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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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I’ve often wondered how we have come to call what we have in our country the American “healthcare” system. Within that system, we have large “healthcare” institutions, “healthcare” providers and patients or employers buying “healthcare” insurance. Yet, most of the work done by these entities doesn’t have much to do with keeping people in good health. Oh, we certainly do a great job at restoring health to those who are ill.

As a neonatologist, I’ve seen tremendous advances in my 35 years of practice in our ability to save the life of a premature baby. Babies who had no chance of survival 10 or 15 years ago routinely survive. But the parents of these babies often have unaddressed needs related to the stress of having a critically ill infant. The resulting parental anxiety and/or depression has a tremendous impact on that child’s subsequent development. Have we really done our job of “caring” for the “health” of that family?

Obviously, this example is from the world of my specialty, but other examples are abundant throughout our current system of care. The problem is that we address the consequences of poor health but rarely the root causes of that poor health. In my example, the best solution for the baby and the family would be for the premature birth to have been prevented in the first place. Yet, in all my years of practice, we have accomplished very little in discovering why a baby is born preterm and how we can prevent it.

That’s not to say we don’t give lip service maintaining good health. We do “wellness” visits, give nutritional advice and perform preventative screening tests. Still, the vast portion of our time is taken up treating illnesses. The vast portion of one’s healthcare premium dollar goes to paying for hospitalizations and medications, and the vast portion of hospital and healthcare system costs (and profits) are from treating disease, not promoting health. Further, I would argue that all our wellness visits and all our well-intentioned advice and screening is not addressing the underlying root causes of the poor health that we see in our patients.

The driving forces behind most of our health problems are known. The American Hospital Association (AHA) estimates that 80 percent of health outcomes are determined by socioeconomic factors, health behaviors and the physical environment. But, to date, the healthcare system’s response to this reality is to try to manage the consequences of these social determinants, not to address their causes. Of course, it’s easy to understand why this is the case. Trying to address the causes of poverty, hunger, homelessness and violence is something that we are neither trained for nor have “medical” solutions for. Because of this, it’s easy to say, “These are not our problems.” But trying to “treat” the consequences of adverse social conditions and the stress they cause results in excessive medical expenditures and contributes to physician burnout.

We get frustrated when patients don’t follow our advice to quit smoking, lose weight or stop drinking. But do we recognize that these adverse health behaviors may be that patient’s only coping mechanisms to deal with the stress experienced by their financial condition, or by the fact that they’ve been abused or discriminated against, or by their exposure to community violence? Do we understand that this chronic stress is behind many of the mental health issues we see all too frequently?

We shouldn’t be surprised, or judgmental, when our advice or education is not heeded. Rather, we need to find ways to identify social stressors in a trauma-informed manner, support patients impacted by these stressors, involve them in appropriate community human services and continue to work with these agencies on a continual basis.

What I’m suggesting cannot be accomplished by doctors alone. The
entire healthcare system, payers and providers alike, needs to change its approach to one that promotes good health, not just treats poor health. The entire system needs to develop and pay for models of care which value a multidisciplinary team approach to modifying social stress. These models must enhance communication and collaboration between traditional healthcare providers, public health and human service programs, and the multitude of community service nonprofits in our area. It is only through this collaboration that we can help our patients develop the resiliency needed to combat social and financial stress. This type of care requires time. Time for physicians and other providers to develop meaningful and trusting relationships with their patients. This time is not currently there in our present model of care.

Of course, our ultimate goal, as an entire society, must be to minimize the toxic and chronic stress brought about by poverty, violence and disparities. Increasing meaningful employment opportunities, decreasing poverty (especially in children) and addressing systemic racism (and all the other -isms) are all needed to achieve this goal. Until then, we must do a better job at helping patients deal with their stressors by providing social and emotional buffers to minimize them turning to maladaptive health behaviors. The task ahead of us is not easy. It will demand that everyone involved in this system rethink what we really mean by “healthcare.” But, when I think of accomplishing large, difficult tasks, I harken back to the words of JFK, when he said:

“We choose to go to the moon … not because (it) is easy, but because (it) is hard, because that goal will serve to organize and measure the best of our energies and skills, because that challenge is one that we are willing to accept, one we are unwilling to postpone, and one which we intend to win …”

Our challenge isn’t going to the moon, but it is converting our healthcare system into one that truly promotes health in a caring way. This challenge is every bit as important as going to the moon, and likewise cannot be postponed.

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

DEVAL (RESHMA) PARANJPE, MD, FACS

The old canard about “organizing physicians is like herding cats” is only funny because it’s true. But have you ever thought about what made us into the rugged individualists that we are? We didn’t start out this way; we started out as fresh-faced college students eager to help our fellow man and excited to share the future of medicine together. I picture us as happy, eager pups, joyfully falling all over each other in the pursuit of a communal supper dish.

Somewhere between the sheer terror of failing organic chemistry and the ferocity of studying for MCATs, many of us internalized the lesson that our careers hinged on competing with each other for a limited number of coveted spots. This applied to medical school, residency, fellowship and perhaps attendinghood. Every medical school class has gunners; perhaps you were one, or perhaps you were a “stealth gunner” who kept his or her fierce academic drive hidden under a cloak of nonchalance until grades were announced and you were revealed. Maybe you wished you were a gunner. We all tried as hard as we could.

Healthy, and sometimes unhealthy, academic competition is the hallmark of medical training, but the mindset of constant competition can lead to isolation and loneliness. As students and trainees, we are encouraged and rewarded for individual success. We are not incentivized to help each other succeed individually. Our identities as cats are born.

Unlike some of the other professions in the world, we manage to keep a healthy perspective on competition most of the time. We are all united by a noble goal: We all want to do what’s best for the patient. On the rare occasions we might get annoyed or upset at each other, it’s because of a perception of not having taken care of the patient as thoroughly as we would have hoped. Yes, there are bad apples and sociopaths in every field, but the emotional and intellectual rigors of our training have a way of weeding out the vast majority in a way not seen in other fields. Compared to their counterparts in business, law and other fields, the biggest jerks you can think of in medicine are still not so bad – they are still partners and colleagues trying to do the right thing for the patient. Even though we are individualists, our collective bond and raison d’être is compassion and kindness. If we compete with each other, we compete only to serve our fellow man better than one another.

So why do we stereotypically have such trouble organizing and working together in teams? We may have a lot to learn from our cousins, the engineers. I’m currently enrolled in the executive MBA program at Pitt, the only physician among 20-odd engineers and a few marketing, finance and HR professionals. Together, we have pulled each other through accounting, statistics, HR, industry convergence, financial management, information technology economics and entrepreneurship.

The experience is a bit different from medical training; I was astounded at how incredibly helpful everyone is toward each other. Imagine a class where every single member is vying for the title of Miss Congeniality. The engineers are as competitive as any medical school gunners, but they also believe a rising tide lifts all boats; they go out of their way to volunteer help to anyone who is struggling or needs an extra explanation. They also think nothing of pointing out the flaws in each other’s logic and correcting each other’s work. The justification is simple: The goal is success. Every team member is valued, and therefore every team member wants to contribute. Checking each other’s work is crucial and not thought of as putting each other down. Without this atmosphere of collaboration and interdependence, bridges and buildings may fall, lives may be lost and lawsuits may happen. Not so different from our world.

Continued on Page 398
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It took me a very short while to relax, trust and appreciate the fact that my new engineer classmates had a different philosophy of learning and working – one that not only incentivizes individual and group success but also incentivizes individuals to help each other succeed. In short, it is an atmosphere of disarming kindness and frankness, which is so gladly adopted. Engineers go through their own brutal trials by fire in their training, but they learn to survive by depending on each other as much, if not more, than they depend on themselves.

How can we create a disarmingly kind and frank atmosphere at work with our colleagues? How can we better foster trust and cooperation? How can we better incentivize each other to help each other succeed? Think about how much a kinder work environment could help lower your stress level and increase your sense of fulfillment and productivity. These are the questions whose answers will help not only us, but our patients.

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Most physicians end up encountering and caring for terminally ill patients in some capacity as a part of their routine clinical practice. Likewise, most physicians also have been forced to face the aftermath of a death by suicide. It may have been an established patient, a relative or friend of a patient, or, even more tragic – a personal friend or family member. These circumstances always seem to have a sudden painful recourse, often with so many unanswered questions: so many “what-ifs?” and/or “what could I/we have done differently?” to prevent such an unexpected act of finality. It is important to try and gain a better understanding of when terminal illness and suicide intersect in the end-of-life continuum.

