

LEHIGH COUNTY

Health & Medicine

Official Publication of The Lehigh County Medical Society



TELEMEDICINE

INCREASES PATIENT ACCESS
TO PRIMARY AND SPECIALTY
CARE IN LEHIGH



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BY SUSAN HURD
Registered Dietitian,
Licensed Dietitian-Nutritionist



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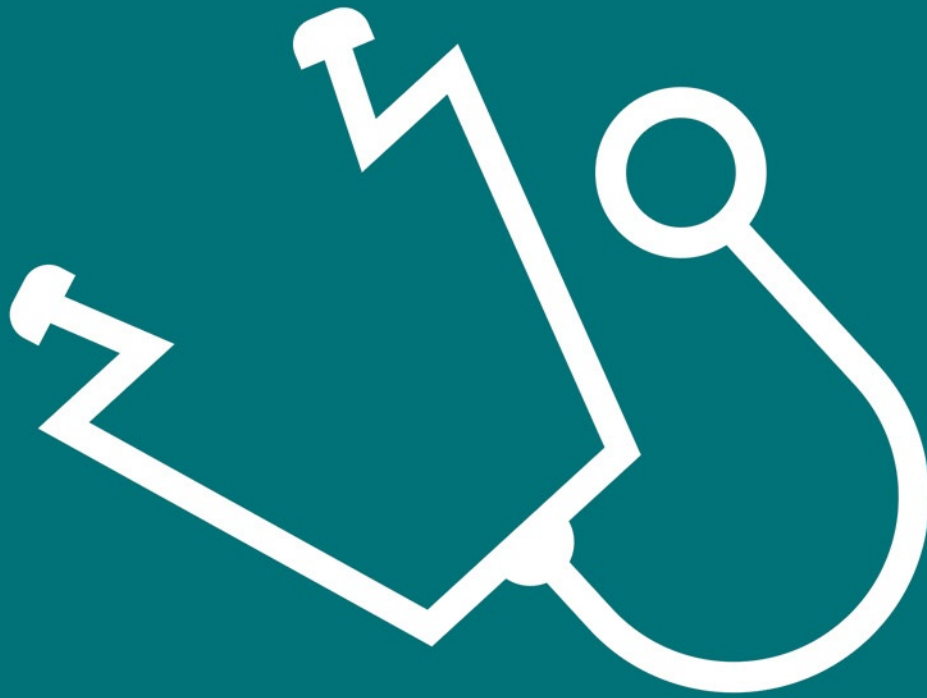
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IN THIS ISSUE



BRUCE D. NICHOLSON, MD

Lehigh County Medical Society President

Spring is here, as is the Spring edition of *Lehigh County Health and Medicine*. We hope you have found prior issues educational, and look forward to hearing your responses, ideas, and contributions.

This issue will feature articles on a variety of topics. We discuss Health Literacy as well as a brief history on Telemedicine in the Valley and how our local health networks are using it to benefit our health. Two of the health topics for March are National Athletic Training Month along with National Nutrition Month. Both topics are featured in this month's issue. In addition, the month of May includes American Stroke Awareness Month plus Arthritis Awareness Month. Inside you will find an article on post stroke spasticity and one on the myths and treatment options for Arthritis.

Look for the article from the United Way of the Greater Lehigh Valley (UWGLV) where you will find how they are working to make the Lehigh Valley a better place for the Aging. As the state and our area are seeing an increase in those over age 65, UWGLV set a goal to increase the number of seniors who could remain in their home. See what they are doing.

Written by the wife of a resident, who herself is training to become a marriage counselor, we feature an article that discusses common matters that couples in the medical field face on a daily basis. This article was originally published in the Winter 2018 issue of *Physician Family Magazine*, available at www.physicianfamilymedia.org.

Check out our Practice Management section for information on the change to the licensing system for physicians. Additionally, we have a really nice self-help piece for Practice Administrators and Managers, or for that matter, anyone.

Thank you for reading. +

Reading

THE WAY TO BETTER HEALTH

BY AKSHAY SHANKER



**CANCER.
LOOP DIURETICS.
INTUSSEPTION.
CHOLECYSTECTOMY.
HYPERTROPHIC
CARDIOMYOPATHY.**

Of these five words, how many did you recognize, and how many did you understand? Whether all five or none at all, your answer is probably related to:

A. your personal interest in the condition (e.g. if you or your family/ friends have had it),

B. your level of understanding with the healthcare field, or

C. your willingness to Google Search the words that may have been confusing to you.

Either way, it is clear that in today's world—with the Internet becoming ubiquitous—patients have the potential to access a huge array of resources, case histories, and information about just about any condition imaginable.

There is a wide range in the numbers of individuals who can access health care information, and the people who can understand and use that information. This can have a significant impact on their ability to get and stay well.

WHAT EXACTLY IS HEALTH LITERACY?

The most widely-accepted definition of health literacy comes from the Institute of Medicine (IOM) in 2010. It states that health literacy is “the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.” Put simply, health literacy refers to the way patients understand what is happening with their health and have the ability to make rational decisions about what to do.

Although health literacy is linked with basic literacy skills, they are not the same thing. While many patients can at least read and process short texts and documents, over 47% of adults in the United States have “difficulty locating, matching, and integrating information in written texts with accuracy and consistency” (per IOM, 2004). This means that many patients that may not be picked up in traditional literacy screens still have problems applying their knowledge to the healthcare system—such as scheduling appointments, taking medications, negotiating with insurance, understanding consent forms, and describing accurate medical histories to their doctors.

This problem is widespread, even in the Lehigh Valley, where roughly 13% of people lack basic literacy skills. According to the most recent National Assessment of Health Literacy, only about 12% of Americans today have “proficient health literacy,” and over 1/3rd of Americans (roughly 77 million people) are unable to follow directions on a prescription drug label or schedule immunizations based on a simple chart.

Secondly, health literacy is context dependent, and not something that can be ascertained just by looking. Even if patients are highly literate, they may be unfamiliar with human physiology or particular aspects of medicine, scared or confused regarding their specific diagnosis, or simply unable to navigate the

increasingly complex medical system we have today. Thirdly, poor health literacy tends to be associated with certain demographics, such as low socioeconomic status, lack of higher education or insurance, the elderly, non-native English speakers, and racial and ethnic minorities. This is especially troublesome, as many of these same demographics are at risk for severe and chronic diseases in which the lack of proper management and treatment can dramatically worsen their course.

WHY IS HEALTH LITERACY IMPORTANT?

Unfortunately, the difference between having high or low health literacy has numerous and wide-reaching impacts on well-being throughout one’s life. In terms of health outcomes, studies show that patients with limited health literacy and chronic illness have:

- Higher likelihood of poor blood sugar control
- Less knowledge of illness management than those with higher health literacy
- Decreased ability to share in decision-making about cancer treatment
- Lower adherence to medications
- Lower self-reported health status.

WHAT FACTORS LEAD TO POOR HEALTH LITERACY IN THE 21ST CENTURY?

Unfortunately, scenarios like the one above are all too common. While there are many places to lay “blame” for poor health literacy, I believe that the causes seem to fall into three “buckets”: how physicians are trained, factors involving the patient, and society at large.

Speaking as a second-year medical student, the process of learning about medicine has forced me to adapt a completely new vocabulary regarding the human body. “Middle” becomes “medial,” “feel/ touch” becomes “palpation,” “bumps” become “nodules.” While I have learned how to describe health conditions in a much more precise manner, with each year of medical education comes a further departure from the language that would be ideal for patients and laypeople to understand. Without meaning to, doctors often speak in a language that may

not make sense to the patients that they treat. Additionally, many healthcare providers face increasing pressures to shorten their appointments and see more patients in less time. Since a proper assessment of health literacy requires a conversation on a range of topics, it is difficult to assess knowledge gaps and probe for difficulties in just one visit.

This problem can be exacerbated by patients who may be much older or younger, come from different racial or ethnic backgrounds, or have different education and/or socio-economic status. It may be difficult for patients to feel comfortable asking questions regarding concepts that they don’t understand or to disclose personal health information. In fact, patients with low health literacy often self-report that they attempt to hide their lack of understanding. Often, this can be seen as patients who appear to agree with the clinical discussion by nodding or smiling, wanting to fill out forms or questionnaires at a later time, or giving alternate reasons as to why they cannot read resources, such as “forgetting their glasses.” Once again, these examples reiterate the point that health literacy is not a metric that can be simply ascertained by looking.

HOW CAN WE WORK TOGETHER FOR BETTER HEALTH?

While many patients are affected by low health literacy and adverse health outcomes are evident, it is surprisingly difficult to detect and fix. But many opportunities exist for healthcare professionals and institutions to begin improving their ability to help these at-risk populations. At a macro-level, hospitals and healthcare clinics must acknowledge the problem and develop top-down metrics to attack this issue. Healthcare materials should be redesigned to include simple language and appropriate figures, with information presented in the order in which it is needed for the reader to understand it. While time is an issue, proper patient education should be a priority for all clinicians. Research shows that a back-and-forth dialogue between patients and physicians provides a larger benefit in health education than any other form of media. An institution-wide emphasis on “teaching moments,” such as having a discussion of proper contraceptive use at the same time as discussing

Continued on page 8

FEATURE

HIV/AIDS and other STD disease prevention, or the coupling of public health education with routine immunizations, is also beneficial.

