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LEHIGH COUNTY

Health & Medicine

Official Publication of The Lehigh County Medical Society

THE FIRST PACEMAKER

BY JAMES REX, MD

Coping with a NATIONAL OPIOID EPIDEMIC

BY KIMBERLY POORE MOSER,
President, AMA Alliance


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WINTER 2018

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Health & Medicine

LEHIGH COUNTY MEDICAL SOCIETY
1620 W Highland St, | Allentown, PA 18102
610-437-2288 | lcmedsoc.org

EDITOR
David Griffiths
Executive Officer

Cover Photo: Amanda K. Buss, executive director of the Cancer Support Community of the Greater Lehigh Valley, poses with her husband, Mark Sivak, and daughter, Madalyn. Photo Credit: Beth Ravier Photography

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BRUCE D. NICHOLSON, MD
Lehigh County Medical Society President

Welcome to the Winter issue of *Lehigh County Health and Medicine.* We hope you have enjoyed our prior issues and have found them educational. We look forward to hearing your responses, ideas, and contributions.

Our Winter issue has articles on a range of health topics, including perspectives on what creates a healthy community, testing for radon in your home, and information on contraception. Our cover article is from a retired physician as he looks back on implanting the first pacemaker in the Lehigh Valley. An article on Teen Health week, March 19-23, 2018, discusses the history and focus for the week.

One of our articles from PAMED is on current legislation in Harrisburg dealing with insurance prior authorization delays. The article talks about what prior authorization is, how it can affect your health and what this bill is intended to do.

We have an article on opioids from the AMA Alliance that reflects on their actions to help with this growing health crisis.

As with the last issue, we continue to add more information on non-profits that are aiding our community. In this issue we reached out to the United Way of the Greater Lehigh Valley. Read on to learn more about these organizations, and the important work they do.

Check out our Practice Management section for information on the change to how physicians obtain informed consent. For those of you interested, we have the Pennsylvania Medical Society quarterly legislative update.

Thank you for reading! ✚

THE FIRST PACEMAKER IN ALLENTOWN

BY JAMES REX, MD

In today's technologically advanced medical world, insertion of a pacemaker has become almost "routine" surgery, if such a thing exists. Nearly a quarter million Americans benefit from the electrical impulses generated by a pacemaker, which normalizes the beating of their hearts, often alleviating symptoms like fatigue and providing a better quality of life for patients who require such assistance. But the pacemaker is a relatively new medical intervention, the first wearable pacemaker having been developed only about 60 years ago.

I am honored to have inserted the first pacemaker to be installed in Allentown during the early 1970s, at what was then known as The Allentown Hospital, now, Lehigh Valley Hospital 17th and Chew. I'd been in practice for about a decade at the time.

The first pacemakers were rather crude affairs contrasted to the later refinements. Initially, they were used in patients who had a very slow heart rate, less than 40 beats per minute. In such patients, there was always the danger of sudden death when the heart rate slowed further or cardiac standstill occurred. Our Mrs. E, who was in her 60s, was such a patient. She had a very slow heart rate and it was impossible for her

to sit or stand without fainting. She also had severe diabetes and had been in bed for such a long time, she had developed a decubitus ulcer in the sacral (buttocks) area.

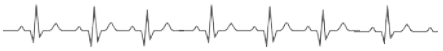
Dr. Kasperian, a cardiologist from Philadelphia, came to The Allentown Hospital and inserted a temporary transvenous catheter into the right ventricle of Mrs. E's heart. This, when connected to a battery powered external generator, would transmit a small electrical stimulus that would make the heart go faster, the rate depending on the one you set.

We had no battery powered unit in The Allentown Hospital at that time. But, fortunately, someone knew the family of a recently deceased patient who had used an external battery powered pacemaker, and the family agreed to let us use the unit. This consisted of a wooden box with special odd-sized batteries. Because of the odd design of the batteries, we did have some difficulty obtaining backup batteries. Using this temporary setup, Mrs. E's heart was now being paced and she was comfortable. But a permanent completely implanted pacemaker was needed if she were to enjoy any real quality of life.

The original implanted pacemakers consisted of wires (electrodes) to transmit the electrical impulse and an implanted battery and timer (generator) encased in material that would not cause any appreciable bodily reaction. The generator was about three inches in diameter and one inch thick. Medtronic Corporation manufactured the pacemaker units, electrodes and battery generators. These units were called fixed rate pacemakers because they sent out a fixed electrical impulse, usually set at 60 times per minute.

I explained the insertion of the pacemaker to Mrs. E and her family and they agreed to have the procedure. Then I called Medtronic Corp. in Minneapolis, MN and ordered a fixed rate pacemaker. At that time, there were two ways it could be sent, either by Air Freight or Air Express. I knew when to expect the package, but it didn't arrive. The company assured me the device had been shipped, so I found out the name of the carrier who had handled the package and discovered that Mrs. E's pacemaker had

NEARLY A QUARTER MILLION AMERICANS BENEFIT FROM THE ELECTRICAL IMPULSES GENERATED BY A PACEMAKER



mistakenly been delivered to Allentown, NJ instead of Allentown, PA.

When I explained to Mrs. E and her family what had happened, they reached out to a family friend who had a small private airplane and he agreed to fly to Allentown, NJ and retrieve the package. The pacemaker finally arrived, but it wasn't sterilized because the electronic components couldn't withstand heat sterilization, the most common method of sterilizing surgical instruments and such. The only way the pacemaker could be sterilized without damaging it was with gas sterilization, a common method of sterilization today, but at that time we had no gas sterilizers in Allentown. Fortunately, there was one available at St. Luke's Hospital in neighboring Bethlehem, and they agreed to sterilize our pacemaker.

Next, I tested the generator by placing it on a radio and turning the dial to the lowest AM band setting. Every time the generator sent out a signal, we could hear a beep, confirming that the unit was working. Then the entire unit had to be cleaned and wrapped in cloth. Following gas sterilization, the unit had to be aired for 12 hours, because the gas used in the process is irritating to body tissue and had to be completely dissipated before implantation.