Our hospice had two “successful” suicides in the past six months, and we all have been asking ourselves these exact same questions over and over. Both patients were middle-aged men with cancer, who had been enrolled in our hospice for several months before ending their lives with self-inflicted gunshot wounds. They were both at home and found by loved ones immediately. They both had a history of partially treated depression and had some degree of uncontrolled emotional and physical suffering brought on by their terminal cancer. When asked previously by hospice staff, they both denied having access to firearms in their homes. Neither had previously expressed suicidal thoughts, ideations or suicide attempts. Neither had pursued requests for palliative sedation or anything to hasten death from hospice staff. It would be unfair to classify these patient outcomes as “typical” or “not surprising,” but instead they have amounted to a somewhat rare and unexpected suicide cluster in an organization that admits and pronounces around 3,000 patients annually.

There is very little data and research on suicide in terminally ill patients, but cancer patients have been shown to have nearly twice the incidence of suicide than the general population (rate of 31.4/100,000 vs 16.7/100,000 patient-years). Other suicide risk factors which are common in the terminally ill patient population would be advancing age, psychiatric comorbidity, uncontrolled pain and, of course, family history of suicide and male sex.

Certainly, assessing and treating anxiety, grief and depression can have a huge impact on preventing suicide in end-of-life patients because of the high prevalence of such in this patient population. It also is important to differentiate between grief and depression, with the latter being more persistent, but also more amenable to treatment with therapy and medication. Common measurable and observable physical end-of-life symptoms such as pain, dyspnea and fatigue contribute to and exacerbate the pervasive existential suffering in terminally ill patients.

All hospice team members, including nurses, social workers and chaplains, must be proficient at screening and recognizing the often subtle symptoms of depression, as well as suicidal thoughts and ideations that can accompany depression. Ensuring patient safety is paramount, so screening for weapons in the home is typically routine in all hospice admissions.

In caring for terminally ill patients, both casual and direct requests to hospice clinicians to hasten death by a patient and/or family member is not uncommon. Sometimes it may be an “off the cuff” remark or request, or
sometimes it can be a pointed request to prescribe or increase their medicine to make them “go to sleep and never wake up.” This may stem from untreated symptoms, extreme loss of function or often the overwhelming feeling of being a burden to family, friends and society.

Sometimes these conversations may occur privately in a calm and peaceful setting, while other times they can be significantly more dramatic, when a patient is in crisis in the hospice unit. Pain and dyspnea can predominate in an actively dying patient, who may yell out or demand in front of others to “Please, just end my suffering!” In either case, further discussions to clarify the patient’s question/request, as well as providing the patient with the right amount of support and treatment to address unremitting physical and psychological distress is imperative.

The Death with Dignity Act, which originated in Oregon in 1994, was the first legislation in our country to empower terminal patients with autonomy, in regard to the manner in which they die. The momentum has significantly increased nationally in recent years, and five more states (Washington, California, Colorado, Vermont and Hawaii) as well as the District of Columbia, have adopted similar statutes. Not surprisingly, there remain many ethical and moral dilemmas surrounding this legislation which have polarized various special interest groups. Even the language defining the act has been modified in recent years. The term “Physician Assisted Suicide” has appropriately been replaced with “Physician Assisted Death” (PAD) when referencing these practices.

Pennsylvania appears to be far from adopting a Death with Dignity Act. Although state Sen. Daylin Leach re-introduced a Pennsylvania Death with Dignity Bill in 2017, the previous six times it failed to make it out of the Senate Judiciary Committee. Certainly, one can’t help but wonder if our two recent hospice patients who chose violent suicide would have chosen an alternative pathway if they lived in a state with a Death with Dignity Act? Personally, although I support advocacy to promote Death with Dignity legislation, I have very mixed feelings on whether I would feel comfortable prescribing a lethal dose of medication if it were legal to do so in my state. I have seen firsthand so much peace and solace with actively dying patients, as they spend time alone or with their loved ones in the final hours and days of life.

The evolution of palliative care as a medical subspecialty has likewise occurred simultaneously with Death with Dignity legislation these past two decades in the United States. There are legal and peaceful alternatives to PAD, which still promote patient autonomy and allow goals of care that may hasten death to alleviate suffering. What if these men would have felt comfortable expressing their fears and wishes to their hospice physician? Perhaps alternatives to hastening death could have been discussed, such as Voluntarily Stopping of Eating and Drinking (VSED). Alternatively, implementation of more aggressive symptom control could have been attempted, and if necessary, the use of palliative sedation at home or on an inpatient hospice unit could have been offered for specific refractory symptoms. These are discussions that are welcome at the end of life and can occur between patients and the hospice inter-disciplinary team.

At our hospice, in the aftermath of these recent suicides, we have offered bereavement and grief support to all staff involved in caring for these two patients. We also have reviewed and re-developed our curriculum to make sure that all disciplines are re-educated on symptoms of depression and risk factors for suicide, with the hopes of reducing and eliminating this ultimate form of hastened death. The suicide crisis resource, resolve, available to all Allegheny County residents, also will be providing additional education on-site at our hospice in the immediate future. It is imperative that ongoing evaluation and re-evaluation of these hospice patients at highest risk of suicide is required by all hospice disciplines, even if their lifespan is measured in only days or weeks.

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A century of modern influenza: 1918 to 2018

BRYAN STEVENS, MD

Fall is a great time of year in Western Pennsylvania. The leaves have changed colors and the heat has given way to milder temperatures, at least until the snow arrives. The annual influenza season also is just around the corner, and vaccinations are well underway. The influenza viruses have been a burden on the human race for a significant portion of our history. Historical records of influenza-like outbreaks date to the early 16th century, affecting populations worldwide. The origin of modern-day Influenza A strains can be traced back to the 1918 Pandemic.

The early 20th century during the time of World War I marked a unique period in human history. Global wartime conditions included overcrowding of urban environments and military camps, international troop movements, respiratory injury from chemical weapons, and poor sanitation and nutrition. During winter of 1916, a British army base located at Étaples, in northern France, experienced an outbreak of highly virulent respiratory illness. The army base was home to a large cohort of soldiers, including more than 1 million using the camp en route to the Western Front and housing 100,000 soldiers per day, mostly in tents and wooden barracks. The clinical picture was that of an acute respiratory infection with high temperature, cough, heliotrope (blue/violet) cyanosis and a high mortality rate. Throughout 1917, similar outbreaks of virulent purulent bronchitis were seen in British and American military camps in Europe. As World War I drew to a close in 1918, soldiers began to return to their home countries throughout the world.

The 1918 pandemic occurred over a series of three waves, starting in spring 1918. The first wave was remarkably mild, even to the point where clinicians of the time argued whether it represented influenza at all. Unfortunately, a more devastating second wave followed in fall 1918. Widespread clinical disease with increased mortality rates, particularly in young adults, was seen throughout North America, Africa and Europe. Compared to prior influenza epidemics, influenza and pneumonia death rates were more than 20 times higher for individuals 15 to 34 years old, and approximately half of all influenza-related deaths during the pandemic occurred in those 20 to 40 years of age.

Contemporary reports from U.S. military camps described severe epidemics of influenza, often affecting up to more than a quarter of stationed troops. A significant portion of those ill developed secondary bacterial pneumonia, with many dying as a result. For those hospitalized due to pneumonia and influenza, the overall case fatality ratio was 4.9 percent. Similar patterns of disease were seen in the civilian population as well. In addition to those dying from secondary bacterial pneumonia, pathologists noted a significant subset of patients were dying from a form of the disease designated as "atypical pneumonia." These patients demonstrated extreme cyanosis, high fever, coarse bubbling rales and pink frothy serous fluid coming from the mouth and nostrils. Autopsy later would reveal intense congestion and edema of the lungs without evidence of pneumonia. To pathologists of the time, these findings appeared quite similar to lungs of victims exposed to poison gas during the war. It is now understood that these patients had suffered from primary viral pneumonia.

The range of total deaths due to the 1918 influenza pandemic is estimated to be between 50 to 100 million individuals. However, it is difficult to know what the true number of deaths are due to the global reach of the disease and lack of adequate historical records from all parts of the world. It is evident that the total number of deaths due to the 1918 pandemic is greater than the total number of casualties from World War I, which is placed at 37.5 million individuals. By comparing the world population in 1918 of 1.8 billion
persons with the 2018 population of 7.6 billion persons, one could extrapolate the total number of deaths in today’s terms to be approximately 212 million to 424 million individuals. For a sense of scale, the 2018 U.S. population is approximately 328 million individuals. This obviously does not consider potential exacerbating and remitting factors such as today’s ease of travel, population density and advances in medical therapy.