Experts tend to agree that there is an opportunity to observe the Universal Precaution rule of health literacy. AHRQ recommends assuming that every patient may have difficulty understanding and suggests creating an environment where all patients can thrive. They note that only 12 percent of U.S. adults today have the health literacy skills needed to manage the demands of our complex health care system.

Doctors and healthcare professionals can also employ strategies to improve their patient-communication skills. People tend to retain less than half of what is said during their encounters with physicians, but techniques exist to improve patient understanding during their visits.

Use plain, common language. Instead of explaining all of the pathophysiology and treatment for hypertension at once, limit the discussion to three main points, which can be repeated for emphasis later on in the visit.

Experts in health literacy recommend the teach-back method, where healthcare professionals ask patients to explain a concept or plan in their own words back to the clinician.

Use the "Ask Me 3" rule—where healthcare professionals encourage patients to know:

1. What their main problem is,
2. What they need to do about it, and
3. The reason why it is important to take action—is another way of establishing a process of shared-decision making.

Provide additional non-medical resources to patients and encourage them to speak up and ask questions if they are confused or unsure about any part of their visit.

Taken together, all of these changes can slowly bring about a culture of support, education, and improved health for all those involved. +

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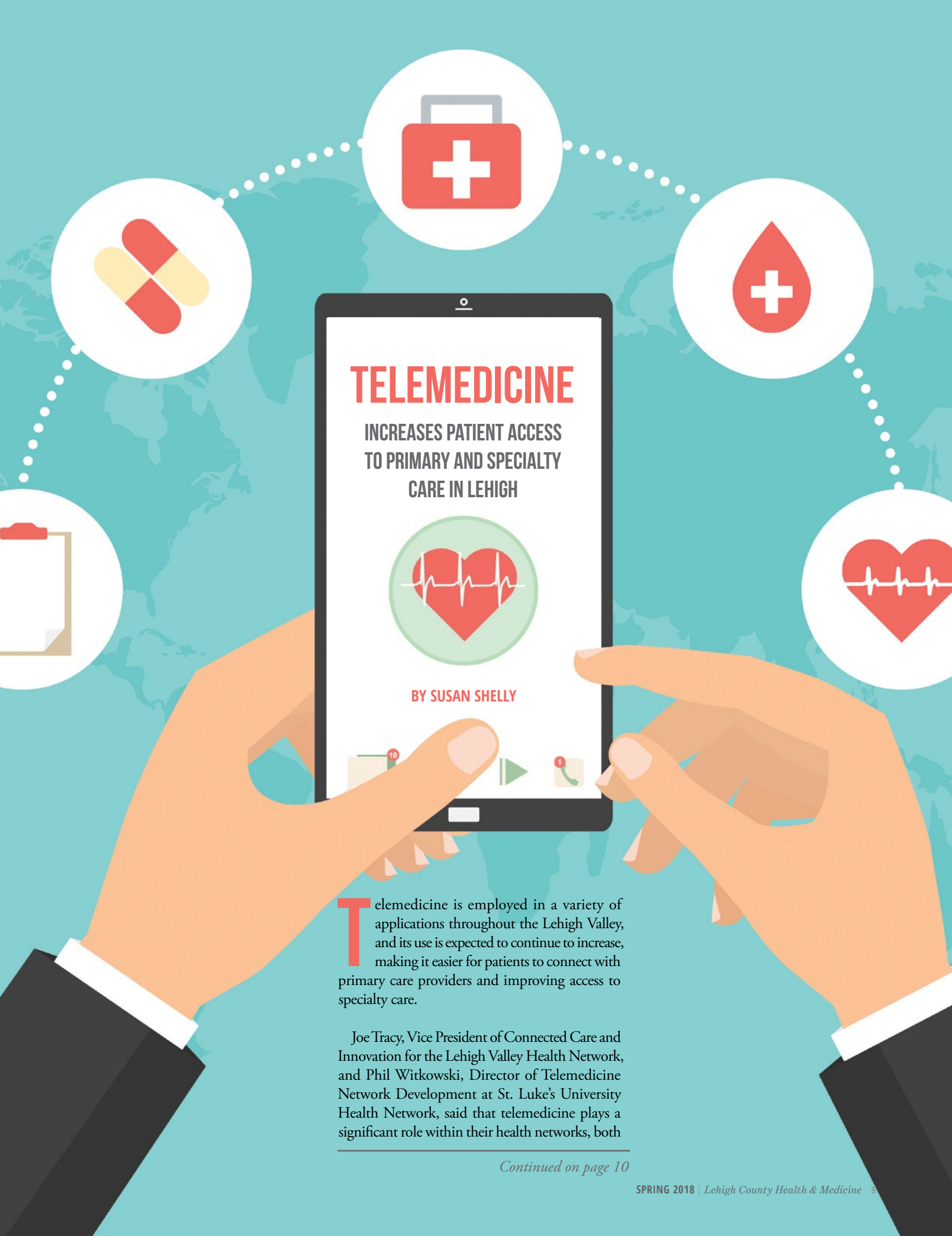


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TELEMEDICINE

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BY SUSAN SHELLY

Telemedicine is employed in a variety of applications throughout the Lehigh Valley, and its use is expected to continue to increase, making it easier for patients to connect with primary care providers and improving access to specialty care.

Joe Tracy, Vice President of Connected Care and Innovation for the Lehigh Valley Health Network, and Phil Witkowski, Director of Telemedicine Network Development at St. Luke's University Health Network, said that telemedicine plays a significant role within their health networks, both

Continued on page 10

for patients who are hospitalized and those who are not.

We asked them to explain what telemedicine is, share some ways in which it is currently in use, and talk about what telemedicine may look like in the future.

WHAT IS TELEMEDICINE?

Telemedicine, which literally means “care at a distance,” is a means of healthcare that uses telecommunication and information technology to enable providers to diagnose and treat patients remotely. It has many applications and is used in many different ways, but its primary intent is to eliminate distance barriers and increase access to care.

TELEMEDICINE IS NOTHING NEW

Contrary to what many people believe, telemedicine is not new, Tracy shared. In fact, a 2010 report by the World Health Organization found that telemedicine can be traced back to the mid-1800s, and was featured in published accounts in the early part of the 20th century.

Tracy began working with telemedicine 25 years ago at the University of Missouri, early in its modern stages. Technology became primed for telemedicine in the early 1990s, and Lehigh Valley Health Network began implementing it during the early 2000s. St. Luke’s has been utilizing telemedicine for patient care since 2008.

“Most people think it’s new, but it’s not,” Tracy said. “However, it’s grown immensely during the past decade or so.”

That growth, explained Witkowski, is due to advances in mobile phone technology, expansion of internet access and increased internet bandwidth.

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With just three easy steps on a mobile device, patients can access Care Anywhere, an always-open service that enables someone to see a doctor, get a diagnosis and receive a prescription, if necessary, without leaving the house.

Witkowski said the telemedicine service is hugely popular and widely used, and is not restricted to St. Luke’s patients.

“We hear many stories from customers who utilize Care Anywhere while on their lunch break at work, on vacation or are away at college,” he said. “It’s great for someone who needs to see a doctor for a common issue but doesn’t have time to travel to an office or sit in a waiting room. And, the service is offered 24 hours a day, seven days a week, 365 days year.”

Lehigh Valley Health Network offers its patients a similar service called MyLVHN Video Visits. Users are connected with a Lehigh Valley healthcare provider who has access to their medical records or will establish a record if the user is not an established LVHN patient.

LEHIGH VALLEY’S ADVANCED INTENSIVE CARE UNIT A MODEL NATIONWIDE

Since 2004, Lehigh Valley Health Network has operated an Advanced Intensive Care Unit (AICU), an off-site location from which three critical care nurses and a physician who specializes in critical care monitor more than 100 patients in six critical care units each night.

The team remotely monitors vital signs and electronic medical record information, looking for changes minute by minute in a patient’s condition. This includes, but is not limited to, monitoring lab results, imaging studies, blood pressure, respiration, heart rate, temperature and other factors that can indicate a situation requiring immediate attention.

The AICU staff can quickly notify the hospital’s critical care bedside-team of any changes in a patient’s condition, and video and audio links enable doctors and nurses at the AICU to work with healthcare providers in the hospital in real-time.

A study that appeared in a 2010 issue of the *Archives of Internal Medicine* reported that Lehigh Valley Health Network’s AICU program decreased patient mortality by 31

percent and also significantly reduced the use of mechanical ventilation for critically ill patients.

“People have come from all over the United States and from other countries to see this program in operation,” Tracy said.

OTHER APPLICATIONS AND USES OF TELEMEDICINE

Telemedicine has a wide variety of applications, and the ways in which it’s used are growing quickly. St. Luke’s Care Anywhere provides access to select orthopedic care, cardiology device checks, mental health services, genetic counseling, new mother lactation consultation and other services, Witkowski said.

At Lehigh Valley, telemedicine plays an important role in areas including pulmonology, neurology, psychiatric services and the diagnosis and treatment of stroke. It also is widely used to provide the services of an infectious disease specialist to hospitals who do not have a specialist on staff.

Using telemedicine, a specialist can examine a patient, monitor vital signs and have access to medical records and other information. For a patient, this can mean remaining close to home instead of being transferred to a hospital with an infectious disease specialist.

“Basically, we virtually bring the infectious disease doctor to their hospital,” Tracy said.

WHO BENEFITS FROM TELEMEDICINE?

People in rural areas who do not have access to primary care benefit greatly from telemedicine services. So do those with physical limitations that make it difficult for them to leave their homes.