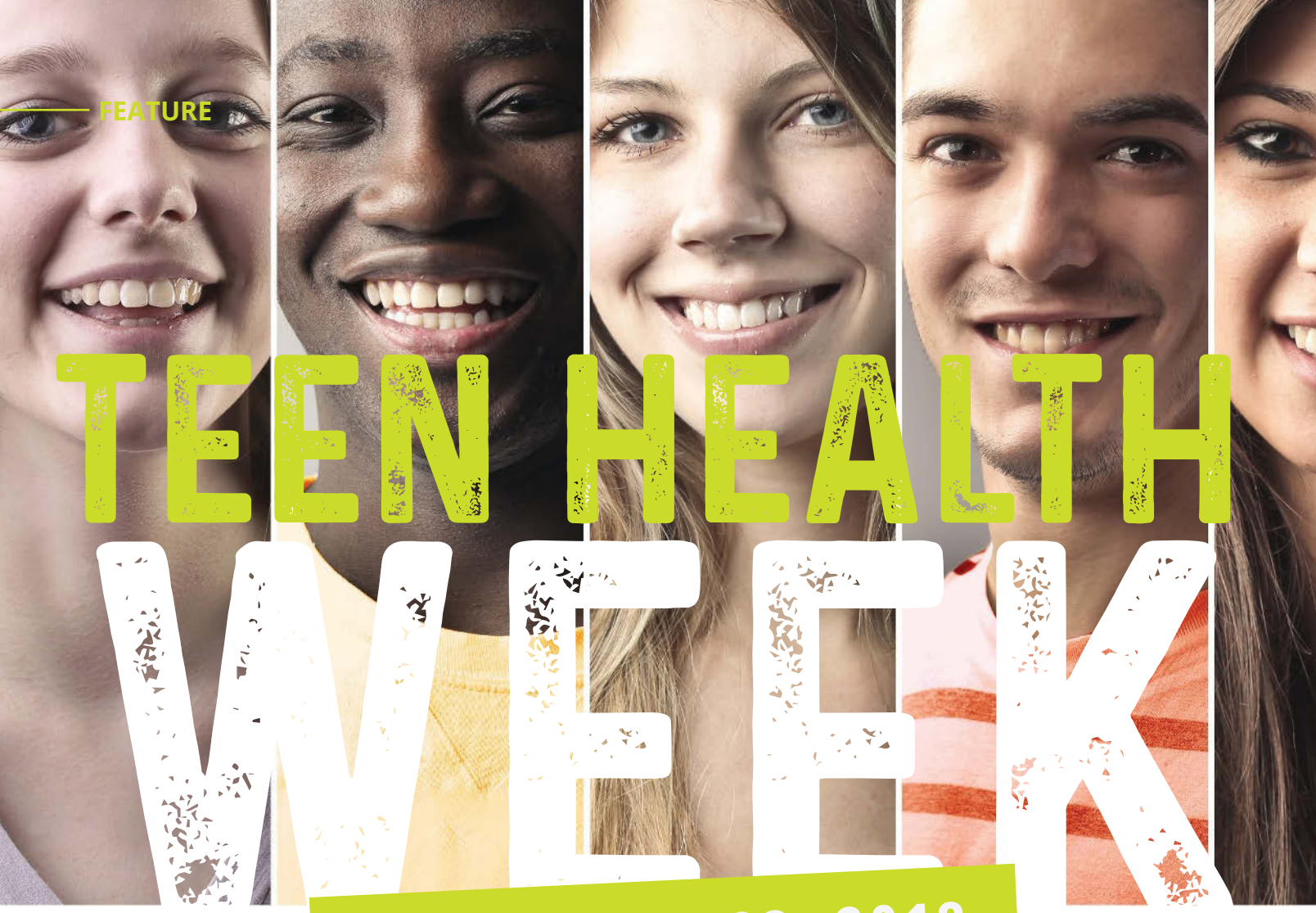
After all of that advance effort, we were finally ready to proceed with the implantation. The early pacemakers required a thoracotomy incision into the pleural cavity (the space between the two cavities which contain the lungs) to expose the heart. A left thoracotomy to open the chest wall was performed and the pericardium, the membrane protecting the heart, was then opened to expose the heart muscle. An area of the left ventricle of the heart was selected and the tips of the electrodes, about one half inch long, were inserted into the heart muscle and sutured to prevent their dislodgement.

We placed the pacemaker generator in the subcutaneous tissue under the clavicle (collarbone) so that it would be accessible when needed to service the pacemaker in the future. The temporary wire electrode which had previously been inserted was removed. The surgery was successful, the pacemaker was installed, and worked as expected. Mrs. E's recovery and convalescence went well, even though her hospital stay was prolonged until her decubitus ulcer was adequately healed.

I must have followed Mrs. E for at least 10 years after we installed her pacemaker, during which time several additional minor surgeries were performed to replace pacemaker generators and electrodes. Sadly, her husband eventually passed away and Mrs. E became senile. At a certain point her sons, both ministers, decided that no more pacemaker changes would be made. Mrs. E finally passed away when the generator failed; she was in her seventies, having lived a far longer life than she likely would have without the pacemaker.

Mrs. E was my first patient to receive a pacemaker, but there were many more to follow. At the height of my practice, from which I've been retired since 1990, we followed about 500 patients with pacemakers – so many that we employed a full-time pacemaker follow-up technologist named Mary Moyer.

Subsequent pacemaker implantations were far simpler, and the electrodes were vastly more complex. One of the major changes has been in the size of the units. The generator which I implanted into Mrs. E was about an inch thick and 3-4 inches wide, and now they're the size of a silver dollar. It has been gratifying to watch the advancement of pacemaker technology since I implanted that first one into Mrs. E over 40 years ago. ✚



TEEN HEALTH WEEK

IS MARCH 19-23, 2018

The Global Teen Health Week is an annual week-long designation to raise the profile of adolescent health. With more than a billion adolescents worldwide, this age group comprises one of the largest segments of the world's population. The rapid physical and emotional growth of this age group differentiates it from the needs of children and adults. Health behaviors resulting in illness later in life often start in the teen years.

The idea for a Teen Health Week stems from a movement that began in 2015 in Pennsylvania developed jointly by Real Talk with Dr. Offutt, the Center for Education and Public Initiatives at the College of Physicians of Philadelphia, and the Pennsylvania Department of Health. The PA Teen Health Week went on for two consecutive years since 2016 and the state remained the only one to celebrate Teen Health Week. While there are observances for specific teen health issues (e.g. Teen Dating Violence Prevention Month, Teen Pregnancy Prevention Month, Youth Violence Prevention Week) PA Teen Health Week and now the Global Teen Health Week, are unique in that they focus on a holistic view of teen health.

DURING GLOBAL TEEN HEALTH WEEK, ACTIVITIES ARE FOCUSED AROUND SUGGESTED OVERARCHING THEMES EACH DAY:

MONDAY, MARCH 19:
Healthy diet and exercise

TUESDAY, MARCH 20:
Violence Prevention

WEDNESDAY, MARCH 21:
Mental Health

THURSDAY, MARCH 22:
Sexual Development and Health

FRIDAY, MARCH 23:
Substance Use and Abuse

#TEENHEALTHWEEK

www.collegeofphysicians.org/thw

The 2018 week brings together the American Medical Association, the Society for Adolescent Health and Medicine, the WHO Collaborative Centre for International Child and Adolescent Health Policy at the University of St Andrews, and the Health Behavior in School-aged Children study. Teen Health Week is proudly endorsed by the Delaware County Medical Society.

Schools and organizations working with adolescents can celebrate any aspect of teen health that is relevant to their work, for instance: a short presentation on healthy relationships during the school assembly can support conversations about interpersonal violence in smaller settings throughout the week; a free teen yoga class can be held any day that week or sponsored to support mental health day; healthy snacks can be sold or offered throughout the week or given out for free to those wearing lime green to support healthy eating; or a debate around why the USA is 1 of 3 countries in the world yet to ratify the United Nations Convention on the Rights of the Child (UNCRC) can help students understand how international protections like these can enhance their ability to advocate for themselves when it comes to health. Activities can be as big or small as determined by the school community; the important aspect is that they contribute towards increasing awareness and dialogue about adolescent health.

Behaviors of young people are influenced both positively and negatively by friends, family, schools, community, and society. Teen Health Week provides an opportunity across our global communities to emphasize health education and engagement in a positive way. Teens are agents of change and Teen Health Week specifically includes health discussions. In addition to learning the very important skills of health self-advocacy, which they will need as they embark onto adulthood, teens too can positively influence health behaviors in other teens, their own families, and communities. ✚

RADON

BY DAVID HERSH

Whether you are purchasing or own a home in Pennsylvania, you may have heard about radon testing. Currently, Pennsylvania is one of the most radon-laden states in the US, with an estimated 40% of PA homes having levels above the EPA's guideline of 4 pCi/L (picocuries per liter). This naturally occurring, gaseous byproduct of uranium breakdown in rock, soil, and water penetrates through the small cracks and fissures of a property's foundation, where it can accumulate to toxic levels. It can be found in schools, offices and homes, however, household levels are of greatest concern due to the prolonged exposure of domestic living. Additionally, radon is a known carcinogen that is specifically linked to lung cancer. According to the Surgeon General, this odorless gas is responsible for the second highest rates of lung cancer deaths in the US, falling second only to smoking-related lung cancer fatalities.