The modern-day concern is a genetic reassortment event occurring between a zoonotic Influenza A virus, such as H5N1 or H7N7, with a currently circulating human Influenza A virus, such as H1N1 or H3N2. Such a reassortment event could result in an influenza virus with a novel hemagglutinin molecule, leading to a repeat of the events of 1918. Work continues on the development of universal influenza vaccinations, a number of which are in Phase 2 clinical trials, with hopes to target more conserved areas of the virus. As we enjoy the fall season and cooler weather, we soon will be dealing with the coming 2018-19 influenza epidemic. It is important to remember we still deal with influenza-associated mortality during these annual epidemics. During the prior 2017-18 influenza season, there were 181 influenza-associated pediatric deaths. Approximately half were otherwise healthy children, and less than a quarter of vaccine-eligible children who died had received an influenza vaccine prior to disease onset.

I hope everyone has had an opportunity to receive their flu shot. I know I have.

Dr. Stevens is an anatomic and clinical pathology resident in his final year of training at UPMC. He can be reached at bulletin@acms.org.

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The voice of the people and Medicare coverage

THOMAS JAMES III, MD, FACP, FAAP

At a Medicare Evidence Development and Coverage Advisory Committee (MED CAC) meeting Aug. 22, a quiet but important determination was made. The MED CAC panel recommended to Centers for Medicare & Medicaid Services (CMS) that the National Coverage Determination (NCD) include patient reported outcomes (PRO) in its final product, to be published in February 2019, on Chimeric Antigen Receptor-T cells (CAR-T). The use of modified killer T cells to attack certain Acute Lymphoblastic Leukemia and some B-cell non-Hodgkin Lymphomas is itself revolutionary. But the focus that this MED CAC panel had was to recommend to CMS whether PRO were important enough for CMS to ask of manufacturers seeking an NCD to guide Medicare coverage. Such coverage also would apply to Medicare Advantage plans that cover one-third of all Medicare beneficiaries.

I was fortunate enough to be one of the 14 individuals on that MED CAC panel. We were instructed not to consider the science behind CAR-T or its costs, which are significant – well over $500,000 for treatment. Instead, we were instructed only to consider whether adding a PRO to the information included in an NCD would add value. We also were to make recommendations of the eight different PRO instruments commonly in use. The individuals on our panel came from academic institutions, private practice, pharmaceutical industry and payers. There was one patient, a man who received CAR-T some eight years ago.

At the start of the morning, we heard from the Food and Drug Administration (FDA), followed by representatives of Novartis and of Kite/Gilead, the manufacturers of the two commercially available products. They argued that the cost of performing PRO and the delays in bringing product to market made the inclusion of PRO in the submission for NCD too burdensome. They were followed by physician researchers from Mayo Clinic and Fred Hutchinson Cancer Center in Seattle, also arguing that the effort to track down patients who had returned to their home communities made the research effort much more difficult. However, their counterparts from Sloan Kettering and from the University of North Carolina argued from a different position, as both centers have been using PRO to help guide their treatment strategies. Those two institutions found that computer surveys allowed them to keep in touch with patients coming from elsewhere.

A significant point was raised by Dr. Ethan Basch at the University of North Carolina, whose research has shown that patients engaged in PRO activity had better survival results as measured on Kaplan-Meier scales. His research only has demonstrated that the rates of subjective adverse events included in the labeling of standard chemotherapy underestimate the same symptomatic adverse events on PRO. He speculated that patients experiencing side effects tend to minimize the symptoms to please their oncologists. However, the point he made was that PRO is a better indicator of the patient’s real experience than symptoms filtered through their physician’s recording.

PRO are not the same as patient satisfaction. The eight different instruments presented all were validated in multiple trials. Some, like PROMIS, the most common one in this country, have up to 700 data points but are modular so can be made disease-specific. They all contain modules related to symptoms, physical function, fatigue, pain, mental health and social health. Some instruments include cultural and ethnic variations in response.

But what about the implications of inclusion of PRO in data collection? If patients have access to information about other patients of similar social and cultural heritage, will they make decisions on treatment that may vary from the medically oriented bias of the treating physician, or will the doctor’s
preference for treatment, based upon the doctor’s experience plus literature support, be of greater value to the patient? The literature does not have a consensus. For example, Holmes et al. found that there was no evidence that PRO aided the patient in the management of pain syndromes, whereas Olde et al. found that in older patients involved in integrated care programs, PRO did help inform their treatment decisions.

PRO are the tip of the iceberg in terms of the voice of the patient in medical decision-making. National patient advocacy groups like Planetree, CPR, Picker Institute, and Consumers Union have been advocating for greater patient-centered care that encompasses the values of the patient. If there are clinical options, then these and other advocacy groups – including medical professional societies – are suggesting that physicians must offer the various choices. Such choices should be presented in a fashion commensurate with a patient’s educational level, be culturally appropriate and patient value-based. CMS considering adding PRO adds to this growing humanistic trend in medicine. After all, we are here to provide care that patients need and want.

Dr. James is senior medical director of Highmark, Inc. He can be reached at Thomas.James@highmark.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.

References
It’s time for Allegheny County physicians to embrace harm reduction

Wendy E. BraunD, MD, MPH, MSeD, FACPM

Allegheny County’s opioid-related overdose rate rose from 2014 to 2017 and is currently higher than that of Pennsylvania and the nation. Heroin was the most frequently identified substance in fatal overdoses from 2008 to 2015, when fentanyl overtook it. And loss of life does not capture the impact of opioid use disorder (OUD) extending beyond all those tragic deaths. People who use opioids experience greater negative consequences associated with use, such as high-risk behaviors, co-occurring mental health issues, family conflict, contact with the legal system and health-related issues. Injection drug use, in particular, is associated with increased transmission of blood-borne infections such as HIV, Hepatitis B and C, endocarditis, as well as sexually transmitted infections and tuberculosis.

Something has to change, because what we’re currently doing to stop the opioid epidemic clearly isn’t enough. It’s time for physicians in Allegheny County to embrace harm reduction. The continuum of strategies to combat OUD and substance use disorder (SUD), more broadly, goes from prevention to treatment to recovery support; interventions and services need to be expanded in all those areas, including incorporating harm reduction techniques with more conventional evidence-based approaches.

According to the Harm Reduction Coalition (HRC), “Harm reduction is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use. It is also a movement for social justice built on a belief in, and respect for, the rights of people who use drugs.” Harm reduction addresses the conditions of use in addition to the use itself, recognizes that people who use drugs (PWUD) have the power to reduce the harms of their use, and works via collaboration with users and communities to provide the tools and education needed to promote, maintain and improve health.

Overdose prevention and rescue with naloxone hydrochloride (naloxone) is an increasingly prevalent harm reduction strategy. Naloxone is an opioid antagonist that immediately reverses the effects of an opioid overdose. There were 481 successful naloxone reversals in Allegheny County in 2017. Regularly utilized by first responders, it can be administered by lay persons with little or no formal training, and anyone can legally administer it in this county. It’s available by prescription or without a prescription at pharmacies with a standing order; dispensers of naloxone often provide education about overdose prevention and recognition. Naloxone has proven to be a valuable tool in combating overdose deaths and associated morbidity. Barriers to naloxone availability include cost, access and lack of buy-in from “traditional prescribers.”

Syringe service programs (SSPs) allow people who inject drugs (PWID) to exchange used needles and syringes for new, sterile needles and syringes. Developed in the mid-1980s to combat the HIV epidemic by reducing the spread of blood-borne diseases among PWID, many SSPs have become multiservice organizations, providing health and social services to participants, such as HIV and HCV testing, peer education, and linkage to care and treatment for SUD. There are seven SSPs in Pennsylvania, including Prevention Point Pittsburgh. These programs have been proven to be effective, safe and cost effective in reducing HIV transmission and increasing SSP users’ access to other medical and social support services. Barriers to the establishment of SSPs include a lack of social and/or political will and legal impediments. Needle exchange is illegal in 15 states, including Pennsylvania, although local jurisdictions (e.g., Philadelphia and Pittsburgh) have granted authority to operate SSPs.

Opioid substitution therapies (methadone maintenance and agonist pharmacotherapy) provide a less
harmful opioid (methadone) or an opioid-receptor agonist (e.g., buprenorphine) under medical supervision in both specialty and outpatient clinics. Buprenorphine is both a partial agonist and antagonist, effectively blocking other opioids while allowing for some opioid effect of its own to suppress withdrawal symptoms and cravings. Some would say that medication-assisted therapy (MAT) is treatment, not harm reduction, but in the context of abstinence-only treatment, it would be considered the latter. Several reviews have identified opioid substitution as effective in reducing illicit opioid use, HIV risk behaviors, criminal activity and opioid-related deaths. The demand for MAT in Allegheny County exceeds the availability.