Psychiatric patients who can communicate with doctors at another location also benefit enormously from telemedicine, as many areas are underserved in the area of mental health.

Telemedicine can make getting medical services easier for many types of patients, Witkowski said, and patients who can

access a physician remotely often can avoid a trip to an urgent care center or emergency department.

DO MOST INSURANCE PLANS COVER TELEMEDICINE SERVICES?

Not surprisingly, many insurers place restrictions on what applications of telemedicine they will cover, or what types of patients qualify for telemedicine coverage.

Last June, however, State Senator Elder Vogel (R-Beaver) introduced legislation calling for lawmakers to require that healthcare payers provide reimbursement for telemedicine services if they pay for the same service when provided in person.

The bill, which enables insurers to negotiate the amount they reimburse for telemedicine services, gained approval from the Senate Banking and Insurance Committee in late January.

“We are hopeful this bill moves quickly through the next steps and goes to Governor Wolf’s desk for his signature,” Witkowski said.

THE FUTURE OF TELEMEDICINE

With an emphasis across healthcare of keeping patients healthy at home, the use of telemedicine will become increasingly important, Tracy predicted.

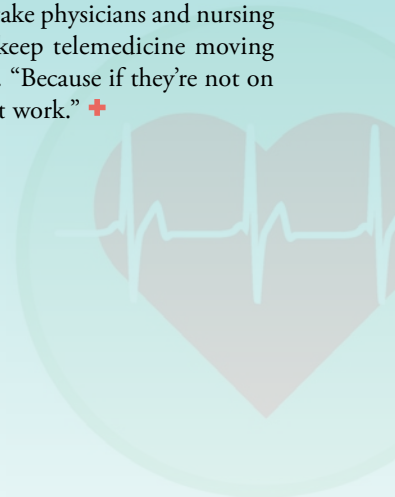
Lehigh Valley is constantly exploring new ways of employing telemedicine, and healthcare providers often make suggestions for expanding its use. With smart technology widely available, patients with chronic conditions can be monitored from their homes and treated before a serious problem occurs, reducing unnecessary doctor visits and readmissions to the hospital, Tracy explained.

Witkowski believes that telemedicine will result in more patients getting care that they need, as it removes barriers

such as lack of transportation or trouble leaving the home.

As the use of telemedicine increases, healthcare providers will need to embrace the concept and be willing to make changes in how they treat patients, Tracy said.

“It’s going to take physicians and nursing champions to keep telemedicine moving ahead,” he said. “Because if they’re not on board, it doesn’t work.” +



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3 WAYS

Medical Couples Must Think Differently About Time

BY SARAH EPSTEIN

Over the last seven years, my husband and I have walked the path of medical training. We began dating while he was studying for the MCAT, navigated the ups and downs of medical school and are now halfway through his emergency medicine residency.

During his third year of medical school, I began writing my book, *Love in the Time of Medical School*, which combined research, interviews and personal experience to reflect on the challenges of dating someone endeavoring to become a physician. Along the way, I learned about the ways that medical couples must think about and use time to their advantage. Here are three key insights that will help manage the journey.

RENEGOTIATING TIME

One key ingredient of being a successful medical couple is time and expectation renegotiation. Successful medical couples become communication ninjas who consistently negotiate each person's responsibility for staying in touch, making time for the relationship and checking in. When one or both of you faces an especially busy stretch, discuss how you are going to keep in touch and be affectionate, even when you may not see



one another much. Renegotiation requires couples to approach communication with a level of intentionality beyond what many other couples adopt. It requires making a conscious decision to notice the way medicine's shifting expectations impact the relationship, deciding that it is important enough to discuss and following through with shifted responsibilities when a new schedule emerges.

FLIP THE SCRIPT

During medical training, we learn to accommodate difficult training periods—be it the study time before Step 1 or an insane rotation. While having one's own life is important, it is also important to make sure that the result is not the two of you living parallel lives.

So how do you balance the reality of building your own life and goals with staying connected to your partner's medical training? Flip the script. This strategy involves aligning your goals and schedule with your partner's goals and schedule to create a framework in which you work toward your goals in tandem. Are you working on a project for work or have a new idea or hobby that you want to pursue? Talk to your partner about that goal and fit it into the time slot of one of those rotations or blocks. This makes medical training something you use rather than something that uses you.

As adults, we lose the authority figures that push us to sign up for something new and no longer have the built-in deadlines of tests, recitals and games to push us to improve at a certain pace. Motivating one's self to reach a goal without external pressure can be difficult. So. Your partner has an exam next month and needs to spend a lot of time studying? Set the exam date as your goal for completing a project phase or whole project. Tell your partner your goal and then, after the exam, you can both celebrate your accomplishments.

I used this strategy when my husband was in his fourth year of medical school. He

did back-to-back rotations out of state that took up most of his time. That summer, a few months before our wedding, I decided to do a round of Insanity Workouts. The program was 60 days—about the length of his two rotations. I knew I wanted to do this anyway, but I lacked the motivation to begin. I used Brian's rotations as a hard deadline. He kept up to date on my progress, I kept up on his, and we both ended the summer feeling accomplished.

DON'T FALL INTO THE POSTPONEMENT TRAP

Medical couples are experts at delaying gratification—putting off vacations, dinner plans and important relationship conversations. This has been called “the psychology of postponement”¹ and has been described as what happens when a medical couple “grow accustomed to living a life of waiting. They pin their hopes of eventually getting around to enjoying their life and relationship upon the completion of the current quest.”

This mindset makes some sense. Medicine requires couples to adjust their expectations: vacations must adhere to a training schedule and sometimes difficult conversations must wait until after a busy rotation. It can be healthy to remember that medical training is temporary and to stay cognizant of the short-term sacrifices in favor of long-term satisfaction.

For many medical couples, postponement arises out of a feeling of loving support for the training doctor. A partner may postpone a difficult conversation because it never felt as urgent or important as the next test. In these cases, the non-medical partner takes on the burden of an issue to protect and support the medical partner. Very quickly, however, postponement can become a crutch that allows each partner (and the couple together) to avoid other uncomfortable conversations, leading to unresolved issues.

If adopted as a way of life, Sotile and Sotile note that postponement “allows people who are unhappy in their relationship to continue

avoiding the anxiety that comes with trying to maintain closeness. They put off dealing with problems. They're always ‘waiting until...’ In this way, a healthy attitude of delayed gratification becomes an avoidance mechanism that drives a wedge between couples.”¹ Altruistic motives cannot protect medical couples from the erosion of affection that occurs by ignoring unresolved issues.

On a practical level, postponement is impractical. After medical school, residents take on additional responsibilities and after that, many physicians work long hours. Instead of waiting for the day that the schedule eases up, medical couples must embrace the medical lifestyle and build a life within it. Otherwise, they risk waking up in 10 years and realizing all the experiences they never explored and all the conversations left unspoken.

Harnessing the principles outlined in renegotiation, flipping the script and avoiding postponement, medical couples can maintain both individual and relationship health goals during medical training. +



Sarah Epstein is the #1 Amazon bestselling author of *Love In The Time Of Medical School: Build A Happy, Healthy Relationship With A Medical Student*. She is currently finishing her master's degree in Marriage and Family Therapy and working at The Council for Relationships in Philadelphia. She writes about medical relationships on her website www.DatingMed.com. Her book may be purchased on Amazon at https://www.amazon.com/Love-time-medical-school-relationship/dp/1546625984/ref=tmm_pap_swatch_0?_encoding=UTF8&qid=1513963130&sr=8-1.

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YOUR BODY IS A MACHINE

MAKE IT GO FURTHER WITH FOOD

BY SUSAN HURD

Registered Dietitian, Licensed Dietitian-Nutritionist

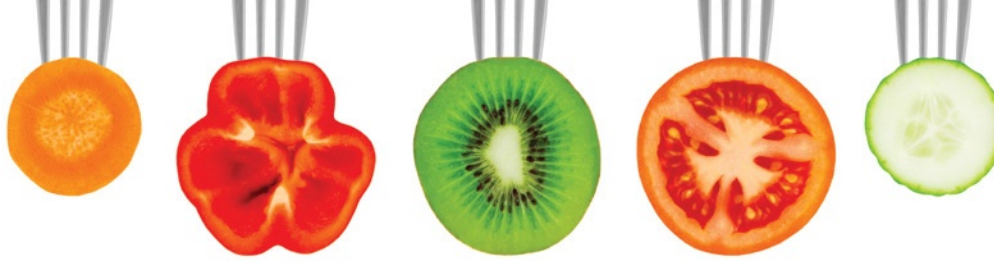
A CAR? REALLY?

Fueling your body may seem daunting, but in actuality it is pretty basic. If you consider the car, you know it requires gasoline to run. The tank also needs enough fuel to prevent debris from migrating to the engine. Cars also need different grades of fuel, or octane, which affects the car's performance.

Your body is no different. It is a finely tuned machine equipped to keep us alive and allow us to do some pretty incredible things. Missed meals or sub-optimal food choices force the body to essentially "run on fumes" or low octane fuel. Your body will use available nutritional stores to keep it going, but you will fade fast. Over time, improper fueling stresses the body and can set it up for conditions such as diabetes, obesity, and cardiovascular problems. You need fuel, high octane food, and you need to fill up regularly throughout the day so that the body can work efficiently and optimally for health.