Radon gas in the air breaks down into tiny units called radon progeny. These small particles are radioactive and when inhaled, can cause tissue damage in the lungs and eventually lead to pulmonary cancer. The majority of radon-related lung cancer cases occur in smokers, due to the combination of smoking and radon inhalation. However, radon is also suspected to cause a significant number of lung cancer deaths among non-smokers as well. Studies performed on people and in the lab were utilized to form the body of evidence that supports a link between radon inhalation and lung cancer. On the contrary, the relationship of radon to other forms of cancer, such as childhood leukemia, has also been researched. Yet, according to The American Cancer Society, the evidence is mixed and the link is not as strong as it is for lung cancer.

Given these facts, it is equally important to know that there is not set criteria that places one home at a higher risk than another for accumulation of this gas. Radon can amass in both old and new homes, with or without basements. Furthermore, testing a residence is a crucial step in protecting your family from this harmful, radioactive gas. In fact, both the EPA and the Surgeon General recommend testing all homes below the third floor for radon. So, if your home has never been tested before, it may be time to consider doing so.

There are several testing options available for the everyday consumer. However, prior to conducting a radon test in your home, the time of year should be considered. Radon levels vary seasonally, and with changes in heating and ventilation in the home. Therefore, the highest likely radon levels may be found during the cold months, when the house is closed up and radon is less likely to escape. Commonly, two types of tests are used; they include either a short term or long term option. Short term tests can remain in your home anywhere from two to ninety days, depending on the type used. There are various mechanisms that short term tests employ, including charcoal canisters, charcoal liquid scintillation detectors, and continuous monitors to name a few. The short term option of testing is great if quick results are needed; also, following up a short term test with a second one can be a valid way to determine if further action is necessary. However, this avenue may not be the best option for finding out a yearlong average amount of radon in your home. Contrary to short term options, long term testing can more accurately portray the yearlong average amounts of household radon levels. Long term tests remain in the home for ninety days or more and include such styles as alpha track and electret detectors. Radon test kits can be purchased from a PA certified laboratory or a local hardware store. When executing either test, be sure to follow the manufacturer's instructions and verify that the analysis of the test is conducted by a PA certified laboratory. This information can be obtained at www.dep.pa.gov.

After testing is completed and the results have been obtained, action steps may need to be taken. Currently, the EPA's recommended action level is set at 4 pCi/L. Any test yielding numbers above 4 pCi/L should result in further action being taken by the home owner. If a short term test result is higher than 4 pCi/L, then a second follow up test should be administered. The second test can be either a short term or long term test. However, if a short term test yields numbers that are more than twice the EPA's action level, then an immediate second short term test should be administered, to verify the results in a quicker fashion. After testing is completed and if results reflect levels higher than 4 pCi/L, the remediation process should begin.

Fortunately, radon remediation techniques can be simple and affordable. The most basic, preliminary step to take would be to seal up any cracks and fissures in the floors and walls. However, this step may only work in some cases where levels are not excessively high. In other cases, soil suction systems, sometimes known as sub-slab ventilation, employ pipes and fans as a means to eliminate radon. Soil suction systems work by removing the radioactive gas from the soil underneath the house before it can penetrate the foundation. Choosing the right type of remediation efforts for your situation will depend on the amount of radon in your home and the style of home you have. The Pennsylvania Department of Environmental Protection (PA DEP) recommends using a certified radon mitigation contractor to fix a radon problem in your home, due to the technical skills and knowledge needed for the job. A list of state certified radon mitigation contractors can be found at www.dep.pa.gov.

Due to the prevalence of radon in Pennsylvania, the PA DEP offers a plethora of materials created for its residents. These materials include The PA Consumer's Guide to Radon Reduction, The PA Citizens Guide to Radon, and The PA Home Buyers and Sellers Guide to Radon, to name a few. All of these resources and more can be found at the PA DEP website. ✚

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CREATING A Healthy Community

BY BONNIE S. COYLE, MD, MS
Chair, Dept of Community Health and Preventive Medicine, St Luke's University Health Network

At first glance, it may seem that we have a paradox when you look at the health of our nation. Despite being a world leader, our country lags behind many other countries on health-related metrics. Our life expectancy is shorter than many other countries, and in a concerning turn of events, life expectancy dropped slightly this past year for the FIRST time in my 30 years serving as a preventive medicine physician. We pay nearly twice as much per person for health care as the next closest country, and yet we have higher rates of most chronic diseases, higher rates of suicide and injury, and significantly worse behavioral health problems. So how can it be that our country, with all of our technological advances and our high standard of living, still cannot compete with many other industrialized countries in keeping our residents and communities healthy? While the answer to this question is complex, understanding a few key concepts helps to get a better understanding of why we compare so poorly to other countries on our health rankings. Ultimately, we will need to adopt a paradigm shift related to how we view the concept of health in order to become the healthiest country.

The first important concept is the Social Determinants of Health. Over the past twenty years a large body of evidence has accumulated that reveals a powerful role for social factors – apart from medical care – in shaping health across a wide range of health indicators, settings, and populations. In fact, it is now generally accepted that medical care only impacts about 20% of measures of morbidity and mortality in our country. Other social determinants, such as education, income level, housing stability, employment, neighborhood environments and individual behaviors are stronger predictors of how long we will live, and how healthy or unhealthy our lives will be. Countries that spend more on social programs rather than medical care have better health outcomes than the US. Spending more on medical care does not necessarily produce better health outcomes – building and promoting social capital may be a more effective approach.

In the book *Blue Zones,* Dan Buettner has identified communities around the world where people live the longest and healthiest lives. After immersing himself in these communities he found the main reasons why residents thrive to be the result of healthy diets comprised mainly of plants, physically active lifestyles, social cohesion, the importance of family, and having a well-defined sense of purpose. Closer to home, in the local town of Roseto, researchers identified a similar concept in the 1960s - Rosetans had much lower rates of heart disease than residents in other local towns such as Nazareth, Bangor, and Stroudsburg. After looking at many possible explanations, they concluded that it was the close social ties of this community that protected them from the heart disease ravaging our country. At first it may seem far-fetched that social interaction can prevent heart attacks and other chronic diseases, but there have been many studies since the "Roseto effect" was identified that corroborate this finding. More recently the Adverse Childhood Experiences study has shown that children exposed to abuse, violence, neglect and other psychological traumas early in life live shorter lives and suffer more frequently from a long list of chronic and mental health conditions. Our social environments are strong predictors of both our physical and mental health. We are most definitely social beings, and having close social ties and a strong sense of purpose can and does contribute to our health as surely as access to top-notch medical care.

Six years ago, my oldest son had a massive stroke that, but for exceptional medical intervention in the most timely manner, would have taken his life. While I have reason to be grateful to a number of highly trained doctors for intervening expertly to help him, there is one that stands out to me above all others – the ER doctor who first called to give me the terrible news. This doctor called me not once but three times during my 90-minute scramble to get to the hospital where my 19-year-old son lay semi-paralyzed and unable to speak – to keep me updated, reassure me, and just be "present" with me through my anguish. As soon as I arrived, he hastened to my side to explain what was happening. As paramedics loaded my son onto the Medivac helicopter, he personally went and got me a cup of coffee to take on my hour-long drive to the hospital my son was being transferred to for his life-saving procedure. As I prepared to leave, this physician reassured me that the surgeon waiting to operate on my son was the best in the nation, and asked me to keep him informed about the outcome – he didn't just provide quality medical care to my son, he connected with us, fretted with us, and made us all feel like he was personally invested in our family. Yes, he delivered exceptional care to my son – but what really touched me, what has stayed with me to this day, was the way he showed how much he cared.