Safe injection facilities (SIFs), also called drug consumption rooms, supervised injection rooms – or, in Philadelphia, the planned Comprehensive User Engagement Site – are legally sanctioned facilities where PWID can inject pre-obtained drugs under medical supervision. These facilities provide sterile injection equipment, information about reducing harms, health care, treatment referrals and access to medical staff. Some offer counseling, hygienic amenities and other services. More than 25 studies have been published documenting significant reductions in needle sharing and reuse, HIV and hepatitis transmission risk, overdoses, injecting/discarding needles in public places, reduction in fatal overdoses and increased enrollment in detoxification and SUD treatment, although the quality of the research has come into question recently and the concept of SIFs remains highly controversial.

Allegheny County physicians can play a vital role in supporting and facilitating access to harm reduction services. Physicians can prescribe naloxone if appropriate for their practice, educate themselves about sources of naloxone and share that information with patients. We can support the expansion of SSP services within Allegheny County, such as the new proposed Prevention Point Pittsburgh site in Carrick. Physicians’ voices advocating for the removal of syringes from the definition of drug paraphernalia in state statute would help facilitate the legalization of SSPs, opening up the potential for funding from multiple sources. Physicians can incorporate Screening, Brief Intervention, and Referral to Treatment (SBIRT) into patient encounters, become knowledgeable about treatment resources, and consider providing MAT, if appropriate. We can follow the research on SIFs in order to form educated opinions.

It’s essential to get to know our public health, social service and nonprofit colleagues working on SUD to identify opportunities for greater collaboration. Most importantly, we must assess our individual preconceptions and biases to determine factors that might keep us from mobilizing the tremendous resources within the physician community to end the opioid epidemic.

Dr. Braund is director, Center for Public Health Practice; associate dean for Public Health Practice; and professor, Health Policy and Management, University of Pittsburgh Graduate School of Public Health. She can be reached at wendy.braund@pitt.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.

Reference

We welcome your editorial submissions!

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Despite decades of efforts focused on improving safety, efficiency and clinical outcomes, there has yet to be a care delivery model that achieves breakthrough results in all areas, because care has been siloed and uncoordinated. Adopting a “disruptive innovation” within existing organizational structures is necessary to upend the status quo in healthcare and maximize operational and clinical efficiencies to deliver value-based care for patients and providers.

Disruptive innovations such as the Hospital Within a Hospital (HWH) approach create a sense of urgency as a driver for better care and continued innovation. An HWH is customized specifically for healthcare and implemented with existing resources. A specialty-focused HWH is the model to achieve operational efficiency while improving patient outcomes and experiences and engaging staff.

**From focused care centers to the HWH**

**What is a Hospital Within a Hospital?** An HWH is a “focused care center” which cuts across service-line silos to create a unique, barrier-free experience for patients and families. An HWH can be a new, free-standing hospital, or it can be created within the existing walls of any facility. The goal is to coordinate and deliver as many of the services that are provided as part of the full care experience. In this way, outcomes, value and efficiency are improved and patient and staff satisfaction achieved.

**Hospital Within a Hospital: Step by step.** The first step is to select the care experience and then shadow that experience to create a complete picture of the pathway from the perspective of the patient. The goal is to deliver care for a specific disease or condition, but through the lens of the patient and family and through a full cycle of care. With stakeholders identified from across the experience, along with the caregivers and touchpoints identified through shadowing, the focus – from the very first call through testing, treatment, discharge and aftercare – is on designing the ideal experience for the patient. Through the shadowing process, cross-functional, high-performance care teams are created and are responsible for the allocation and management of resources and hold responsibility for both outcomes AND costs. According to Harvard Business School Professor Regina Herzlinger, “Focused healthcare teams are ... more likely to provide lower cost, higher quality medical care than large everything-for-everybody IDN’s.” As a result, the HWH model puts accountability for resource and care management squarely at the feet of those involved in the care of the patient, ensuring that the needs of the patient and family are at the forefront of the design of the care pathway.

**Patient-focused care and co-design.** Moving away from the traditional service line mentality shifts the focus of care to the experience of the patient and family. The HWH approach sets the stage for delivering value by coordinating all care and prepares you for bundled payment models. By shadowing patients through the care experience, they become partners in the improvement of that experience. In this way, they are helping to fill the gaps between the current state and the ideal state through co-design, a process which involves patients in the design of a care experience by understanding their met and unmet needs. Engaging patients in their own care also will improve their clinical outcomes.

Whether a standalone specialty facility or within an existing hospital, an HWH should be designed with the mindset of “building care by design from the ground up.” Since building an HWH is a fundamental restructuring of
how care is delivered, providers and administration have the opportunity to reimagine the ideal experience with patients, families and front-line staff. With the singular goal of delivering ideal experiences throughout the full cycle of care, patient and family needs become the top priority. With this in mind, all stakeholders are represented in the process and are invested in the coordination of patient care and services. By focusing on experiences, truly "user-friendly and patient-centric" care pathways can be created.

**Coordination of care.** An HWH requires the close coordination of stakeholders: administrative, financial and functional. From an administrative view, the essential steps to create an HWH include securing buy-in from executive leadership to reconfiguring infrastructure. The direct line of communication with leadership is necessary, as their support allows for the creation of multi-disciplinary teams and the elimination of traditional silos. It also is essential to engage the financial team very early in the process. With their support, existing resources can be refocused without the expenditure of new ones. Through shadowing and the mapping of the actual patient flow through the care experience, true costs are captured, which allow for financial reports that are HWH specific. Functionally, an HWH coordinates the delivery of a full cycle of care – outpatient to inpatient to outpatient. The reorganization of resources and personnel is done with a priority placed on meeting the needs of the patients and their families. Within this innovative model, staff can be cross-trained to ensure organizational efficiency by eliminating hand-offs and anticipating needs at the point of care, “low-tech” solutions are identified to eliminate unnecessary complexity, and teamwork is fostered within all levels and between departments.

**Operationalize the HWH using the Patient Centered Value System.** Creating an HWH can be facilitated by adopting the Patient Centered Value System (PCVS) as the operating system for care coordination and delivery. This operating system includes three core building blocks: shadowing, team-building and true cost identification. These components are the foundation for creating value for patients, as well as a system for coupling clinical and financial success. The goal of PCVS is to provide effective care as efficiently as possible through the development of a team-based approach to care and encouraging patient and front-line staff involvement in designing the care delivery systems.

Herzliger notes that it can be difficult for innovations and focused care concepts to “catch hold” within healthcare. However, these barriers can be overcome with the PCVS operating system as the umbrella to drive operational change. Successes are possible, and innovation can thrive because of the strict focus on care and the experience of patients and families. PCVS is the vehicle to implement a program like HWH and leads to rapid adoption and scale across facilities.

**Real world examples.** Using the PCVS as the new operating system for healthcare, it is finally possible to adopt an HWH model to create value, while improving outcomes and efficiencies. The HWH approach is an achievable and transferrable model designed to maximize impact on the process of care delivery for all stakeholders. With a dedicated focus on the total care experience, an HWH can streamline care pathways across disciplines.

There are already examples of HWH's in clinical areas, like total joint replacements, Level I Trauma Centers, bariatrics, organ transplant and maternity care. HWH and PCVS have the potential to transform and create wide-reaching impact for any care experience. By maintaining a focus

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on patient and experience-driven care, an HWH or focused-care center can be implemented with no additional resources, leading to improved outcomes, enhanced experiences and reduced costs, while creating centers of innovation.

Dr. DiGioia is founder/medical director of The Bone and Joint Center at Magee-Womens Hospital of UPMC and the PFCC Innovation Center of UPMC, and a practicing orthopaedic surgeon. He developed the Patient and Family Centered Care Methodology and Practice and Shadowing, a simple approach to viewing care experiences through the eyes of patients and families, which has been shown to improve outcomes and experiences while decreasing costs.

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

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

The authors can be reached at bulletin@acms.org.

References

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Save the date: ACMS hosting opioid, child abuse programs

- The Allegheny County Medical Society will host “Pain Management, Identification of Addiction and Prescribing Practices for Opioids” at 8:30 a.m. Saturday, Dec. 1, at the ACMS building. This course meets Act 124 opioid education requirements for licensure.
  
  The cost is $35 for ACMS members and $70 for non-members. To register, visit https://act124training.eventbrite.com.