EAT MORE THAN LESS

Eating right is about getting more rather than less. Choose foods with the biggest nutrient 'bang for the buck' that will provide the best quality for each calorie. Whole foods such as fruits, vegetables, whole grains, seeds, nuts, legumes and lean whole meats are nutrient dense and usually unprocessed, loaded with vitamins and minerals and, in plant-based foods, additional phytonutrients and fiber. A 150 calorie



candy bar can't stack up against a 150 calorie apple when it comes to nutrient density. The apple delivers vitamins such as A and C, antioxidants, complex carbohydrates plus fiber and fluid. The candy bar is merely a combination of simple carbohydrates in the form of sugar with not much else.

LET CHOOSEMYPLATE GUIDE YOUR PLATE

USDA's ChooseMyPlate promotes a balance of food with respect to variety and portion size. ChooseMyPlate represents equilibrium of all food groups: fruits, vegetables, whole grains, dairy, meat and plant-based alternatives. Each and every food has a purpose to sustaining life, so a balance of all foods is essential for health. When dining, consider what you've already eaten in the day and fill in the food gaps with guidance from ChooseMyPlate. An educated diner knows that proper food combinations provide a multitude of nutrients to promote overall health.

THE ABC'S & 1, 2, 3'S OF EATING WELL

Sluggish during the morning? Stomach growling loudly that it disrupts a meeting? Can't make it through that afternoon energy slump? It might be a good time to evaluate your personal energy needs. Follow some of these simple steps to improve your overall energy and nutrient intake.

Alter your perception of healthy foods. Healthy foods include more than simply grilled chicken breast and salad. Allow yourself to experience ALL foods and their benefits to the body. Did you know red meat contains the type of iron the body best absorbs? That calcium is best utilized from dairy foods? That berries provide antioxidants, but so do all plant-based foods? That food and the body are so intertwined and connected and that this is slowly being uncovered by science? Don't let current perceptions limit you or you might miss out on what new and different foods have to offer.

Breakfast IS the most important meal of the day. In 2014 the Kellogg's Breakfast Council proposed the following definition for breakfast. It is "...the first meal of the

day that breaks the fast after the longest period of sleep and is consumed within 2 to 3 hours of waking; it is comprised of food or beverage from at least one food group, and may be consumed at any location." Ample research supports claims that breakfast eaters perform better on the job and in school when compared to non-breakfast eaters and that they are also better able to maintain weight. Breakfast stimulates our metabolism so that the body can begin to work. Not a breakfast eater? Set a goal to eat something in the morning. Already enjoy a morning meal? Improve it nutritionally by increasing complex carbs or adding protein. Start your day with breakfast. If you habitually go for sugar sweetened cereal, mix it with a whole grain unsweetened cereal and slowly increase the amount of unsweetened while decreasing the sweetened variety. Consider substituting a piece of whole fruit for fruit juice to improve the nutrient density of your breakfast. Don't limit your breakfast to traditional breakfast foods either. A peanut butter sandwich on whole grain bread includes the same food groups as scrambled eggs and toast.

Challenge yourself with new foods. Food variety ensures you are getting optimal nutrition. Promise yourself to try at least one new food a week. Be open and you might surprise yourself! Add to your food repertoire and place your palate in an exotic location while giving you an extra nutrition boost.

1 meatless meal a week. Meatless once per week has been linked to risk reduction in disorders such as cancer, diabetes, cardiovascular disease, and obesity. Mondays work well to go meatless. Taking healthy steps at the beginning of the week increases the likelihood of maintaining those healthy changes all week long. Meatless meals once per week also reduce your carbon footprint and may even improve your personal budget.

2 Snacks added to your normal routine. Smaller meals, more often throughout the day help maintain steady blood sugar and insulin levels resulting in improved energy balance throughout the day. Alter your perception of what a snack should look like.

Snacks are most beneficial when consumed as components of the whole day rather than as "extras." Choose complex carbs (fruit, veggies, whole grain bread and cereals) with some protein (low-fat milk, eggs, nuts, seeds, lean meats and cheeses) to sustain you between meals rather than chips, cookies and candy.

3 or more meals cooked at home. Enjoying meals from home not only benefits you, but your family too. Research tells us that children who eat family meals tend to be happier and healthier overall. The family may apt to eat less food of lower nutritional quality, and reduce their carbon footprint too. The key to successful home meals is planning. Sit with your family once per week to plan meals, grocery lists and essential meal preparation duties within the context of the family's schedule.

With some basic knowledge and a little planning you should be able to improve your overall nutrient intake. Choosing foods from a variety of sources and spacing meals and snacks accordingly will certainly help you go further with food! +

RESOURCES:

1. <https://www.choosemyplate.gov>
2. <http://www.meatlessmonday.com/about-us/why-meatless/>
3. <https://www.cambridge.org/core/journals/public-health-nutrition/article/is-cooking-at-home-associated-with-better-diet-quality-or-weight-loss-intention/B2C8C168FFA377DD2880A217DB6AF26F>
4. <http://www.eatright.org/resources/national-nutrition-month>
5. *The Role of Breakfast in Health: Definition and Criteria for a Quality Breakfast*, published in a December 2014 *Benefits of Breakfast* supplement of the *Journal of the Academy of Nutrition and Dietetics (JAND)*.



ATHLETIC TRAINERS

THE FRONT LINE OF ATHLETIC CARE

BY SUSAN ROTH

**JORGE PEREZ
VIVIDLY
REMEMBERS
WATCHING A
TOUCHDOWN
CELEBRATION TWO
YEARS AGO.**

A running back for the Northampton High School football team had just scored a touchdown after bouncing off a would-be tackler.

“He was celebrating with everyone, and then in a matter of seconds, I could see he was deteriorating really fast,” said Perez, an Athletic Trainer with St. Luke’s University Health Network who is assigned to Northampton Area High School.

“He walked to the sidelines and said, ‘I don’t feel so well.’ We started evaluating him and he was completely out of it. He couldn’t walk. He couldn’t stand. He was not making sense. We activated EMS and he was taken to the hospital for further evaluation which determined he had an epidural hematoma, a brain bleed.”

Not so long ago, without a Certified Athletic Trainer on the sidelines, the running back’s life could have been in jeopardy.

The old days of coaches taping ankles and telling bruised athletes to put ice on their bumps has given way to Certified Athletic Trainers patrolling sidelines and practice sessions throughout every high school in the Lehigh Valley.

Other than the coach, the Athletic Trainer is typically the first person on the field when an athlete sustains an injury.

Athletic Trainers do much more than tape ankles and apply ice packs these days. They serve an integral role as healthcare professionals who can help prevent sports injuries, provide emergent care, and work with physicians and other members of the health care team to work with injured athletes and help prepare them to return-to-play in a safe manner.

ASSESSING INJURIES

“Every athlete can have different nagging injuries,” explained Cheree Iadevaia, a St. Luke’s athletic trainer assigned to Easton Area High School, who works mainly with football, wrestling and baseball. “But it’s the serious ones like head injuries, spinal injuries and joint injuries that demand immediate concern.”

Assessing the athlete, stabilizing the injury, and getting the athlete appropriate, rapid referrals helps aid proper diagnosis, treatment, rehabilitation and recovery for return-to-play.

Witnessing an athlete go down on the field for whatever reason and not get up spreads fear among parents, fans and coaches, but athletic trainers remove themselves from that emotional investment in order to maintain analytical objectivity.

“When I see an injured student-athlete, I don’t really feel anything,” said John Ostrowski, an athletic trainer working with Sports Medicine Relationships for St. Luke’s Orthopedic Care.

“My first reaction is always to get out there and assess the urgency of the situation. It’s a pretty simple thing for me. I ask myself if this athlete is going to need a high level of emergent care. If the answer is no, I start dialing it back and assess the injury from there.

“Outside the most common injuries such as ankle sprains, head injuries are prominent in football because it’s a collision type of sport,” Iadevaia said. “I worked with several athletes dealing with concussions this past fall.”

MARCH IS NATIONAL ATHLETIC TRAINING MONTH.



Athletic Trainers assess, treat and help prevent the full scope of injuries from knees and shoulders and bone fractures to bruises, scrapes and cuts, but anything with the head or spine takes on increased scrutiny and demands proper training and care.

Most times ACLs are non-contact injuries where an athlete’s foot plants and pivots, and the knee buckles. Athletic Trainers administer the Lachman’s test, among others, to assess laxity in the knee ligaments.

Athletic Trainers put athletes through a quick battery of neurological, cognitive and balance assessments when a head injury is suspected. They ask how the athlete feels at the moment, assess their short- and long-term memory, ability to balance physically, and perform a simple neurological screening to their cranial nerves and cognitive function.

Much like the NFL’s concussion protocol, once an athlete is assessed for a potential head injury, they cannot return-to-play unless cleared by a medical professional.

“The nice thing about football is that we have either a Primary Care Sports Medicine Physician or orthopedic surgeon on the sideline that can take over care of that athlete and clear them or refer them,” Iadevaia said, “but in other sports, where a physician is not present, I have to utilize our protocols to make the best clinical judgement as to whether or not it is safe for them to return to activity.

“Knee injuries like ACLs can be serious, don’t get me wrong,” said Ostrowski. “But in football, a neck injury or a head injury has the potential to impact every area in that student-athlete’s life from being a student to the future profession they will hold in the working world, to being a husband or a wife. We’re seeing more and more reports of these complications in former athletes.”

Dislocations of the upper extremities like the shoulder and elbow can often be more challenging than ACL tears. Reducing them becomes problematic because there is potential to cause nerve or vascular damage. The athletic trainer’s management of these injuries must be based on their training and a sound protocol.