This type of meaningful personal connection has often been lost – not just in our medical care system, but in our daily lives as well. Our fast-paced lives, filled with all kinds of time-saving technologies, have rendered us disconnected more than ever from the very social energy all of us need to feel fulfilled and achieve healthier lives. As such, behavioral health problems, violence, and chronic health conditions are becoming worse as all of us look to cope with growing isolation. Technologically advanced medicine can't come close to solving socially complex problems, and in some cases may inadvertently contribute to making things worse.

And this brings me to the second concept I see as so important to creating healthier communities – collective impact. With medical care only contributing a small degree toward our overall health, the answer to a healthier America can not and will not be the medical care system by itself. To make our communities healthier will require collective impact efforts. No one sector can solve the complex social issues which have caused us to rank so low compared to other countries on measures of health. Instead, health care systems must partner with other health, social, political, academic and public safety institutions to understand the root causes of poor health status and collaborate to create meaningful systems change that will create the conditions in which people can be healthy.

So the answer to healthy communities rests just as strongly with the education system, the justice system, social agencies, the business sector, housing policies, transportation agencies, etc., as with our medical care system. True impact comes not from silo-ed work done in each of these disciplines, but rather in bringing all these systems together to work collectively. As the Chairman of the St. Luke's Department of Community Health and Preventive Medicine, I have had the privilege to work with other local agencies to take a broader look at the concept of health and develop initiatives that can truly advance the health of our communities. I have seen over and over the power of a simple human connection to build trust that makes a difference in vulnerable lives.

Over the past twenty years I have observed collective impact strategies gain traction in very exciting ways here in the Lehigh Valley. St. Luke's University Health Network, initially through the Bethlehem Partnership for a Healthy Community, and more recently through the Affordable Care Act's Community Health Needs Assessment process, has partnered with hundreds of other organizations in our local area to improve the quality of life for community members. No one organization can do this work alone. Complex social and health issues require systems change thinking by many diverse organizations. The United Way of the Greater Lehigh Valley has been a strong and vocal leader in the collective impact arena, and has made

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great strides bringing diverse groups together to make positive changes.

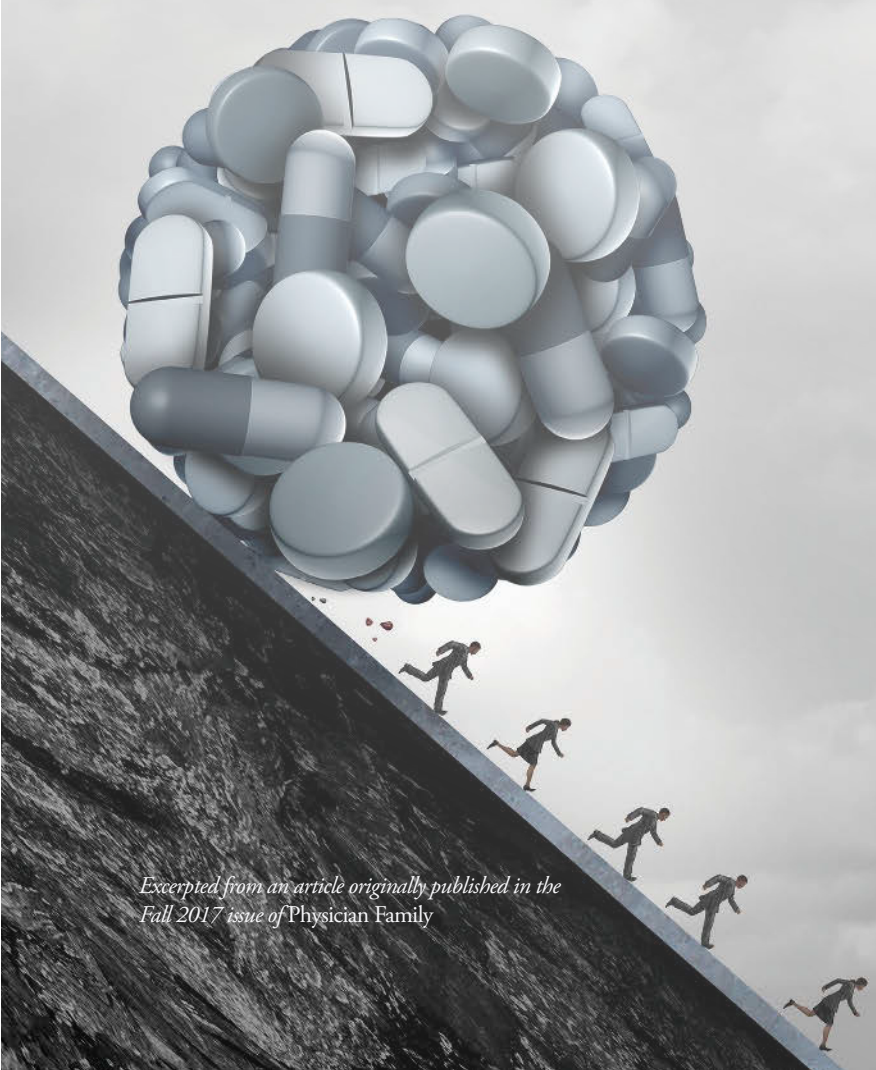
About two years ago, I joined the board of the Lehigh Valley Community Foundation (LVCF), and this work has helped me even more to appreciate the true definition of a healthy community. LVCF's purpose is "connecting people who care with causes that matter" and they are an excellent example of an organization striving to make our local community healthier by addressing the social determinants of health through a collective impact approach. LVCF takes a broad view of thinking about what makes our local communities thrive, providing grants to local organizations to promote the arts, education, health, and environmental sustainability. In the past few years they have added multi-year impact grants to encourage local organizations to collaborate with others on longer-term systems change work that can really make a difference. Their 50th Anniversary "Be the Spark" grants are addressing a broad array of social and health related topics such as food and housing access, mental health, cultural enrichment, human trafficking, and environment and sustainability. This kind of work challenges all of us to re-think what it means to be healthy, and sets the bar for the kind of work we all need to engage in to make the Lehigh Valley one of the healthiest communities in the country.

It's time for a paradigm shift if we want America to become a world leader in health care – time to recognize that to make our communities healthier we need to put the spotlight on the Social Determinants of Health. We need to take lessons from the Blue Zones and the town of Roseto, and look to promote social capital, to help folks reconnect with one another and find purpose in their work. We must expand our definition of health to include access to a good education, employment and cultural opportunities that build social capital. We need health care, education, business, government and social agencies to come together to collectively look for solutions to the complex societal issues that hinder our progress in becoming not only the richest nation in the world, but also the healthiest. There is great work underway right now in the Lehigh Valley, and the more all of us partner with the innovators of collective impact the better off we will all be. If we all work together to "Be the Spark" that makes our community healthier the social cohesion and life of purpose that results will benefit all of us! ✚

Bonnie Coyle, MD, Medical Director, St. Luke's Community Health Department, is a member of our Board of Governors of Lehigh Valley Community Foundation.

Coping with a NATIONAL OPIOID EPIDEMIC

BY KIMBERLY POORE MOSER, President, AMA Alliance



As the nation grapples with an epidemic of addiction to opiates and heroin, the AMA Alliance is finding ways to support communities to educate and bring easily implemented, common-sense solutions to every corner of the nation.

The AMA Alliance Board decided in 2015 to take on the problem of opioid misuse as a public health crisis as one of our national initiatives. It is important to us as an Alliance to improve the health and well-being of our communities and help eliminate this scourge in our society and the devastation it causes to families. It is also vital to reduce the stigma associated with addiction and promote national best-practice standards to allow individuals suffering from the disease of addiction to get the help they need and deserve.