- ACMS also will host “HOW, WHEN & WHY TO REPORT: Mandated Reporter Training for Professionals” at 10 a.m. Saturday, Dec. 8, at the ACMS building. This program meets the requirements for licensure and license renewal.
  
  The presenter will be Jacqueline Wilson, PhD, CEO of Three Rivers Adoption Council since 2000.
  
  The cost is $35 for ACMS members and $70 for non-members. To register, visit https://2018mandatedreporter.eventbrite.com.

Medical Student Career Speed Dating event held

The University of Pittsburgh’s medical student American Medical Association (AMA) chapter hosted a Medical Student Career Speed Dating event Oct. 22 at the Herberman Conference Center.

Co-chaired by Ms. Patricia Campos, Ms. Alexandria Harris and Mr. Emade Jaman, all MD candidates, Class of 2021, University of Pittsburgh School of Medicine, this informal program served as a “career exploration” for medical students by providing an opportunity

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for students to speak with physicians to learn about a variety of specialties.

More than 70 medical students engaged in question-and-answer, round-table-by-specialty sessions. Numerous physicians representing eight specialties, including Cardiology, Emergency Medicine, Internal Medicine, Obstetrics and Gynecology, Psychiatry, Neurology, Otolaryngology and Pediatrics, shared insight into their respective specialty and addressed questions such as: what it’s like to practice on a day-to-day basis; why they chose a specific specialty; what attributes are important to medical students considering a specialty; and how to balance career and personal life.

For several years, ACMS has collaborated with the officers of the University of Pittsburgh’s AMA Chapter to host this program as it recognizes the value of candid one-on-one discussions between physicians and medical students about the realities of choosing a career path.

POS announces 39th Annual Harvey E. Thorpe Lecturer

Sharon L. Taylor, MD, president of the Pittsburgh Ophthalmology Society (POS), is pleased to announce Wallace L.M. Alward, MD, as the 39th annual Harvey E. Thorpe Lecturer. The 55th Annual Meeting will take place Friday, March 29, 2019, at the Pittsburgh Marriott City Center.

Dr. Alward completed his glaucoma fellowship at the Bascom Palmer Eye Institute. Following his fellowship, he became director of the Glaucoma Service at the University of Iowa, where he is professor and vice-chairman. Since 2006, he has held the Frederick C. Bodi Endowed Chair in Ophthalmology. Dr. Alward has co-authored more than 150 peer-reviewed papers. He served as a director of the American Board of Ophthalmology from 2006 to 2013 and was chair in 2012.

Dr. Alward’s real passion is teaching. He has trained 35 glaucoma fellows. He also has authored two textbooks: “Color Atlas of Gonioscopy” and “The Requisites: Glaucoma.” The Archives of Ophthalmology listed the “Color Atlas of Gonioscopy” as one of the 100 important ophthalmology books of the 20th century. It has been translated into Russian, Polish and Portuguese.

He maintains a free website to teach gonioscopy (gonioscopy.org) that contains more than 250 gonioscopy videos. In 2017, gonioscopy.org had 51,000 users in 174 countries. His most recent website (curriculum.iowaglaucoma.org) was released in late 2015. It is a 50-lecture curriculum aimed at beginning ophthalmology residents. This site contains more than 900 still images and more than 90 video clips. The curriculum has most recently been made into a free iBook.

Distinguished guest faculty who also have confirmed their participation include: Andrew G. Lee, MD, neuro-ophthalmologist and chairman of the Department of Ophthalmology, Blanton Eye Institute, Houston Methodist Hospital; and professor in the Departments of Ophthalmology, Neurology and Neurosurgery, Weill Cornell Medical College; Peter Veldman, MD, assistant professor of Ophthalmology and Visual Science, and director, Residency Program, University of Chicago Medicine; and Sophie Bakri, MD, professor of Ophthalmology, Mayo Clinic, Rochester, Minn.

In addition, POS is honored to welcome local guest faculty José-Alain Sahel, MD, professor and chairman, The Eye and Ear Endowed Chair, Department of Ophthalmology, director, UPMC Eye Center, University of Pittsburgh School of Medicine. Dr. Sahel is known worldwide for his expertise in vision restoration techniques. He has developed several interventions – including stem cell implantation, gene therapy, innovative pharmacologic approaches and the artificial retina – for retinitis pigmentosa, age-related macular degeneration, vascular eye disease, and other vision impairments that currently are untreatable.

The Annual Meeting brochure will be sent to all members in January 2019 with online registration beginning Jan. 20, 2019, at www.pghoph.org.

40th Annual Meeting for Ophthalmic Personnel set

The 40th Annual Meeting for Ophthalmic Personnel, presented by
the Pittsburgh Ophthalmology Society (POS), will run concurrently with the POS Annual Meeting Friday, March 29, 2019, at the Pittsburgh Marriott City Center.

Planning for this well-respected annual program, which is designed for ophthalmic technicians, assistants, technologists, scribes and administrative personnel, is currently underway.

Course directors Pamela Rath, MD, Laurie Roba, MD, and Pradeepa Yogananthan, MD, are pleased to announce highlights of the course, which include presentations on: posterior segment imaging, retina hot topics, artificial intelligence, HIPAA Security and Privacy, Fraud and Embezzlement, Medical Ethics in Eye Care, Scribing and more.

The conference has provided exceptional educational opportunities for ophthalmic personnel in and around the region and continually attracts well-respected local faculty who present relevant and quality instruction through numerous breakout sessions.

Online registration begins Jan. 15, 2019, at www.pghoph.org. Contact Nadine Popovich, administrator, for details and more information at npopovich@acms.org.

Geriatrics Teacher of the Year Award nominations open

The Pennsylvania Geriatrics Society – Western Division (PAGS-WD) is seeking nominations for the Geriatrics Teacher of the Year Award. 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 healthcare discipline including nursing, advanced practice, physical therapy, pharmacy, occupational therapy, dentistry, audiology, speech-language, pathology and social work, who

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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, is available on the Society’s website at www.pagswd.org. Nominations must be received on or before Jan. 25, 2019. Questions regarding the awards or nomination process can be directed to Nadine Popovich, administrator, at npopovich@acms.org or (412) 321-5030.

Awardees will be recognized at the dinner symposium held in conjunction with the 2019 Clinical Update in Geriatric Medicine scheduled for Thursday, April 25, 2019, 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 holds annual fall program at University Club

The Pennsylvania Geriatrics Society – Western Division (PAGS-WD) held their annual fall program Nov. 1 at the University Club in Pittsburgh. More than 50 internists, family practitioners, geriatricians, pharmacists, nurses, nursing home administrators and social workers attended the evening dinner program. Thank you to the following who provided support: Aspire Healthcare, Astellas, CommunityLIFE, naviHealth, Optum, Portola Pharmaceuticals, Presbyterian SeniorCare Network and Valeritas.

The audience welcomed Karen Wolk Feinstein, PhD, president and chief executive officer of the Jewish Healthcare Foundation (JHF) and its three operating arms, The Pittsburgh Regional Health Initiative (PRHI), Health Careers Futures (HCF) and the Women’s Health Activist Movement Global (WHAMglobal). Dr. Feinstein presented “Living a Good Life – Not Just a Long One,” which explored the challenges of finding new meaning and purpose in life as we age. Her discussion delved into the roles that define adult years – doting parent, accomplished professional and weekend warrior athlete and the changes that occur when they start to fade. Dr. Feinstein presented that a growing body of research suggests that finding renewed purpose later in life can, quite literally, be a life-saver. Seniors who have a clear sense of purpose in their lives tend to have better physical, mental and even spiritual health compared to those who do not.

The annual fall program, which began in 2003, is a popular and well-respected program attracting distinguished guest speakers, comprised of both national and local faculty. For more information on becoming a member of the Society, please visit www.pagswd.org. Members receive complimentary registration for many programs hosted by the Society. Questions may be directed to Nadine Popovich, administrator, at npopovich@acms.org or (412) 321-5030.
About the ACMS Physician Wellness Program

The ACMS Physician Wellness Program (PWP) was created for our member physicians to provide confidential assistance with common life difficulties including family issues, depression and anxiety, substance abuse, and difficulty managing stress.

Addressing Physician Burnout and Stress

Being a physician in the current healthcare climate is not easy. Adhering to constantly changing regulations and requirements while maintaining a healthy work/family life balance and handling everyday stressors can take a serious toll on a physician’s overall well-being. Addressing physician burnout is the first step to decreasing stress and sustaining a healthy lifestyle.