OBSERVING FROM THE SIDELINES

Before they even get started evaluating player injuries, Athletic Trainers get involved in preventing them by watching them perform in practices and games.

“I’m watching for movements and making sure the athletes have good skills and aren’t doing anything that can lead them to an injury or put them in position where they get hurt or can hurt someone else,” Perez said.

In football, for instance, Perez will observe how a player’s head is positioned when making a tackle, making sure they’re looking up and seeing the target they’re tackling instead of looking down

Continued on page 18

FEATURE

and hitting with the crown of the helmet, which could lead to cervical issues.

“I’m looking for subtle changes in movement patterns and joint angles, indicators of potential muscle strength imbalances that could lead to an injury,” Iadevaia agreed.

Athletic Trainers will often observe when an athlete is limping or favoring a side, dropping an arm before many teammates or coaches because they are focusing on the players themselves. With ankle injuries, they’ll often see immediate compensation as the athlete bears weight more on one side than the other.

“If we let things like that imbalance go, then we may end up dealing with two injuries rather than one because there’s too much stress on one side to compensate for the other,” Perez explained.

Getting that athlete’s pain, strength and range of mobility back to the injured joint is a critical step in making sure the athlete doesn’t sustain a compensatory injury on the opposite side.

“We’re looking at making them at least the same or better than before they got hurt,” Perez said.

DEVELOPING CAMARADERIE

And, because there are so many sports going on at the same time between practices and games, injured athletes are often grouped together not only for efficiency in their treatments and rehabilitations efforts, but for peer motivation.

“You first have to reassure the athlete that this this is something we can work through together,” Iadevaia said. “We reassure them they can come back from it. And when we have a group of athletes with similar injuries, even if they are at different stages of recovery, it’s a great motivator for them because it becomes almost competitive.”

From the basics of rest, ice, compression and elevation to more technical therapies like TENS and other modalities to help control pain, and ultrasound to increase blood flow to promote healing, Athletic Trainers wear many hats and thus require many years of education and clinical experience.

WHAT IT TAKES

When Ostrowski was an undergraduate at the University of Michigan, he applied for secondary admission to the Athletic Training Education Program so that he could sit for the Athletic Training Board of Certification Exam upon graduation, and then went on for his master’s degree even though it wasn’t required at the time.

Now, the certification is steadily moving toward requiring a master’s degree plus all the required clinical experiences to enter the profession. Some programs provide an immersive clinical experience that exceeds the minimum requirements.

In order to retain their National Board Certification (ATC) and Pennsylvania or New Jersey State License (LAT), Athletic Trainers are required to earn 50 continuing education credits every two years. Of these, 10 units must be designated as evidence-based courses by the Board of Certification (BOC).

The practical side, just like sports, requires a game plan.

When it comes down to game time or practice time, Athletic Trainers have already prepared their checklist of communicating with the coach, other medical personnel and emergency responders.

“Everything in life comes down to communications,” Ostrowski said, “so whether it’s with the coaches, staff, physicians, parents, or the athletes themselves, if everyone knows what their role is when an emergency takes place, then you can execute the game plan to get that athlete evaluated as quickly as possible and off the field for appropriate treatment.”

That football player Perez helped treat is on course to graduate. He stopped playing football but played other sports during his senior year. A junior wrestler whose dislocated elbow he helped stabilize was able to come back for his senior year to participate in football and wrestling.

Iadevaia has treated a football player with a shoulder dislocation, another with a hematoma of the spleen, and a volleyball player who ruptured a blood vessel in her elbow on a missed spike that caused compartment syndrome, requiring an emergency fasciotomy that night.

Ostrowski has worked with ice hockey players who have severed nerves in their leg with a skate, a team being accidentally poisoned by noxious gas, and a woman who ruptured her hamstring roller skating.

It’s all in a day’s work for an Athletic Trainer, and so much beyond the old school pictures of taping ankles and applying ice packs.

Athletic Trainers are on the frontline of quality, evidence-based healthcare for injured athletes, helping them to be better prepared on and off the field in preventing, evaluating and rehabilitating injuries. +

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ALLENTOWN
VOLUNTEER
MEDICAL RESERVE
CORPS (AVMRC):

WE
NEED
YOU!

Public health emergencies such as pandemic flu, and natural disasters such as Hurricanes Harvey, Irma and Maria, highlight the need for medical and non-medical volunteers. Are You Available?

We have a responsibility to be prepared for these emergencies and this is where the Medical Reserve Corps (MRC) comes in. MRC is a national network of medical and non-medical volunteers who organize locally to respond to public health, natural and other emergencies within their communities.

There are currently more than 100 volunteers affiliated with Allentown Health Bureau through Allentown Volunteer MRC (AVMRC). AVMRC volunteers register with Allentown Health Bureau through a Pennsylvania Department of Health system called SERVPA (Statewide Emergency Registry of Volunteers in Pennsylvania). Through SERVPA, the Allentown Health Bureau can

AVMRC volunteers have been activated during major events in our community such as:

THE H1N1 PANDEMIC IN 2009-2010.

More than 20,000 doses of H1N1 flu vaccine were provided in our community – AVMRC volunteers helped.

SUPERSTORM SANDY IN 2012.

Emergency shelters were opened in our community due to long-term, widespread power outages – AVMRC volunteers helped.

GAS OUTAGE IN ALLENTOWN IN JANUARY 2018.

A warming shelter was opened due to the extremely cold temperatures – AVMRC volunteers helped.

prepare a message that is simultaneously sent to all AVMRC volunteers with a request for help, and then AVMRC volunteers reply with their availability to help.

Health care professionals who are licensed, certified and/or retired fulfill crucial roles during a large-scale emergency or disaster response. Our community needs your knowledge, skills and experiences. The time to get involved with AVMRC is now... before an emergency occurs so we can plan for how to incorporate you into the response. Please join today!

To become an AVMRC volunteer or for additional information about AVMRC, please contact MaryEllen (Mel) Shiels at the Allentown Health Bureau at 610-437-7510 or MaryEllen.Shiels@allentownpa.gov. You can also go to www.allentownpa.gov/avmrc for additional information. +



AN ANCIENT REMEDY OFFERS HOPE TO STROKE PATIENTS

BY ASARE CHRISTIAN, MD, MPH

Each year, more than 700,000 people suffer a stroke, which occurs when an interruption of needed blood, oxygen or sugar supply results in damage to a portion of the brain. It is one of the leading causes of disability in the United States.

The after-effects of a stroke vary from person to person and are based on several factors, including patient age, severity and duration of the stroke and what portion of the brain is damaged. Some patients experience a variety of chronic problems, including loss of movement and/or feeling on one side of the body, difficulty with communication and swallowing, loss of bladder or bowel control, coordination difficulties, personality changes and depression.

One of the most common challenges patients face after a stroke is a movement disorder called spasticity. Patients with spasticity often experience involuntary muscle tightness and stiffness, spasms and slow or uncontrollable movements. While commonly associated with stroke, spasticity can occur with other neurological conditions like multiple sclerosis, spinal cord injury, Parkinson's disease and traumatic brain injury.

Those who have experienced spasticity describe it as the "worst charley horse you can imagine" and compare it to a "rubber band stretched almost to the point of breaking." For many, spasticity does not just cause physical pain, it also causes weakness, limb deformity and the inability to move. In severe cases, these individuals often need extensive care by a family member or caregiver, because the condition can make activities of daily living, such as walking, personal hygiene or the ability to dress or feed themselves, extremely difficult.



Many people who come to Good Shepherd with spasticity are of the mistaken belief that they have to live with the problem. While treatments such as physical therapy, surgery and various medications have traditionally been useful in alleviating spasticity, an ancient substance is offering a new – and incredibly effective – method to combat the disorder.

Generically known as botulinum toxin, locally placed injections of Botox® alleviate spasticity by relaxing muscles, in much the same way it relaxes wrinkles. It works by blocking acetylcholine, a neurotransmitter that causes muscles to contract. Injections are customized to best address the patient's individual symptoms and are generally administered every three months. While Botox® is the most well-known brand of botulinum toxin, there are several on the market, each with their own performance profile.

For many Good Shepherd spasticity patients, these injections are life changing. Prior to treatment, they are often unable to walk or properly move a limb(s). Many are confined to wheelchairs. The change, even after one

dose of Botox®, is dramatic for most. Within three days, they experience a tremendous reduction in spasticity and can move more freely and with less pain.

Thanks to the reduction in symptoms, patients can more fully participate in their physical therapy program. During therapy, we help patients regain their strength and relearn how to use their muscles through a process called neuroplasticity (see sidebar). This helps to ensure true, lasting functional gains. +

Asare Christian, MD, MPH, is the Associate Outpatient Medical Director at Good Shepherd Rehabilitation Network in Allentown. He is a physical medicine and rehabilitation (PM&R) physician who specializes in musculoskeletal disorders, degenerative disc and joint disease, stroke, brain injury and spinal cord injury rehabilitation, non-interventional pain management, ultrasound-guided MSK injections, spasticity management, dystonia management, Botox® for musculoskeletal pain, spasticity and migraines and urodynamics.



WHAT IS NEUROPLASTICITY?

Neuroplasticity is the capacity for the continuous alteration of the neural pathways and synapses of the central nervous system (CNS) in response to injury or repetitive experience. The CNS may respond to a stimulus, such as physical rehabilitation, by reorganizing its structure, function and/or neural connections. New neural connections may form in order to compensate for injury or loss of function or in response to one's environment.