In 2015, 52,000 people – sons, daughters, sisters and brothers – died as a result of drug overdoses in the U.S., with 33,000 of those people dying due to opioids and heroin specifically. That is more than 142 people who die each day, the equivalent of a plane crash. Deaths due to opioid overdoses now exceed car accidents and are the leading cause of accidental death in the United States each year.

We know that addiction knows no boundaries and cuts across all demographics. It does not care where you live, how much money you make or where you went to school. We know that addiction is a long-term, chronic, debilitating, potentially fatal disease. Addiction affects entire families, especially the children of those afflicted. It is the reason for 83% of those incarcerated. It touches us all, some personally and all as citizens and taxpayers. It is critical to understand the reasons for this recent explosion in opioid misuse and address it systematically.

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Excerpted from an article originally published in the Fall 2017 issue of Physician Family

If there are best-practice prevention efforts to build coping skills and resilience in children, the Alliance is engaging. We are continuing to educate patients, parents and people of all ages on the dangers of opioid misuse and have designed materials to use in your community projects. These outstanding materials, created in conjunction with the Missouri State University Master of Public Health Program with the assistance of our partners in the AMA, can be ordered for distribution in your communities on the AMA Alliance website. (http://www.amaalliance.org/advocacy-opioid)

In supply reduction efforts, the Alliance is promoting safe disposal of medications and drug take-back initiatives, and educating the public on the importance of cleaning out medicine cabinets. We know that roughly 80% of individuals who end up addicted to opiates and heroin started with a prescription pain pill, whether legitimate or diverted. It is for this reason that we are partnering with the AMA in an effort to educate patients about alternatives to addictive medications. We're also advocating for legislation to improve outcomes for individuals living in the cycle of addiction.

We know that addiction is a brain disease with many causes. Oftentimes, there is a genetic predisposition, co-occurring mental illness or a legitimate pain issue which leads to the addiction. Opioids were once thought to be non-addictive if used to treat legitimate pain, which we know now is not true. Opioids were aggressively marketed as new "miracle drugs," promising to remove all discomfort or pain. We now know that taking opioids for as few as three to five days increases the chance of addiction exponentially.

Until recently, pain was viewed as a fifth vital sign. Physicians were encouraged to treat pain as aggressively as they would any other medical condition or symptom. In fact, patient satisfaction surveys still include questions regarding pain management, tying patient satisfaction about the relief of discomfort and pain to physician payment. There is so much wrong with this practice.

Through education, we are changing attitudes about addiction and stigma in positive ways. This is an important step as we work with and within our communities to combat this scourge. As community leaders and volunteers, our networks are connected in our neighborhoods, with schools and with the health care system, stretching far and wide across the U.S., allowing us to mobilize our members in ways that no other group can, to provide support and resources to our communities.

Educational materials designed specifically by the AMA Alliance are available for community projects both large and small. These postcards, brochures and DVDs can be co-branded. They're available on the AMA Alliance website (http://www.amaalliance.org/advocacy-opioid) along with numerous other resources including a free downloadable white paper.

WE ARE CONTINUING TO EDUCATE PATIENTS, PARENTS AND PEOPLE OF ALL AGES ON THE DANGERS OF OPIOID MISUSE AND HAVE DESIGNED MATERIALS TO USE IN YOUR COMMUNITY PROJECTS.

Utilizing best-practices and demanding change in your state legislatures and communities makes a huge difference. Local and state Alliances are uniquely suited to advocate for things like improving prevention initiatives, insurance parity, expanding treatment or use of Narcan in your county and more.

Take advantage of the materials and toolkits which the AMA Alliance provides and share them in your community. Additional innovative tools are being developed for our members to share. Get creative and leverage your Alliance efforts by partnering with a local school, PTA, hospital or business to raise awareness and distribute educational materials.

The Pennsylvania Medical Society Alliance has purchased a large quantity of the opioid materials developed by the AMA Alliance for distribution in Pennsylvania. Alliance members from all over PA have already begun to distribute the materials to community organizations, schools, health care groups and more. If your group would like to obtain some of these materials, contact the PAMED Alliance office at Alliance@pamedsoc.org. ✚

Addressing the OPIOID ABUSE EPIDEMIC in Pennsylvania

BY THE PENNSYLVANIA MEDICAL SOCIETY

We've all heard about the opioid abuse crisis facing the nation in the news, and Pennsylvania has been hit particularly hard. Consider these statistics.

IN THE NATION:

- There were about 64,000 drug overdose deaths in 2016 (higher than peak car accident deaths, peak HIV deaths, and peak gun deaths) – Up 22% from 2015.
- Drug overdoses are expected to remain the leading cause of death for Americans < 50.
- 14,400 overdose deaths between 2000 and 2016 involved prescription opioids.

IN PENNSYLVANIA:

- 4,642 drug-related overdose deaths were reported in 2016, opioids found in 85% (25% of which were prescribed).
- The increase in drug-related overdose deaths between 2015 and 2016 was larger in rural counties (42 percent) compared to urban counties (34 percent).
- The drug-related overdose rate was 36.5 per 100,000 people, national average 16.3 per 100,000. Seventy-eight percent of counties had overdose death rates higher than the national average.
- Many stakeholders, such as the Pennsylvania Medical Society (PAMED), various state departments, and county and specialty medical societies, are working together to address the crisis in Pennsylvania.

WHAT'S BEEN DONE?

- In 2016, PAMED created its Be Smart. Be Safe. Be Sure. program to help educate patients about the safe use of opioids and the warning signs of addiction and help physicians prescribe opioid drugs with more precision and less potential for abuse. Learn more and get resources at www.pamedsoc.org/OpioidInfo.
- The state has worked with stakeholders such as PAMED and other provider associations to create specialty-specific voluntary prescribing guidelines. Find them on PAMED's website at www.pamedsoc.org/OpioidGuidelines.
- In August 2016, the state launched the Prescription Drug Monitoring Program (PDMP). Since its launch:
- The PDMP has about 97,000 registered users searching about 1.1 million patients per month.
- The number of patients who went to 5+ prescribers and 5+ pharmacies in 3 months for Schedule II drugs decreased by 86 percent in the first year.
- The number of youth who received prescriptions for painkillers decreased 30 percent in the first year.
- The PDMP is currently sharing data with 15 other states and Washington, D.C.
- The PDMP can now integrate with electronic health records (EHRs) and pharmacy management systems of all eligible health care entities in Pennsylvania. For more information and to sign up, visit www.doh.pa.gov/pdmp.
- PAMED members can get crosswalks of how PA's PDMP compares to bordering states' systems as well as other information on the PDMP such as querying requirements for prescribers and dispensers at www.pamedsoc.org/PDMP.
- PAMED, working with other stakeholders, created two educational series designed for physicians. They can also help physicians meet the new opioids education requirement for licensure/license renewal. Find the education on PAMED's website at www.pamedsoc.org/OpioidsCME.
- PAMED continues to advocate on behalf of Pennsylvania physicians and patients to help ensure that any opioid-related legislation takes a common sense, patient-centered approach.
- PAMED's Opioid Advisory Task Force continues to collaborate on topics such as education, the use of naloxone, drug collection boxes, opioid-related legislation, and the PDMP.
- A standing order for naloxone – an opioid-reversal drug – was signed by Pennsylvania Physician General Rachel Levine, MD, in 2015. Since that time, more than 3,800 opioid overdoses have been reversed by naloxone in Pennsylvania.

