again based upon the existing Medicare Physician Fee Schedule, which remains in effect throughout this period except for the elimination of the SGR penalties as described above. In order to qualify for the 5 percent bonus (and avoid the potential MIPS decreases) physicians must transfer volume from regular Medicare Physician Fee Schedule payments to the APM payment models, in the following parameters:

- 2019 and 2020: At least 25 percent of the physician’s Medicare Physician Fee Schedule payments must be via APMs.
- 2021 and 2022: The physician must either (a) generate 50 percent of Medicare revenue from APMs or (b) 50 percent of total revenue from any APMs and at least 25 percent of the Medicare revenue from APMs.
- 2023 and thereafter: the physician must generate (a) at least 75 percent of Medicare revenue from APMs or (b) at least 75 percent of total revenue from APMs and at least 25 percent of that revenue from Medicare APMs.

CMS is still in the process of identifying APMs which qualify for this last component. Eligible APMs will include the Medicare Shared Savings Programs (MSSP) for ACOs, other health care ACO payment models, health care quality demonstration programs, and any other demonstration required by federal law.

One of the early examples of an APM that will qualify as eligible is Medicare’s Comprehensive Care for Joint Replacement model (CJR – https://innovation.cms.gov/initiatives/cjr). CJR will bundle payment to acute care hospitals for hip and knee replacement surgery, and it will be implemented on a mandatory basis in 67 geographic areas across the country including Pittsburgh. The model would hold participant hospitals financially accountable for the quality and cost of a CJR episode of care that continues for 90 days following discharge. All of the providers and suppliers involved would be paid under the usual Medicare Physician Fee Schedules and, following the end of a model performance year, actual spending for the episode would be compared to the Medicare episode price for the responsible hospital. Depending upon the participating hospital’s quality and episode spending performance, the hospital could either receive additional payments from Medicare or be required to repay Medicare for a portion of the episode spending.

The model proposes to waive certain existing payment system requirements, with the potential application of Stark and Fraud and Abuse laws (to incentivize participation by non-employed physicians), and other requirements such as the three-day prior inpatient stay as a condition for Skilled Nursing Facility (SNF) coverage, payments to physicians for telehealth home visits, and payments for certain types of physician-directed home visits for non-homebound beneficiaries.

Conclusion

Therefore, it appears that the only definitive development from MACRA is the elimination of the SGR threat in return for a standard Medicare physician fee schedule payment that will only rise 2.5 percent over the next 10 years. Although MIPS promises significant potential bonuses, it also comes with equal payment disincentives. The APM would exempt physicians from the MIPS risk and allow potential incentives of up to 5 percent, but the conditions for those alternative payment programs remain to be developed.

Mr. Cassidy is a shareholder with 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.
For medical practitioners whose patients have a desire to parent but have not realized that dream, it may be useful to know that Allegheny County Department of Human Services (DHS) is working to make the experience of foster parenting more accessible and fruitful for families and children than ever before.

Over the past year, as it has moved away from using group placements for children, DHS has been working with its foster care provider agencies and experienced foster parents to improve supports for prospective parents and is beginning to spread the word about the benefits of fostering for parents and children alike.

DHS’s work has included identifying former foster parents who can mentor current and prospective parents; rebooting of a Foster Family Advisory Council; ongoing development of consistent training standards for the provider agencies who match children and families; and training of specialists at the county’s Director’s Action Line (DAL) to answer questions about fostering and to disseminate materials.

Research shows that placement with blood relatives or other kin – which can include close family friends – generally results in the most positive outcomes for children. But in the instances where that is not possible for safety or other reasons, fostering in a family setting, instead of in group homes, is optimal.

The benefits include the security and warmth provided by a home, rather than an institution; individual attention to emotional and physical needs; and a consistent school setting and oversight of educational goals. In addition, emerging research such as the Adverse Childhood Experience (ACE) studies, conducted by the Centers for Disease Control and Prevention and Kaiser Permanente’s Health Appraisal Clinic in San Diego, about the impact of childhood trauma on health outcomes, point to the critical impact of consistent relationships with caring adults as a healing factor for children.

Those relationships are best formed in family, rather than institutional, settings.

Rewards of fostering can be rich for parents, including knowing that their caregiving positively and forever impacts the life of a child or teen, and the simple fulfillment of the desire to parent. This can be especially true for people who have tried to adopt but found the pool of adoptable children has declined, particularly in recent years when policies here and abroad have blocked adoption of foreign children.

“There are people we at DHS believe would open their homes and
hearts if they knew more about fostering,” said Katherine Stoehr, manager of Program Operations at the DHS Office of Children, Youth and Families, who has been shepherding the department’s foster care initiatives. “Medical professionals can be a gateway to foster care when patients are seeking ways to at least temporarily parent and help a child in need.”

To inform the region of the need for foster parents, DHS contracted with Blender Inc. of Shadyside to devise a promotional campaign for print, television, radio and more. Launched in January, the campaign is called Foster Goodness and is targeted to municipalities where need is greatest, including Penn Hills, Wilkinsburg and McKeesport. Because the department is reducing its reliance on congregate care, it is particularly focused on finding people to foster teenagers as they face the demands of becoming self-sufficient adults.

A website, www.fostergoodness.org, directs inquirers to more information about fostering. Meanwhile, specialists at the DAL, 1-800-862-6783, also will take inquiries and mail materials that answer initial questions.

Through its Office of Community Relations, DHS also has developed a series of videos that give firsthand accounts by teens and adults about how the foster care relationship benefits them. The videos can be viewed at http://alleghenycounty.us/Human-Services/News-Events/Engagement/Foster-Care/Get-Started.aspx.

The American Academy of Pediatrics also has an initiative, Healthy Foster Care America, to support practitioners in improving the health and care of children and teens in foster care. More details can be found at https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Pages/default.aspx.

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

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