How PWP Can Help You

ACMS has partnered with Cranberry Psychological Center, Inc. to provide free, anonymous counseling to active ACMS physician members. Non-emergency sessions will be scheduled during regular business hours; emergency sessions are available 24 hours, 7 days a week. A total of 4 free sessions are offered through ACMS each calendar year at 3 different locations: Fox Chapel, Cranberry, and McMurray. All psychologists are PhDs practicing under Richard G. Frey, PhD, ABPP, clinical director.

To make an appointment or for information, call Dr. Frey at (724) 772-4848, ext. 225.

Help yourself. Help a colleague. Help your patients.
In Memoriam

Charles F. Sturm Jr., MD, 65, of Murrysville, died Wednesday, October 17, 2018.

Dr. Sturm graduated in medicine from Albert Einstein College of Medicine of Yeshiva University and served his residency at Allegheny University Hospitals.

He retired after decades of family practice at Forbes Family Medicine. He also worked with Dr. Eugene Herron, Health America and Monroeville Rehabilitation & Wellness Center.

Dr. Sturm also enjoyed studying fossils and shells, was a research associate at the Carnegie Museum of Natural History, and served as president of the American Malacological Society. Along with Timothy A. Pearce and Angel Valdes, he published a book, “The Mollusks: A Guide to Their Study, Collection, and Preservation,” and discovered a new genus and species of fossil scallop, named after his wife: Patriciapecten iona.

Surviving are his wife, Pat; sons AJ (Jodi) and Jim (Derek); grandchildren Briana, Levi and Asher; and his second family at Forbes Family Medicine.

Services will be held at 11 a.m. Wednesday, November 21, at St. John de la Salle Parish, Delmont. A celebration of life will be held Sunday, November 25, from 1 to 4 p.m. in the Carnegie Music Hall Foyer, 4400 Forbes Avenue, Pittsburgh, PA 15213. Details about the celebration can be found at www.doc-fossil.com. Please RSVP to doc-fossil.rsvp@gmail.com.

Thank you for your membership in the Allegheny County Medical Society

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

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Erenumab-aooe (Aimovig™): A new biologic to prevent migraine in adults

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Introduction

Migraine is a primary headache disorder generally characterized by recurrent attacks of throbbing headaches that often are unilateral in location and associated with nausea, vomiting, photophobia and phonophobia. According to the latest edition of the International Headache Society (IHS) classification of headache disorder guidelines, migraine has two major subtypes: migraine without and with aura. A migraine without aura presents as a headache disorder with attacks lasting 4-72 hours with characteristics including unilateral location, throbbing quality and an association with nausea, photophobia and phonophobia. A migraine with aura presents as recurrent attacks lasting only minutes with characteristics such as transient focal neurological symptoms that develop gradually, followed by a headache. IHS defines a chronic migraine as a headache occurring on at least 15 days per month for more than three months, with features of a migraine on at least eight days per month.

There have been improvements in the understanding of the pathophysiology of the migraine over recent years. Calcitonin gene-related peptide (CGRP) is a neuropeptide that has been identified as a mediator of migraine and a target for preventative therapies. Studies have shown that migraine-specific triggers can cause vasodilation of cranial blood vessels, innervated by sensory fibers of the trigeminal nerve. The vasodilation of the blood vessels activates trigeminal nerve fibers which send a pain signal to the brainstem. The brainstem reacts by releasing vasoactive peptides such as CGRP from trigeminal fibers. These vasoactive peptides cause exacerbation of vasodilation of cranial blood vessels and can cause neurogenic inflammation. Vasoactive peptides also increase activation of the trigeminal fibers and facilitate transmission of pain signals to the brain. Serum concentrations of CGRP have been found to be elevated during chronic migraine episodes and in episodic migraine attacks. Relief of migraines often is associated with a decrease in the serum concentration of CGRP, further supporting CGRP as a target for effective prevention of migraines.

What it is: Erenumab-aooe (Aimovig™) works to inhibit the receptor for the neuropeptide, CGRP. It is a human immunoglobulin G2 (IgG2) monoclonal antibody produced using recombinant DNA technology. Erenumab was approved by the FDA for use as preventative treatment of migraine in adults in May 2018. The four-letter suffix –aooe has no pronunciation or meaning; such suffixes are now added to biologic drugs to distinguish reference products from their biosimilars.

How it works: Erenumab binds to the CGRP receptor and ultimately antagonizes the receptor function.

Dosage: The recommended initial dosing is 70 mg injected subcutaneously once monthly. However, there may be patients who benefit from a dosage of 140 mg injected subcutaneously once monthly. The dosage of 140 mg is administered as two separate consecutive injections of 70 mg.

Administration: Erenumab is only available as a subcutaneous injection and is intended for patients to self-administer the medication. It should be administered subcutaneously into the abdomen, thigh, or upper arm.

Adverse events: In randomized controlled clinical trials, erenumab was well-tolerated. The most common adverse effects seen were injection site reactions such as pain, erythema and pruritus (6 percent with 70 mg once monthly, 5 percent with 140 mg once monthly) and constipation (1 percent with 70 mg once monthly, 3 percent with 140 mg once monthly). It is possible for patients to develop anti-erenumab antibodies, which could neutralize its pharmacologic activity. Some participants in the clinical trials demonstrated neutralizing antibody production. In patients receiving 70 mg once monthly, there was an incidence of 6.2 percent for development of anti-erenumab...
antibody development and 2.6 percent in patients receiving 140 mg once monthly.5

Contraindications: There are currently no contraindications listed in the manufacturer’s labeling for erenumab (Aimovig™).5

Use in specific patient populations: Although sufficient clinical trial data does not exist for the use of erenumab in the pregnant population, animal studies of pregnant monkeys suggested there was no harm caused to offspring when this medication was administered. Additionally, there is not sufficient data to provide recommendations for use in the pediatric population or geriatric population and no data for the presence or absence of erenumab in human breast milk.5

Clinical efficacy: Erenumab has been studied as a preventative treatment for migraine in three randomized placebo-controlled trials. Study 1 and Study 2 evaluated the efficacy of erenumab as prevention for episodic migraine, and Study 3 evaluated erenumab as prevention for chronic migraine. All studies allowed the use of acute headache treatments including migraine-specific medications and NSAIDS. The patient population of each study was largely female, Caucasian and approximately 40 years old.

Study 1 was a randomized, placebo-controlled, multi-center, double-blind study evaluating erenumab for the prevention of episodic migraine, defined as 4-14 migraine days per month. In this study, 955 patients were randomized to either erenumab 70 mg/month, erenumab 140 mg/month, or placebo for a duration of six months. Patients taking either dosage of erenumab showed greater reductions from baseline compared to placebo in mean monthly Migraine Physical Function Impact Diary (MPFID) everyday activity (difference from placebo: -2.2 for 70 mg/month, -2.6 for 140 mg/month, p=0.001) and physical impairment scores (difference from placebo: -1.9 for 70 mg/month and -2.4 for 140 mg/month, p<0.001).

Study 2 also was a randomized, placebo-controlled, multi-center, double-blind study evaluating the use of erenumab for prevention of episodic migraines over a course of three months. 577 patients were randomized to receive erenumab 70 mg/month or placebo. Erenumab displayed greater reductions from baseline compared to placebo in MPFID physical impairment scores (difference from placebo: -1.3, p=0.021), but not in everyday activity scores (difference from placebo: -1.1, p=0.061).

Study 3 was a randomized, placebo-controlled, multi-center, double-blind study evaluating the efficacy of erenumab for prevention of chronic migraines over a course of three months. 667 patients were randomized to receive erenumab 70 mg/month, erenumab 140 mg/month, or placebo for three months. Erenumab showed greater reductions from baseline compared to placebo in monthly migraine days during the last month of the study (-6.6 for 70 mg/month, -6.6 for 140 mg/month, p<0.001).5

How supplied: Erenumab is available as a 70 mg/mL single-dose prefilled SureClick® autoinjector or prefilled syringe and is a clear to light yellow colored solution.5 Erenumab is packaged as packs containing one or two syringes or autoinjectors. Patients requiring 140 mg dosing should receive the pack containing two 70 mg/mL prefilled syringes or autoinjectors.