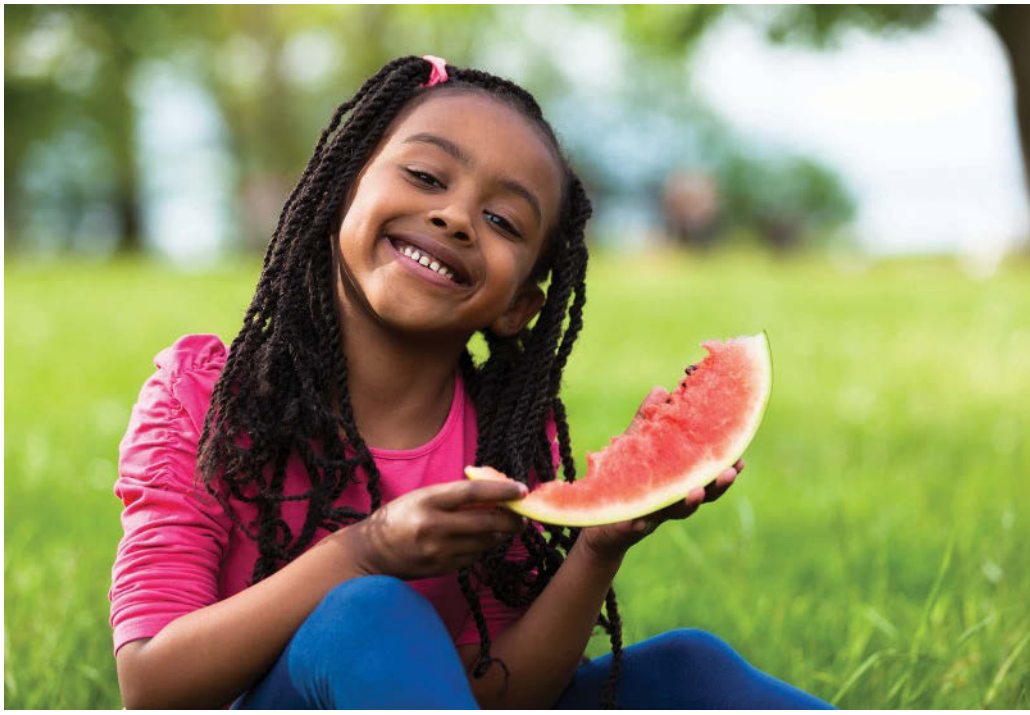
And, it doesn't stop there. Addressing the opioid abuse crisis continues to be a priority for PAMED.✚

Learn more and access resources from PAMED at www.pamedsoc.org/OpioidResources.

Feeding OUR COMMUNITY

BY PRISCILLA ROSADO, Assistant Director, Food Access
United Way Of The Greater Lehigh Valley

Food access is not a given for every resident of the Lehigh Valley. Almost 75,000 people – one in ten – are relying on monthly visits to food banks. In fact, 63,000 people in the Valley are what United Way calls "food insecure" – a household-level economic and social condition of limited or uncertain access to adequate food. The numbers are even worse when you look at children. According to Feeding America, one in seven children is hungry in the United States; however, in the Lehigh Valley, one in three children is hungry, more than 29,000 kids.



Recognizing this need — and acknowledging that access to nutritious food plays a critical role in a student's success and a family's well-being — United Way of the Greater Lehigh Valley set a bold goal: to reduce the number of people in our community who are food insecure by 50 percent by 2022. According to Alliance for a Healthier Generation, "Kids who eat healthier and move more perform better in school. Studies show that healthy kids get better grades, attend school more often and behave better in class. We now know that making time for physical activity and nutrition in school is not a break from academics; it's an investment in higher academic performance."

In pursuit of this goal — and with the backing of generous donors — United Way helped form and mobilize the Lehigh Valley Food Policy Council, a regional effort to reduce food insecurity and strengthen the local food economy. A collaboration of 17 founding partners, the impact effort pledges to reduce food insecurity locally by focusing on key economic issues and barriers to successful food access for all.

"The Lehigh Valley Food Policy Council is made up of people and organizations across the Valley," said Marc Rittle, Vice President of Impact at United Way of the Greater Lehigh Valley. "It includes everyone from farmers who grow the food to grocers who distribute the food."

With backbone support from the Community Action Committee of the Lehigh Valley, the Council has seen great gains in the past few years. The Council established the Lehigh Valley Gleaning Network and rescued, or "gleaned," 13,000 pounds of food from farms last year and redistributed it into the community.

"This food would have been thrown away, but instead it went to the people who needed it most," said Rittle. "This was only possible with the support and buy-in of everyone in the supply chain."

While kids are in school, providing access to nutritious meals is simplified. To address the need during the summer months, the Council established Summer Food Sites throughout Allentown, Bethlehem and Easton. The Council then collaborated with area libraries, the Summer Learning Consortium, Cops N Kids, and many other partners to encourage families to call community hotline 2-1-1 to locate their nearest Summer Food Site.

"Summer is the hungriest time of the year for many school-age children," Rittle said. "Not only are children who are hungry nearly three times more likely to suffer from poor health, but it impairs their ability to sustain their learning and growth. United Way is committed to ensuring healthy food access 365 days a year."

The Council also worked to incorporate nutritious, locally-sourced food into the Meals on Wheels program. Meals on Wheels Northampton County preps the meals for both Lehigh and Northampton County programs and has a partnership with local farms. Last year, 567,000 nutritious and medically-tailored meals were distributed to homebound seniors.

"Our aging population is one of our most vulnerable groups, so it's important for them to have consistent access to fresh, healthy food," Rittle said. "Meals on Wheels offers many the ability to stay independent in their homes. Providing nutritious alternatives is an important part of senior's well-being.

"Supporting United Way means supporting community-wide change," Rittle said. "We turn your dollars into fuel to drive regional efforts like this and to improve lives throughout the Lehigh Valley."

Lehigh Valley Food Policy Council is a collaboration of 17 founding partners that include: Buy Fresh Buy Local – Greater Lehigh Valley, CADCA - Jordan Heights Neighborhood Revitalization, Community Action Committee of the Lehigh Valley, Lafayette College, Lehigh County Community Revitalization and Development, Lehigh Valley Health Network, New Bethany Ministries, Northampton County Department of Economic Development, Nurture Nature Center, Penn State Extension, RenewLV, Rodale Institute, Second Harvest Food Bank of Lehigh Valley & Northeast Pennsylvania, Seven Generations Charter School, Sodexo, St. Luke's University Health Network, and United Way of the Greater Lehigh Valley. ✚

For more information on how United Way of the Greater Lehigh Valley is impacting effective change in the region, visit:

www.unitedwayglv.org/learn-about-united-way/how-we-do-it

MEDICAL SCHOOL SCHOLARSHIPS HONOR

Inspire The Foundation of the Pennsylvania Medical Society

The Foundation of the Pennsylvania Medical Society Executive Director Heather Wilson, CFRE, says, "We are inspired every day by our scholarship winners and the success they find in this profession that ultimately helps humankind. Throughout 2017, we will be featuring their stories and their advice to current medical students on our website. We could not have initiated these kinds of program without visionary donors like Elena Pascal and Carla Vigilante. They established the $1,000 Myrtle Siegfried, MD, and Michael Vigilante, MD, Scholarship through the Foundation to help students in their local community."

Sisters Carla and Elena decided to create a lasting tribute in honor of their parents who were physicians in Allentown. "Working with staff at the Foundation, we established the scholarship in their memory. We accomplished two goals by creating a lasting remembrance of our parents and their achievements, and returning something to the profession our parents loved," says Elena.

Elena says her parents were a dynamic duo who practiced medicine together in the Lehigh Valley. Her mother was a general practitioner raised on a farm in Stony Run, graduating youngest in her class from The George Washington University School of Medicine. Her father was an obstetrician-gynecologist from New York, graduating from Marquette School of Medicine. Though her parents' families were of little means, they sought better lives for their children.