Mounting evidence that the brain and spinal cord are "plastic" and capable of recovery has spurred the development of numerous rehabilitation strategies and technologies for patients who have paralysis or other functional deficits, including vision loss, due to traumatic brain injury, spinal cord injury, stroke or other neurological illness.



National Arthritis Awareness Month

BY OAA ORTHOPAEDIC SPECIALISTS

National Arthritis Awareness Month is observed each May, in hopes of raising awareness about one of the leading causes of disability in the United States. An astounding 1 in every 5 adults and over 300,000 children are affected by arthritis, and the prevalence of this common joint disease is only expected to rise in years to come.

What is Arthritis?

Arthritis is very common but is not well understood. “Arthritis” is not a single disease; it is an informal way of referring to joint pain or joint disease. Joint pain, stiffness, and swelling are the most common symptoms of arthritis, but your range of motion may also decrease as the condition worsens. While arthritis is most prevalent in adults, there are forms of arthritis that affect juveniles. The most common forms of arthritis are rheumatoid arthritis, and the one we often automatically associate with the disease, osteoarthritis.

ARTHRITIS MYTHS DISPELLED

MYTH 1:

ALL JOINT PAIN IS ARTHRITIS.

Arthritis is common, but does not encompass all joint pain. Other conditions, such as tendonitis, bursitis, or other soft-tissue injuries, also cause joint pain.

MYTH 2:

YOU SHOULD AVOID EXERCISE IF YOU HAVE ARTHRITIS.

While exercise can be painful for those with arthritis, it is still beneficial to their overall health and may reduce their arthritic pain. In fact, multiple studies show that exercise is beneficial for people with arthritis. Low-impact and range of motion exercises are great ways to start, and aquatic exercise takes the pressure off painful joints for those with more significant arthritic pain.

MYTH 3:

ARTHRITIS ONLY AFFECTS THE ELDERLY.

Some forms of arthritis become more common in older populations, but arthritis can affect a wide array of ages. Even children are not immune to developing some forms of arthritis.

MYTH 4:

THERE IS NO TREATMENT FOR ARTHRITIS.

There is no cure for arthritis, but there is an array of treatment options to help with its symptoms. Early diagnosis and appropriate management of the disease are important for proper treatment. Please remember that these treatment options, many of which do not involve surgery, are available to improve the quality of life for those suffering from arthritis.

WHAT ARE SOME TREATMENT OPTIONS FOR ARTHRITIS?

The main goal of treatment for arthritis is to reduce the amount of pain someone is experiencing, to prevent additional damage to the joints, and to improve joint function. Here are some common conservative and

ARTHRITIS FACTS

Nearly 53 million adults have doctor-diagnosed arthritis.

This number is expected to grow to 67 million by 2030.

Arthritis and related conditions account for more than \$156 billion annually in lost wages and medical expenses.

Working-age men and women (ages 18 to 64) with arthritis are less likely to be employed than those of the same age without arthritis.

There are more than 100 different types of arthritis.

Arthritis occurs more frequently as people get older and is more prevalent in women than men.

Being overweight can increase your risk of osteoarthritis, as well as the severity of symptoms.

more invasive treatment options for those experiencing joint pain from arthritis:

WEIGHT LOSS People with various forms of arthritis can benefit from weight loss, as the added pressure on the joints can make the symptoms of arthritis more severe.

ASSISTIVE DEVICES Assistive devices such as canes, walkers, and braces can also provide some pain relief. These mobility devices can take pressure off of sore joints and thus, make the symptoms less prevalent during activity.

NUTRITION Although there is no diet cure for arthritis, certain foods have been shown to fight inflammation, strengthen bones, and boost the immune system. Adding fish, soy, healthy oils, and low-fat dairy products to your balanced diet may help ease the symptoms of your arthritis.

MEDICATION While medications can vary, some patients report benefits from NSAIDs and creams. Cortisone injections and viscosupplementation have also provided patients with some symptom relief.

RHEUMATOLOGY Seeing a Rheumatologist is necessary for some people with forms of arthritis or autoimmune diseases that attack the lining of the joints, such as rheumatoid arthritis. A rheumatologist is a physician who is qualified by additional training and experience in the diagnosis and treatment of arthritis and other diseases of the joints, muscles and bones.

PHYSICAL THERAPY Physical therapy that involves exercises that strengthen the muscles around the affected joint can be beneficial to help with symptoms and can also improve surgical success down the road.

REGENERATIVE MEDICINE OAA's Regenerative Medicine Institute offers stem cell and platelet-rich plasma therapies to potentially help alleviate the pain of mild osteoarthritis. These are some of the newest treatment options within orthopaedics and sports medicine.

SURGERY Obviously, this is the most invasive treatment option, but surgery has proven to be one of the most effective ways to eliminate the pain associated with arthritis and improve the quality of life for those that suffer from arthritis. Advancements in medicine, technology, and techniques have also allowed for quicker recoveries from joint replacement surgery. +

With multiple locations in the Lehigh Valley, OAA Orthopaedic Specialists has been a dynamic provider of comprehensive orthopaedic care and research for more than 40 years. The practice is comprised of 27 physicians and surgeons who diagnose and treat conditions related to the foot and ankle, hand and upper extremities, joint replacements, physical rehabilitation, rheumatology, spine and scoliosis, sports medicine, work injuries, nutrition, regenerative medicine, and more.



**Making
the Lehigh
Valley
an Age-
Friendly
Community
with United
Way**

Pennsylvania is getting older. Between 2011 and 2015, the population of seniors ages 65 and older in the state increased by 10 percent. Today, approximately 2.2 million seniors call the Keystone State home, making Pennsylvania's population the sixth oldest in the nation.

Over the past 10 years, the population of people ages 65 and older in the Greater Lehigh Valley has mimicked statewide trends, growing from 99,000 seniors to 109,000. In our region, 26,000 seniors have difficulty meeting at least one daily need at home. This includes bathing, toileting, dressing, getting in and out of bed, grooming and eating. Seniors also need assistance with needs that connect them to the community such as grocery shopping, preparing meals, using the telephone, obtaining transportation for vital appointments or social activities, handling home finances and housekeeping. In 2014, United Way of the Greater Lehigh Valley set a bold goal to increase the number of seniors who are safe and healthy in their homes by 50 percent.

"Families and the community benefit when seniors can stay safely in their own homes," said Marc Rittle, Vice President, Impact of United Way of the Greater Lehigh Valley. "To achieve this goal, United Way founded the Lehigh Valley Alliance on Aging, which is now recognized as the number one collective impact model for healthy aging in the country."

Lehigh Valley Alliance on Aging convenes more than 300 seniors and employees at 100 for-profit, nonprofit and government entities throughout the Lehigh Valley to ensure seniors stay healthier and have a better quality of life. With the support of generous donors, United Way reached its goal of increasing the number of dependent

seniors whose basic needs are met at home by 50 percent in 2017.

"That doesn't mean our work is done," Rittle said. "With an additional 40,000 Lehigh Valley residents becoming seniors by the year 2025, our goal is to maintain our support of those who are dependent and invest in efforts to increase the health and wellness of a growing population."

Invested in Prevention

The percentage of the senior population dealing with chronic health problems is increasing rapidly. Seniors often develop disabilities such as visual impairment or difficulty walking, which prevents them from meeting their own basic care needs such as dressing themselves, cleaning their homes, preparing food or driving. As a result, they require more expensive intervention strategies. Primary prevention services for chronic disease can cost between \$500 and \$3,000 per person. In comparison, seniors who decline supportive service interventions ultimately spend \$15,000 each year.

"Primary prevention services save money and add immense value for seniors," said United Way's Director of Healthy Aging, Carmen Bell. "A vital part of United Way's healthy aging strategy is to address these chronic health issues when they first begin before seniors are unable to care for themselves."

One of the biggest problems facing the elderly is falling, which can result in injuries ranging from anxiety to broken bones. According to the U.S. Centers for Disease Control and Prevention, one in four Americans age 65 and older falls each year. Falls are the leading cause of fatal injury among seniors.

"Lehigh Valley Alliance on Aging works with health care specialists including physicians, first responders, hospitals and non-profit organizations to implement fall prevention programs to help reduce this problem," Bell said.

Lehigh Valley Alliance on Aging also works to help lower the rate of diabetes, which is 44.2 percent in our region according to the Lehigh Valley Business Coalition on Healthcare. United Way currently funds two agencies for diabetes prevention: Hispanic Center of Lehigh Valley and the Allentown YMCA's "Golden Opportunities." In November, United Way hosted a Diabetes Awareness and Prevention program to raise awareness for those who are at risk for or currently have diabetes.

Age-Friendly Communities

Lehigh Valley Alliance on Aging has committed to pursuing the creation and fostering of age-friendly communities using the AARP Livable Communities Model, which is an affiliate of the World Health Organization's Age-Friendly Cities and Communities Program.

"As the U.S. population ages and people stay healthy and active longer, communities must adapt," Rittle said. "Age-friendly communities is an international effort to help cities prepare for rapid population aging and the parallel trend of urbanization." +

Lehigh Valley Alliance on Aging is a nationally recognized collective impact movement that complements the work of United Way's nonprofit program providers. The Alliance convenes over 300 seniors and employees at 100 for-profit, nonprofit and government entities throughout the Lehigh Valley to ensure seniors stay healthier and have a better quality of life.