Estimated cost: It is estimated that the erenumab 70 mg/mL single-dose SureClick® autoinjector or prefilled syringe will cost $575 or approximately $6,900 per year and will likely be considered a specialty medication.6

Storage and handling: Erenumab should be refrigerated at 2° - 8°C (36° - 46°F) in the original carton to protect from light until time of use. It should not be frozen or shaken. Once removed from the refrigerator, erenumab should be kept at room temperature (up to 25°C [77°F]) in the original carton and used within seven days. If more than seven days have elapsed since the pack was removed from the refrigerator, erenumab should be discarded.5

Comparative agents: Management of migraines can include preventative therapy to help reduce the frequency and severity of attacks as well as acute therapy to abort the attack.1 The latest migraine prevention guidelines from the 2012 AHS/AAN (American Headache Society/American Academy of Neurology) assign treatments to one of five levels based on the strength of evidence for the efficacy of treatment: Level A, Level B, Level C, Level U and “Other.” Current Level A recommendations for prevention of migraines include antiepileptic drugs such as divalproex sodium, sodium valproate and topiramate, antidepressants such as amitriptyline and venlafaxine, beta-blockers such as metoprolol, propranolol and timolol, and triptans such as frovatriptan. However, the antidepressants, beta blockers and antiepileptic drugs can lead to intolerable side effects. Erenumab has not has not yet been compared to any of the first-line agents, and therefore

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Materia Medica

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should probably be considered as preventive therapy only after all first-line options have been exhausted. Also, its long-term safety and efficacy remain to be determined. 7

Conclusion: A preventative migraine treatment that is directed toward a suspected underlying pathophysiologic mechanism is an important advance in the management of patients with migraine. Erenumab is currently the only FDA-approved monoclonal antibody against the CGRP receptor. Erenumab should be used when first-line oral migraine prophylaxis medications are not fully effective or are not tolerated. It may be used in addition to other oral prophylactic agents as was done in clinical studies; however, at this time, there is no data that combination therapy is more effective.

At the time of this writing, Ms. Kunkel was on a clinical rotation in the Center for Pharmaceutical Care at Allegheny General Hospital. For any questions concerning this article, please contact Dr. Freedy at the Allegheny Health Network, Allegheny General Hospital, Center for Pharmaceutical Care, Pittsburgh, Pa., (412) 359-3192, or email tucker.freedy@ahn.org.

References
UPMC-Highmark settlement: Preparing for the end

Beth Anne Jackson, Esq.

The official end of the consent decree between Highmark and UPMC (June 30, 2019) was confirmed by the Pennsylvania Supreme Court months ago; however, the Medicare Advantage enrollment period requires Pittsburgh-area seniors to make decisions now. Although spokespeople from both entities state that they are prepared to deal with enrolling and disenrolling beneficiaries, patients and providers may not be. Seniors have only until Dec. 11 to enroll in a Medicare Advantage plan if they decide against traditional Medicare. Medicare Advantage plans are increasingly popular because they typically offer enhanced benefit packages with smaller premiums.

Preparation – immediate. Patients, especially long-term patients, may raise their concerns about Medicare Advantage plan coverage with their physicians. Are you and your staff prepared to readily identify for patients all Medicare Advantage plans that you participate in and plan to continue participation in for the upcoming year? It would be helpful for your practice to prepare a handout listing all such plans to distribute to Medicare beneficiaries. For seniors with difficult situations or needing personal assistance on Medicare insurance matters, Pennsylvania offers a free health insurance counseling program, APPRISE. The toll-free APPRISE Helpline is 1-800-783-7067.

Preparation – long-term. Begin preparing now for the expiration of the consent decree next summer, both for your practice and your patients:

- Payer mix. With respect to your practice, look at your payer mix. If you are not employed by Highmark/Allegheny Health Network (AHN) or UPMC, are there payers that you have ignored because of the Highmark and UPMC Health Plan penetration in the market? Some seniors may be changing to an independent insurer to retain access to both UPMC and AHN physicians and facilities. There are 49 Medicare Advantage plans serving Allegheny County. Should you be participating with more payers or plans? Carefully research your options and consider not only reimbursement, but also formularies, prior authorization requirements, “narrow” networks that limit to whom and to which facilities you refer patients and other requirements that could affect your treatment of patients.

- Patient balances and billing. It will be essential to ensure that, if the patient has an account balance with your practice, arrangements are made to pay the balance off immediately. Patients who have previously made payments on a balance may feel less compelled to continue to pay you if they’re not relying on you for care. Have your staff prepared to address financial issues with patients during visits prior to the new year. Enforce your policy that copayments be collected at the time of service. With respect to billing, submit end-of-year bills promptly and follow up in a timely manner. If you are a surgeon, note that the patient’s change of insurance does not affect the global period for surgery. Accordingly, if a patient was in-network when you perform the surgery in December, and the global billing period is 90 days, you are responsible for their follow-up care related to the surgery into the new year, even if you do not accept their new insurance plan.

- Orderly transition of care. With respect to patients, there may be two waves of patients making transitions: on or before Jan. 1, 2019, and June 30, 2019. Begin asking patients now if they are planning to change their Medicare Advantage Plan. If they are, determine whether they will still be able to see you in-network. Patients in an “episode of care” may be able to continue to see a specialist even if out-of-network. If they cannot, and they plan to switch physicians, have forms ready for patients to fill out to facilitate the transfer of records to the new physician. Ensure that records are timely and accurately transferred. Permit patients to have refills for essential everyday medications for a reasonable period of time. At the same time, prepare to accept new patients. Equip your staff to welcome and accommodate new patients and request records from other physician offices prior to the patient’s first visit, if possible.

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

Ms. Jackson is a shareholder in the Health Care Practice Group of Brown & Fortunato, P.C., which is headquartered in Amarillo, Texas, and serves health care providers nationally. She is licensed in both Pennsylvania and Texas and maintains an office in the greater Pittsburgh area. She may be reached locally at (724) 413-5414 or bjackson@bf-law.com. Her firm’s website is www bf-law.com.
A doctor will embark on many different journeys throughout his or her career, often listening to and learning from patients just as much as he or she is caring for and educating them.

Dr. Paul Caplan, MED’36, knows the importance of embracing life’s journeys, having spent seven decades practicing medicine in widely different settings, situations and specialties. Drawn to medicine at the early age of 9, Dr. Caplan was inspired by a traveling doctor who once treated his mother. He knew that he wanted to dedicate his life to helping patients, just as this doctor had done for his family.

Dr. Caplan, who practiced medicine until the age of 96, created his legacy on the importance of constantly evolving his craft, learning from his patients and bettering his discipline. After graduating from the University of Pittsburgh School of Medicine in 1936, he completed his internship at Montefiore Hospital. His career has left him with many notable experiences, such as treating wounded soldiers on Omaha Beach after D-Day and traveling for more than 20 years as the Pittsburgh Symphony Orchestra tour physician.

“It was a privilege to be a part of each of my patients lives,” Caplan remarks as he thinks about his career. “I think that the secret to success is to do what you like to do. Allow the work to be your hobby.”

In 1960, Dr. Caplan received a grant from the National Institutes of Health to study how osteoarthritis of the spine affects the physical capabilities of coal miners. He spent four years observing these miners and ultimately helped to change the way they received health benefits. He also traveled to Haiti and treated a wide variety of ailments and diseases outside his specialty of rheumatology. During his time there, Dr. Caplan dedicated himself to understanding this new field.

“I carried a textbook, and learned as I went,” he said. “I asked questions and, more importantly, I listened.”

Dr. Caplan served as a professor...
of Medicine at Pitt from 1946 through 2012. He was a Fellow at the American College of Physicians; a 2004 Master of the American College of Rheumatology; and a member of the American Medical Association, the Pittsburgh Rheumatism Association, and the Pennsylvania and Allegheny County Medical Societies. He also authored dozens of publications over the years, covering various research topics and treatments for arthritis.

Through all of Dr. Caplan’s professional triumphs, continued learning and patient care were always at the center of his work. In the spirit of education, he extended his reach into the philanthropic sector, creating the Dr. Paul S. Caplan Award in Rheumatology with his late wife, Gertrude. The award provides support to a fellow or resident physician in the Division of Rheumatology and Clinical Immunology at Pitt, so that an individual who embodies this same spirit may continue to pursue his or her training.

At 105 years old, Dr. Caplan now reflects fondly on his long and accomplished career. Sitting in his home in Oakland, surrounded by countless awards and accolades, Dr. Caplan thought of his advice to current students.

“Remember the art of listening,” he said. “Take time to hear about the whole life of the patient, not just the disease. If you treat your practice as an avocation, not just a vocation, it will never be work.”

The School of Medicine honored Dr. Caplan and his accomplishments on May 22, 2017, at the 2017 Graduation Ceremony and Medical School Diploma Day. He received the Lifetime Alumnus Achievement Award from the School of Medicine and Medical Alumni Association. If you are interested in learning more about the Dr. Paul S. Caplan Award in Rheumatology, please contact Ed Nemanic at (412) 647-5395.