The latest winner, Lucas T. Wittman, of Macungie, attends Harvard Medical School, in Boston. He said that his appreciation for education and desire to practice medicine in underserved communities has stemmed from his own humble upbringing as the youngest in his small-town household of seven. He says, "Motivated in part by my own socioeconomic background, I dedicated a significant portion of my undergraduate years seeking to better understand some of

the implications involved at the interface of society, neuroscience, and health by leading research projects on poverty and pediatric brain development at the Children's Hospital of Philadelphia."

Elena says that for more than 50 years, her parents shared offices on the first floor of the family home practicing the "art of medicine," seeking to contribute in a positive way to the development of patients and their families. Their patients were their friends, and medicine became an integral part of daily life. Telephones were constantly ringing and their two waiting rooms were "standing room only." They took their time, focusing on each patient as if they were part of the family. Elena's husband, Joseph Pascal, MD, fondly recalls his first meeting with his future mother-in-law. "She was cradling a phone in one hand giving insulin orders, while stirring the batter for a cake in the other." At a time when women were a rarity in medicine, Dr. Siegfried was a pioneer.

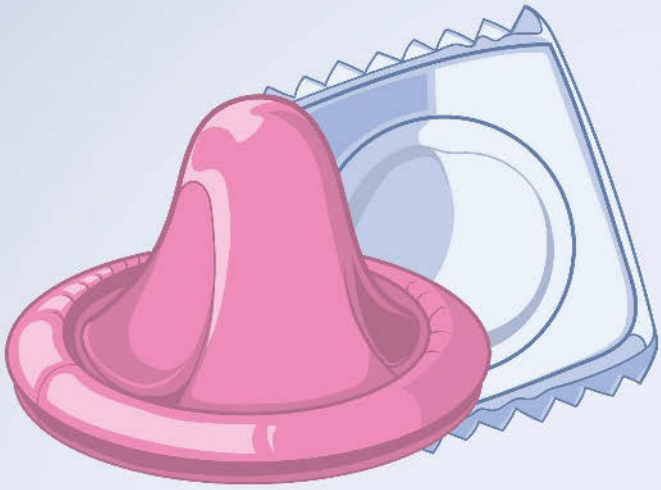
Elena says, "Our father was a storyteller. His flamboyant, outgoing personality, coupled with his colorful tales of his life in the melting pot of New York's Lower East Side, amused his patients and colleagues. He never seemed to need sleep, spending hours on end in the hospital or his office. He welcomed thousands of babies into the world, and cared for many patients by serenading them with his rendition of 'Santa Lucia.'"

Today's high cost of a medical education can sometimes prevent someone from attaining the dream of becoming a doctor. The average, annual medical school tuition and fees has risen from $16,301 in 1990 to $46,963 in 2016. Coupled with the scarcity of low-cost sources of funding, obtaining a medical education becomes increasingly difficult.

Elena Pascal presents the scholarship award to Lucas T. Wittman.

Through this endowment, there is hope for medical students to achieve their dream. "My husband and I are charitably inclined so when we reviewed our estate plan, we chose to give a planned gift to the Foundation. After our deaths, these assets will be used to continue this scholarship fund. My sons understand that this endowment is important to us, and we have encouraged them to also contribute so the fund will continue to grow, helping more students," says Elena.

The Foundation, a nonprofit affiliate of Pennsylvania Medical Society, sustains the future of medicine in Pennsylvania by providing programs that support medical education, physician health, and excellence in practice. It has been helping finance physician education for more than 60 years.



SHOWING A LITTLE LOVE *for contraception*

BY EMILY DU, MS-3,
Lewis Katz School of Medicine
at Temple University

The month of February is a time for a candlelit dinner for two, a dozen red roses… and contraception! According to research published by the Guttmacher Institute, over half of all pregnancies in Pennsylvania were unintended in 2010.

CONTRACEPTION IS KEY IN *preventing unintended pregnancy* AND PROMOTING SAFE MOTHERHOOD

Contraception is key in preventing unintended pregnancy and promoting safe motherhood, but choosing the method that is right for you can be overwhelming. Let's have a look at some of the most popular birth control methods.

THE LONG-ACTING REVERSIBLE CONTRACEPTIVES

Long-acting reversible contraceptives include the intrauterine device (IUD) and contraceptive implant. These methods are extremely effective and low maintenance.

The IUD is a small, T-shaped insert that is placed into the uterus by a healthcare professional. Some IUDs release progestin, while others are made of copper. The IUD is a reversible form of contraception that can last from three to 10 years, depending on the specific type. When used for its full lifetime, the IUD is extremely cost-effective compared to other forms of contraception.

A poorly designed IUD led to increased risk of pelvic infections during the 1970s, resulting in decreased use. Research, however, has verified that today's devices are very unlikely to cause pelvic inflammatory disease, regardless of whether women were screened beforehand for gonorrhea and chlamydia. An IUD cannot be placed in women with an ongoing pelvic infection. With these developments, the rate of IUD use in the United States quadrupled between 2002 and 2012, and continues to rise.

The implant is a small progestin-releasing device that is inserted into the upper arm, providing three years of contraception. The insertion and removal procedures can be done in an office with local anesthetic. It is highly reliable, as less than 0.05% of women using this method will become pregnant in one year!

THE HORMONAL CONTRACEPTIVES

Hormonal contraceptives are delivered into the body by oral pill, injection, patch, or ring. They stop pregnancy by thickening cervical mucus, which prevents the movement of sperm. They also prevent the release of an egg during ovulation.

Oral contraceptive pills must be taken daily and include either a combination of estrogen and progesterone, or progestin alone. While pills are said to be 99% effective, there is a 9% failure rate because effectiveness depends on taking the pill every single day.

A benefit of oral contraceptives is that they can be easily started or stopped. Women can start and stop taking the pill while maintaining the same level of fertility as women who were not on contraceptives. Additionally, the formulation can be adjusted if side effects arise.

A limitation of the pill is that it cannot be used in women over the age of 35 who smoke cigarettes, due to increased risk of blood clots.

The progestin hormonal injectable is commonly known by its brand name, Depo-Provera. Administered every three months by a healthcare professional, it is a low-maintenance option. However, failing to get repeat injections on time contributes to a 6% failure rate. Both the Depo-Provera and the progestin-only oral contraceptive pill, also called the "mini-pill," do not affect a woman's ability to breastfeed.

The birth control patch and ring continuously deliver estrogen and progesterone. The patch is placed on an area of the body such as the abdomen or leg, while the ring is inserted directly into the vagina. Both the patch and the ring are replaced monthly, with a failure rate of 9%.

Increased risk of failure is due to the patch falling off, improper reinsertion of the ring, or not replacing either on time.

THE BARRIER METHODS

The barrier methods work by creating a physical or chemical barrier for sperm. They include male and female condoms, spermicides, diaphragm, and cervical cap. The failure rate of these methods varies, ranging from 18 to 28%, which is significantly greater than the other methods.

Male condoms are critical for reducing the risk of sexually transmitted infections (STIs), for which the long-acting reversible contraceptives and hormonal methods are not effective. While barrier methods are effective in preventing STIs, they must be used correctly every time to reduce transmission of STIs and prevent pregnancy.

Combining two contraceptive methods, such as a condom with a spermicidal agent or a barrier method and one of the hormonal methods, increases effectiveness.

This Valentine's Day, show some love for contraception by learning more. Talk with your doctor about the best contraceptive option for you. ✚

More information can be found at
www.plannedparenthood.org/learn/birth-control

INSURANCE 'PRIOR AUTH DELAYS' HARM PATIENTS

Doctors Must Be Part of the Solution!