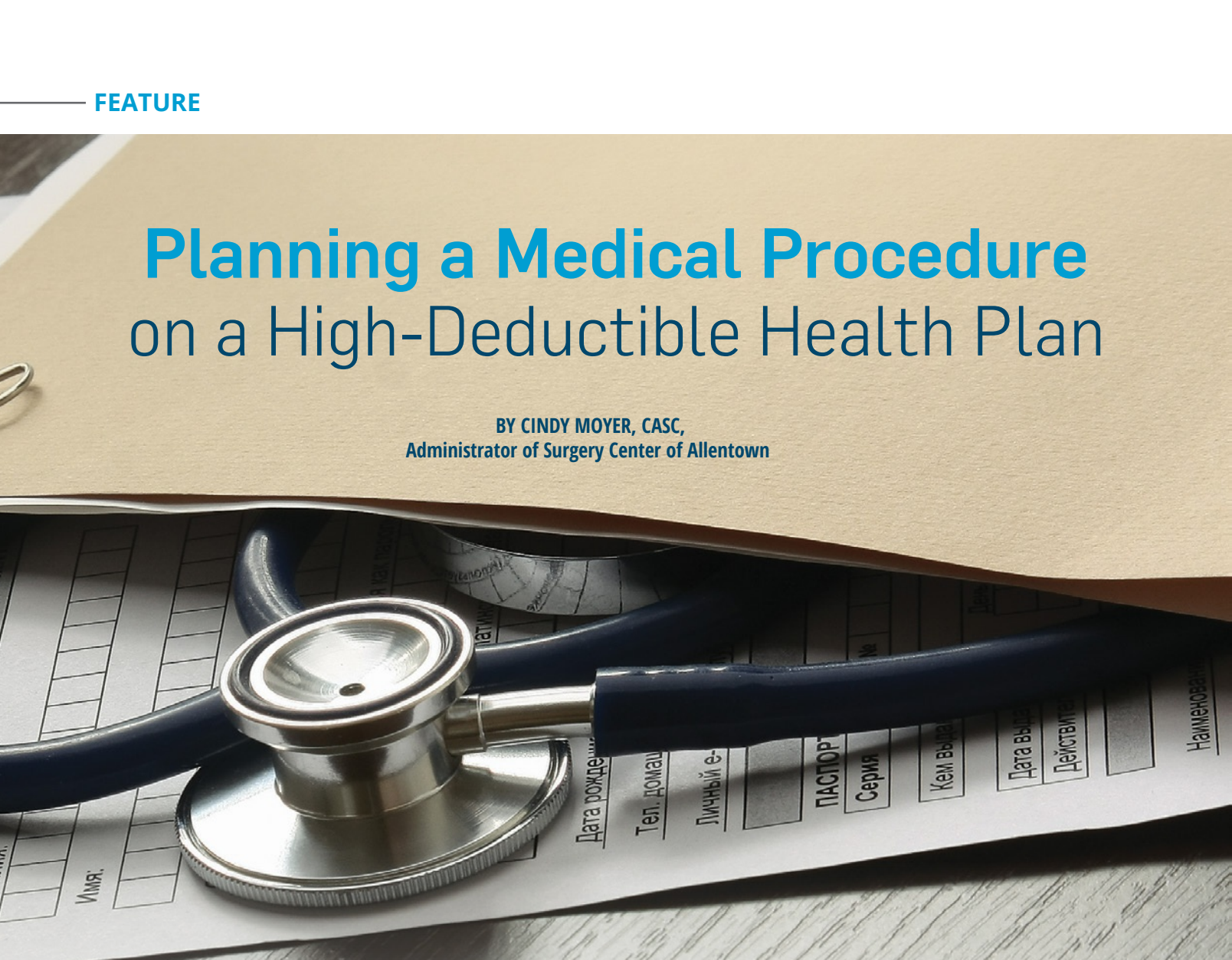
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United Way of the
Greater Lehigh Valley

Planning a Medical Procedure on a High-Deductible Health Plan

BY CINDY MOYER, CASC,
Administrator of Surgery Center of Allentown



High-deductible plans have become an increasingly attractive option for consumers because of their low up-front costs. According to a 2017 report from the Center for Disease Control and Prevention, the percentage of adults (ages 16-64) with employee-based coverage who are enrolled in high-deductible health plans (HDHP) increased from 26.3 percent in 2011 to 39.3 percent in 2016. The percentage of those who directly purchased their HDHPs also increased over the seven-year period.

While HDHPs offer lower monthly premiums and still cover catastrophic illnesses, there is a trade-off. The plans cover fewer expenses and patients pay more out of pocket until they meet their deductibles – at least \$1,350 for individuals and \$2,700 for families – and the insurance company starts to pay its share.

Often, patients who have HDHPs may postpone or skip medical care to avoid the costs. However, there are ways to get the most out of an HDHP. Whether it's a colonoscopy screening or a surgery to repair a torn meniscus, planning thoroughly and being well informed can help bring down the overall cost of care. Next time you plan for medical services while covered by an HDHP, consider these five factors.

Know which Medical Services Are Free

Not all procedures will leave you with a high medical bill. In fact, most insurance plans cover 100 percent of preventive tests and routine health services. This can include colorectal cancer screenings for adults over the age of 50, diabetes screenings, mammograms and immunization vaccines. Even those who are considered healthy should take advantage of these free services. Not only will they

help you maintain your overall health but also help you proactively address any concerns. Before you schedule an appointment, contact your insurance provider to make sure the services are covered.

Take Advantage of a Health Savings Account

A Health Savings Account (HAS) is unique to HDHPs. The account enables you to pay for certain medical expenses with money that has not been taxed by the federal government. According to the Internal Revenue Service, individuals are eligible to reserve \$3,450 (pretax) and families can reserve \$6,900 (pretax) annually. The money that's been set aside can go toward qualified medical expenses, including your deductible, copayments and coinsurance.

Shop Around for the Best Price

If you are planning to have a non-emergency medical procedure, you should research the price of the procedure and comparison shop. Your insurance provider may offer resources to help you find in-network facilities and physicians. Some even offer cost-estimator tools.

One of the benefits of an HDHP is that out-of-pocket expenses are the negotiated rate between the healthcare provider and insurance company, not the market rate. This can bring significant savings. To obtain accurate pricing, ask your physician's billing office for the Current Procedure Terminology (CPT) code for your procedure. Once you have the code, you can try to negotiate the portion you pay out of pocket with your insurance provider.

Focus on Care Quality

In today's healthcare industry, the patient's satisfaction and financial responsibility are an integral part of a high-quality care experience. Rather than focusing on just the medical expenses, consider your physician's experience and the quality of care delivery. Find a reputable physician whom you trust. Research the independent quality ratings of physicians and facilities and ask for patient referrals. You should also be able to have an open discussion with the physician about care

costs. Often, physicians may offer solutions for less expensive tests, services, procedures or prescriptions that can help you make a final decision.

When Possible, Schedule More Costly Services Toward the Beginning of the Year

Timing is important. If you anticipate needing an expensive procedure that approaches or exceeds your annual deductible, it's best to schedule the procedure early in the year. When you reach your HDHP's annual deductible, your insurance provider usually pays a portion of medical costs until you reach your annual out-of-pocket maximum. Once you meet your annual out-of-pocket maximum, your insurance provider will pay for 100 percent of covered services for the rest of the year, saving you money. Insurance plans vary, so be sure to confirm this with your insurance company.

Navigating the healthcare process – all the way from finding a physician and planning for medical care to paying for the services – can seem daunting. Rather than postponing care in fear of incurring high medical bills, you can look for ways to reduce care costs. It just requires a greater understanding of your insurance coverage as well as thorough research to find a physician who provides quality care.

Questions to Ask Your Insurance Provider to Determine Care Costs on an HDHP

To begin using your healthcare dollars more efficiently under your high-deductible health plan, refer to this guide the next time you schedule a procedure:

1. **Call your insurance company and say, "I am considering having _____ procedure.** The Current Procedure Terminology (CPT) code is _____. Can you tell me if this is a preventive service at no charge or if I will be responsible for paying the negotiated rate?"
2. **If the procedure is not a preventive service, ask, "How much have I already paid toward my individual/family deductible?"**

This will give you an idea of the most you'll have to pay out of pocket.

3. Now, you should ask about in-network physicians. If you have already chosen your physician, you can ask, "Would you please verify that Dr. _____ [your preferred physician] is in-network?" If you do not have a preferred physician, you may ask for a list of physicians in your area who are in-network and their contact information.

4. The next step is to inquire about in-network facilities by asking, "Where does Dr. _____ perform this procedure? Is _____ [your preferred location] an in-network facility?" Some physicians have privileges at several hospitals and ambulatory surgery centers (ASC). Choose the location that works best for you. Often, ASCs are more reasonably priced.

5. Ask, "Are there other specialists that will be billed for this procedure such as an anesthesiologist, radiologist or physical therapist?" Gather as much information as you can.

6. If your procedure requires a hospital stay, ask, "How much should I expect my bill to be from the hospital? Is there a daily charge?"

7. You should now research, contact and interview physicians if you have not yet made your selection.

8. After you choose a physician and a facility, check the balance of your HSA. If you have not set aside enough funds through your HSA, ask your physician's billing office or the facility's billing office about a payment plan. **+**

As the Surgery Center of Allentown's administrator, Cindy Moyer is committed to providing patients with the highest quality of care in a comfortable and convenient environment. She holds a Certified Administrator Surgery Center credential. Cindy has more than 11 years of administrative management experience in the ambulatory surgery center care setting.