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Despite its economic, technological and clinical prowess, the United States is the most dangerous place to give birth in the developed world, and among the most dangerous in which to raise a newborn. The maternal mortality rate in the United States is nearly three times higher than in any similar country (approximately 26 deaths per 100,000 live births, according to a 2015 study in *The Lancet*). And, while other countries around the world are reducing maternal mortality, the rate in the United States keeps climbing. Many of those deaths – 60 percent, according to the Centers for Disease Control and Prevention (CDC) – are preventable. Annually, another 50,000 mothers suffer severe complications or life-threatening injuries while giving birth, according to the CDC. Babies also are in peril, with the United States ranking 33rd in infant mortality (5.9 deaths per 1,000 live births) among countries studied by the Organisation for Economic Co-operation and Development.

On Oct. 8, the Women’s Health Activist Movement Global (WHAMglobal), a supporting organization of the Jewish Healthcare Foundation (JHF), hosted a Maternal Health Leaders Symposium at the Westin Convention Center in Downtown Pittsburgh. Nearly 130 local, national and international leaders gathered to identify cutting-edge research and evidence-based programs that address the causes and conditions related to maternal and infant mortality, and identify action strategies.

JHF President and CEO Karen Wolk Feinstein, PhD, kicked off the Symposium by explaining that she founded WHAMglobal to channel the energy of recent women’s marches for concerted action, and to address unmet women’s health needs – a focus of JHF throughout its nearly 30-year history. WHAMglobal sought a “Big Idea,” a focus for its energy and activism that would improve the most lives. WHAMglobal challenged the region’s nonprofit organizations to pitch their top idea for improving women’s health, and crowdsourced the broader community to select a winning issue.

By the end, WHAMglobal had its directive: to address the shockingly high maternal and infant mortality rates in the United States. WHAMglobal aims to accomplish those goals by studying high-quality maternal care models from around the world, championing policy...
and practice reforms, and forming a strong network of women’s health advocates.

“Whether you’re a researcher, policy-maker, advocate, obstetrician, nurse-midwife, health insurer, or a doula, you are here because you are part of the solution and care passionately about the well-being of mothers and babies,” Dr. Feinstein said. “There is no magic bullet solution to our maternal and infant health crises. But we can learn from other regions and countries and create a comprehensive support network for pregnant mothers through teamwork.”

The Maternal Health Leaders Symposium featured action-oriented panels that covered a variety of maternal and infant mortality and morbidity-related topics, including translating research into action to lower maternal mortality; addressing infant mortality through evidence-based interventions; transforming maternity care through innovative payment reforms; and learning from national and global best practices in using a patient-centered approach to lower maternal mortality.

Following the panel discussions, attendees broke into smaller groups to develop strategies to elevate the quality of maternal and infant care. The breakouts focused on creating a team-based workforce and examining scope of practice; redesigning practices and procedures to support high-quality, coordinated maternal care; and optimizing maternal and infant health communication, education and media campaigns.

Attendees identified promising strategies, including incorporating midwives and doulas into an expanded maternal care team; creating an accountable system to track and improve pregnancy outcomes; and assessing mothers’ pregnancy risk levels and needed physical health, mental health and social service supports more frequently. These are cornerstones of the maternal and infant health system of Australia, which has a maternal mortality rate that is five times lower than that of the United States.

Other states also could learn from California, which has dramatically reduced its maternal mortality rate (to a nation-leading 7.3 deaths per 100,000 live births) by implementing basic safety science principles, including checklists, toolkits and safety

Continued on Page 426
the standard of care for mothers and babies. These efforts include establishing the Maternal Coalition and Action Network (MOMsCAN), along another JHF supporting organization, the Pittsburgh Regional Health Initiative (PRHI). MOMsCAN is a perinatal quality collaborative that will build a statewide, multi-stakeholder coalition and use research, training, quality improvement, technical assistance and policy advocacy to lower maternal mortality rates in Pennsylvania and achieve excellent attachment and outcomes for mothers and babies.

“Collectively, we have the components needed to create a best-in-class maternal and infant health system,” Dr. Feinstein said. “Our charge, our duty, is to assemble them.”

For more information on WHAMglobal, contact Women’s Health Specialist Kate Dickerson at dickerson@jhf.org.

2018 Bulletin Photo Contest

The first-place winner of the 2018 ACMS Bulletin Photo Contest is Frederick Doerfler Jr., MD, for his photo “Full Moon at Disko Bay, Greenland.” His photo will appear on the January 2019 cover of the Bulletin. Congratulations, Dr. Doerfler! Dr. Doerfler’s photo “Half Dome at Sunrise” also was a winner.

Additional winners include: Barry Asman, MD (“The Watering Hole” and “Namib Desert”); Alan H. Klein, MD (“Good Morning Washington D.C.” and “Zion National Park”); Maria Paul, MD (“Dali Museum Staircase” and “Simmons Farm Pumpkins”); Malcolm Berger, MD (“Light the Night”); Elias Hilal, MD (“Spice Store” and “Sunset in Glass”); and Terrence Starz, MD (“Beautiful Picture”). These photos will appear on 2019 covers of the Bulletin.

Congratulations to all winners, and thank you to all who participated in the 2018 ACMS Bulletin Photo Contest!
# Special Report

## REPORTABLE DISEASES 2018: Q3

**Allegheny County Health Department**  
Selected Reportable Diseases/Conditions

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<th>Selected Reportable Disease/Condition*</th>
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* Case classifications reflect definitions utilized by CDC Morbidity and Mortality Weekly Report.

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

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

For more complete surveillance information, see ACHD’s 10-year summary of reportable diseases: [https://www.alleghenycounty.us/Health-Department/Resources/Data-and-Reporting/Infectious-Disease-Epidemiology/Epidemiology-Reports-and-Resources.aspx](https://www.alleghenycounty.us/Health-Department/Resources/Data-and-Reporting/Infectious-Disease-Epidemiology/Epidemiology-Reports-and-Resources.aspx).
Two years in the making, the Allegheny County Medical Society announces the publication of “A Tradition of Leadership, Innovation and Caring,” a 200-page history of medicine in Pittsburgh and Allegheny County. The work was commissioned by John G. “Jack” Krah, former ACMS executive director, through Legacy Publishing Co., Birmingham, Ala. Its author is Diane C. Wuycheck, former ACMS director of communications, with layout assistance from Meagan K. (Welling) Sable, ACMS director of publications and Bulletin managing editor.

“Just as the Allegheny and Monongahela rivers merge to form the Ohio, so too the history of medicine and that of the region come together in this book to produce the story that has earned Pittsburgh and Allegheny County its medical place in the world,” Ms. Wuycheck said.

The rugged terrain fed by three rivers was the stage for important battles of the French and Indian War in our country’s fight for independence. Medicine was literally born on this battlefield.

Returning from war, physicians brought innovative techniques to their fledgling practices to stave off water and airborne maladies. They crafted rudimentary tools to save lives and limbs.

Their resiliency and enterprise are characteristic of the region’s people who overcame massive floods, fires and choking pollution to transform Pittsburgh from a “Rust Belt Smoky City” to the “City of Meds and Eds” it is today.

In these pages are stories of captains of industry and medical giants, supported by legions of compassionate caregivers and tireless advocates committed to those in need, their communities and their professions.

The marvels of millennium medicine – from transplants to bioengineering and nanotechnology – predict a future more remarkable than the notable past.

“I appreciate the support of the ACMS staff and the generous input of ACMS physicians along with my healthcare colleagues and historical groups that contributed greatly to the book’s development,” Ms. Wuycheck noted.

The hard-cover book also includes an extensive bibliography and profiles of local physicians, hospitals and healthcare organizations.

Copies are available from ACMS for $49.95. Please call (412) 321-5030 for more information.
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Fax: _______

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Area Code & Phone Number

Home: ____________________________________________

Area Code & Phone Number

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Area Code & Phone Number

Sex: ____________________________ Date of Birth: __________________

Primary Specialty: ____________________________ Secondary Specialty: ____________________________

License: _______ PA No.: _______ Date Issued: _______

Present Type of Practice:
[ ] Employed by Hospital/Health System
[ ] Employed by Physician(s)
[ ] Employed by Industry or Government

[ ] Owner of Physician Practice
[ ] Independent Contractor
[ ] Other (Specify) ____________________________

Practice Name: ____________________________

Employment Status:
[ ] Practicing full-time
[ ] Practicing part-time
[ ] Retired from practice

[ ] Currently not in practice
[ ] Other (Specify) ____________________________

Present Hospital Appointments:
__________________________________________ Dates: ____________________________

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

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

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

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

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

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

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