INVEST IN YOUR INTELLECTUAL SELF

BY SUZETTE BENEDICK, MBA, CHC, CMM
CAO Valley Kidney Specialists, PC President Lehigh Valley PAHCOM Chapter 2018

According to Royale Scuderi¹, “investing in yourself may be the most profitable investment you ever make.” Investing in our intellectual selves is not something medical managers do on a regular basis or even occasionally. Most managers invest time and finances to make sure we present our outward appearance as a professional befitting our position; however, are you investing enough resources in your intellectual self to stay competitive and valuable in your profession?

In my manager network I am aware of individuals that are “counting down,” you know who you are.... marking off the days/years on the calendar as you look to retirement. My message to you is that you are doing yourself and your employer a disservice if you are not capitalizing your resources to invest in yourself. The countdown to retirement is depressing; the focus changes from improvement and support to one of minimal engagement and survival. I challenge you to adopt the mindset of full commitment to the last day, continuing to support and represent your physicians, the organization, and yourself to the best advantage. Retirement from medical management does not mean you set aside your intelligence; instead, change your investment focus to other areas in your life that interest you.

What does it truly mean to invest in yourself; why is this important to you? First of all investing in your emotional health is always good for you; there is no time limit as you never retire from “you.” Secondly invest in your intellectual self through education, pump up your career, perhaps you want to learn something new, bring creativity to the table, or consider your management skills and find an area that you want to polish that will make you a better manager.

Roadblocks or challenges typically revolve around two critical resources needed to successfully advance our careers; time and money.

You may be thinking “who has the time” or “it is too expensive” to take a course, attend school, go to a conference, etc. I will be the first to agree with you that time is our most difficult resource to divide when we already have a busy professional and personal schedule. Funding the cost of an academic degree can be expensive for us personally and also for our employers if they provide tuition reimbursement benefits. I am a proponent of education and encourage those around me to complete their academic degree; we increase our personal value with a diploma or certification and also increase our marketability in a job search. However, we do not have to limit our learning to formal programs or commit the finances needed to earn that diploma. We have access to educational opportunities that do not require a large cash outlay, yours or your employers.

OPPORTUNITIES TO INVEST IN OURSELVES

1. Medical management associations offer education through webinars and conferences; we can earn certifications in compliance, medical management, IT (information technology), and other areas of specialized interest that move us ahead of the traditional manager. Join a group such as ACHE (American College of Healthcare Executives), PAHCOM (Professional Association of Healthcare Management), or MGMA (Medical Group Management Association); as a member you have just become part of a network of highly skilled and experienced individuals that can be a resource to you on almost any topic in our industry.

2. The PA Medical Society is a wealth of information for medical managers; our membership gives us access to current and timely changes in the healthcare industry as well as help to navigate challenges with our payers and federal regulations.

3. Formal academic programs are available both in-class and online; these schools offer certifications in a specific topic or a diploma with the focus on healthcare and/or business.

4. We have access to newspapers, articles, white papers, and books that focus on our industry, government/regulatory changes, and management topics. These resources are available to us free or at a very low cost.

5. Twitter, LinkedIn, and other sites allow us to follow blogs, articles, and conversations related to management and the healthcare industry. Social media is another resource to network with your peers and ask advice. Caution that you do not disclose too much as your reputation is your personal brand; you can never recover from a random disclosure by error or in the heat of the moment.

6. Include your employer in your plans to invest in yourself, negotiate benefits that cover the cost(s) for you to join a medical management association, request your employer cover the cost of a management conference each year – this is a win-win for both of you as you will bring back your new-found knowledge and apply it to move the organization forward. Your employer will see you as invested in your profession and position and will find value in providing these benefits to you.

7. Do not forget to invest in your mental and physical health; meditation, yoga, massage, and physical activity are all ways to care for your mind and body.

Investing in yourself shows you value yourself and your abilities. The reward of accomplishment and personal pride will show in your interactions with others who will also recognize these skills and look to you as a leader in your profession. Raise your bar; challenge yourself, set expectations and goals and stay true to the purpose. Take pride in your abilities and invest in yourself. +

¹ Royale Scuderi, https://www.constant-content.com/Author/64506-Royale_Scuderi-details-0.htm

Spring Break for jazz lovers



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Pa. Dept of State TRANSITIONING TO NEW ONLINE LICENSURE SYSTEM

The Pennsylvania Department of State's (DOS) Bureau of Professional and Occupational Affairs (BPOA) is transitioning to a new online licensing system. This new system, called the Pennsylvania Licensing System (PALS), will replace MyLicense—the state's current online licensing system.

The State Board of Osteopathic Medicine has already implemented PALS. Applications for unrestricted Osteopathic physicians and surgeons are now available only on the PALS system.

The State Board of Medicine is currently transitioning from MyLicense to PALS. However, there is no timetable for when the Board of Medicine will be online with the PALS system.

What can I expect from PALS?

BPOA hopes that PALS will make the online application and renewal process more user-friendly by: streamlining operations, improving processing times, eliminating (to the extent possible) the use of paper records, accepting digital uploads of most documentation, maintaining security and privacy safeguards, and standardizing the collection and maintenance of licensing records and reports.

In addition to online application and renewal, the PALS site (available at www.pals.pa.gov) provides access to various other licensing services. Specific features of PALS include:

Online Application Submission and Monitoring Process: Applicants and licensees can submit and check the status of their applications online. The PALS system will also enable the emailing of application discrepancy notices. Once the system is fully implemented, discrepancy notices will no longer be mailed.

Request Documentation of License Verification: Verification/certification of licenses can be requested. Upon completion of the online request form and fee payment, the Board will electronically send the requested document and a secure link to the designated recipient.

Self-Reporting of Disciplinary Actions: Licensees can self-report their arrest, criminal conviction, or disciplinary action in another jurisdiction via a Mandatory Reporting application.

Complaint Filing: A new link to file complaints online. Complaints previously could be filed online via Board websites.

Online License verification: The PALS Online License verification service allows the public to search and verify BPOA-regulated licensees, facilities, providers, and disciplinary actions.

Mcare Report Filing: Physicians can file Mcare Reports to report medical liability lawsuits. Attorneys, facilities, and other authorized parties may also report on behalf of physicians. +



LCMS NEWS

Upcoming Meetings

NEW MEMBERSHIP

Ric A. Baxter, MD (PLM-FM)
801 Ostrum St., Bethlehem

Gillian Alexandra Beauchamp, MD (EM-PTX)
1200 S. Cedar Crest Blvd., Allentown

Debra D. Esernio-Jenssen, MD (PD-CAP)

Ndeye-aicha Gueye, MD (END-DIA)
1401 N. Cedar Crest Blvd., Ste 200, Allentown

**Venkata Subramanian
Kanthimathinathan, MD (GS)**
325 N. 5th St., Fl. 3, Allentown

Kara Mascitti, MD (ID)
701 Ostrum St., Ste. 103, Fountain Hill

Christopher Melinosky, MD (N-CCM)
1250 S. Cedar Crest Blvd., Ste 405, Allentown

Robert Anthony Palermo, DO (PD-PDC)
1605 N. Cedar Crest Blvd., Ste 119, Allentown

Ashkon Razavi, MD (HS)
3435 Winchester Rd., Allentown

David Christopher Roy, MD (ORS- Resident)
801 Ostrum St., Bethlehem

REINSTATED MEMBERSHIP

Sandra Fogelman, MD (IMG-US)
798 Hausman Road, Ste. 270, Allentown

Lehigh County Medical Society will be holding the following meetings this Spring: members, please look for details coming soon to your mail and email boxes.

MAY 5, 2018

2018 Lehigh County Medical Society
Annual Social Lehigh Country Club



Surgery Center OF ALLENTOWN

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With the many years of experience, our facility treats but is not limited to the following procedures:

- **Colorectal Surgery** • **Ear, Nose and Throat**
- **Hand Surgery** • **Interventional Pain Management**
- **Ophthalmology** • **Orthopedics** • **Podiatry** • **Spine**

The physicians at Surgery Center of Allentown are committed to providing quality care in a safe environment, while delivering the highest levels of personal care. Rediscover the meaning of quality medical care. Encounter it at Surgery Center of Allentown.



OUR PHYSICIANS

Specialists to Serve Your Medical Needs.

Colorectal Surgery

Indru Khubchandani, M.D.
John Stasik, M.D.

Ear, Nose and Throat

Anderw Pestcoe, D.O.
Edward Tomkin, D.O.

Hand Surgery

Richard Battista, M.D.
Patrick McDaid, M.D.
Jay Talsania, M.D.
Lawrence Weiss, M.D.

Interventional Pain Management

Robert Corba, D.O.
Robert Wertz, M.D.

Ophthalmology

Houman Ahdieh, M.D.
Irena Cherfas, M.D.
Mark Krakauer, M.D.
Mark Moran, D.O.
Daniel Ross, M.D.

Orthopedics

Kenneth Brislin, M.D.
Gregor Hawk, M.D.
Christopher Hawkins, M.D.
Jay Kalawadia, M.D.
Paul Pollice, M.D.
Robert Palumbo, M.D.

Podiatry

Jay Kaufman, DPM
Dean Sorrento, DPM

Spine

Jeffrey McConnell, M.D.
James Weis, M.D.



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