BY JEFF WIRICK, PENNSYLVANIA MEDICAL SOCIETY

Insurance companies say they use prior authorization to prevent physicians from prescribing too much medication or ordering too many tests. But physicians say the use of prior auth has grown out of control – and few stories illustrate it better than that of Joe Stanziano.

Stanziano, who currently resides in Montgomery County (Pa.), owned a bakery in New Jersey. Ten years of carrying heavy bags of flour and working 18-hour days took a toll on his back.

Stanziano had just undergone his fourth back surgery in five years and was taking pain medication to help with his recovery. Things were progressing well enough for Stanziano to begin taking a smaller dose of the pain medication – a process known as tapering that could eventually allow him to wean off the medication altogether.

The problem is, Stanziano's insurance company denied payment of the lower dosage that his neurologist prescribed. Hours turned into days and Stanziano continued to wait for his insurance company's approval.

When his current allotment of pain medicine ran out, the withdrawal symptoms began.

"Cold sweats. Shaking. You don't have control," Stanziano described.

This wasn't a one-time mistake by his insurance company.

Stanziano's neurologist prescribed a lower dose of pain medication five times. It was denied five times for up to a week before it was approved.

As the delays grew longer and withdrawals continued, Stanziano opted to buy the medication out of his own pocket. Each pill cost $60.

"One could imagine a reason for (denying it) if we're increasing the medication, but in Joe's case we were gradually decreasing the medication," said Daniel Skubick, MD, Stanziano's neurologist. "In spite of the fact that we were doing the right thing (by lowering his dosage) – getting him off opioids – pre-certs would still be coming."

Stanziano said he was never given a clear answer as to why his medication decrease required a prior authorization.

"You could talk to two different people (at the insurance company) in the same day and get two different answers," he said. "Explain to me the logic – why are you denying it when we were trying to reduce (the medication)? Does it make sense to you?

"Are you trying to cut costs, or are you trying to cut lives?" Stanziano continued. "I can understand trying to cut costs, but put them in my situation. Let them be on the medication for a certain period of time, and not be able to refill it, and have to go through what I went through."

PRIOR AUTHS ON THE RISE

Physicians have seen a dramatic rise in prior authorizations over the past few years for a variety of treatments and medications:

86 percent of respondents to a Medical Group Management Association survey said that they experienced an increase in the number of prior authorizations over the past year.

Medical practices average 37 prior authorizations per week, per physician (taking up an average of 16 hours per physician), according to a survey from the American Medical Association.

A few years ago, "If a narcotic that we're prescribing was thought to be at a very high dose, you might have a pre-cert," Dr. Skubick said. "But the prior auth would last 6-12 months and it might occur occasionally. Now, over the last few years or so, fueled by the opioid crisis, we're running into pre-certs whenever a change is made to the medication."

The delays are proving costly to patients. Here are just two more examples:

Pittsburgh's Jeff Duncan waited eight months for approval on an in-lab sleep study that he needed in order to receive treatment for his severe sleep disorder.

"What if I would have died with this?" he said. "Personally, I'm just irritated that the insurance companies have so much power over doctors trying to get their patients what they need."

Pittsburgh's Kristen O'Toole experienced delays in getting an MRI for her back pain. The weeks' long wait allowed her undiagnosed multiple sclerosis to progress, and she is now in a wheelchair.

"If I had gotten the MRI earlier and started on the infusions, I really believe it could have kept some of these symptoms at bay," O'Toole said. "Maybe I would have never ended up in a wheelchair."

"The doctor knows there's a problem here," O'Toole added. "There's something going on. And how is he going to know before he gets the data from the MRI?"

Dr. Skubick said his biggest frustration with the rise of prior authorizations is that it takes the clinical decision-making out of the hands of physicians.

"I think it is incredible that the insurance company would think that a person who has practiced neurology for 35, 40 years doesn't know more than somebody on the other end without seeing the patient," he said. "I've never had a pre-cert denied for any diagnostic study when I'm able to talk to a colleague that is a neurologist.

"But I'm talking to people (at the insurance companies) who are not even doctors some of the time. And sometimes when you do get a doctor, you're getting an internist or a gynecologist – what do they know about neurology? What do they know about the subtleties about whether an MRI is necessary?"

PHYSICIANS MUST BE PART OF THE SOLUTION

Oncologist Rick Boulay, MD, wrote a recent blog for KevinMD: "Most patients are unaware of this, but your physician is likely your biggest advocate when it comes to getting your care covered" from prior auth.

Similarly, physicians need to step up to support new legislation in Pennsylvania that aims to decrease patient wait times from prior auth.

House Bill 1293, introduced by Rep. Marguerite Quinn (R-Bucks), would:

Increase transparency and consistency in prior authorization criteria

Establish standards for and reduce the overuse of prior authorization

Lessen manual processes and enhance the electronic exchange of information

Develop a standard prior authorization form

The Pennsylvania Medical Society and its coalition of 50+ physician and patient advocacy organizations support HB 1293. But this legislation will only move with a strong grassroots effort from physicians, medical office personnel, and patients. ✚

SEE HOW YOU CAN GET INVOLVED BY GOING TO THE PAMED WEBSITE, www.pamedsoc.org/PriorAuth.

PA Supreme Court Ruling Impacts How Physicians Obtain Informed Consent

BY THE PENNSYLVANIA MEDICAL SOCIETY

In a June 20, 2017, decision regarding the Medical Care Availability and Reduction of Error (Mcare) Act's informed consent requirement, the Pennsylvania Supreme Court ruled that a physician may not delegate to others his or her obligation to provide sufficient information in order to obtain informed consent—the duty to obtain a patient's informed consent is a non-delegable duty owed by the physician conducting the surgery or treatment.

In Shinal v. Toms, a patient alleged that her surgeon failed to provide information required to obtain informed consent prior to the removal of a non-malignant brain tumor. The trial court provided instructions to the jury, permitting them to consider information provided by the surgeon's physican assistant as part of the informed consent process. The trial court subsequently found in favor of the surgeon.

The patient later appealed to the Superior Court, challenging the trial court's instruction. The Superior Court agreed with the trial court's instruction and held that information provided by a surgeon's qualified staff could be considered part of the informed consent process.

The Pennsylvania Medical Society (PAMED) – with support from the American Medical Association (AMA) – filed an amicus brief of the Superior Court's holding that information provided by a physician assistant or other qualified assistant can be used to obtain a patient's informed consent for surgery.

Following arguments before the Pennsylvania Supreme Court in November 2016, the Court issued its decision in the matter on June 20, 2017. The Pennsylvania Supreme Court reversed the Superior Court's order affirming the trial court's jury instruction.

The duty to obtain a patient's informed consent is a non-delegable duty, the Pennsylvania Supreme Court ruled, belonging solely to the physician conducting the surgery or treatment. The Court found no provisions in the Mcare Act allowing for information given by a physician's subordinates to satisfy the physician's burden to obtain informed consent.

Furthermore, the Court held that a physician cannot be confident that a patient comprehends the risks of and alternatives to treatment without direct dialogue. The physician personally satisfying the duty of disclosure ensures that the patient's consent is truly informed.

Reversing the trial court and Superior Court's judgment in favor of the defendant surgeon, the Supreme Court has remanded the case for a new trial.

The decision in Shinal v. Toms could have significant ramifications for Pennsylvania physicians. With this decision, the Pennsylvania Supreme Court holds that physicians alone have the duty to provide patients with the sufficient information required to obtain informed consent. Thus, Pennsylvania physicians can seemingly no longer rely upon the aid of their qualified staff in the informed consent process.

PAMED members can access member-only resources at www.pamedsoc.org/informedconsent, including a Quick Consult fact sheet and brief video, that summarize a physician's obligations under Pennsylvania's informed consent law, discuss potential legal risk, and provide recommendations.✚

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PA MEDICAL SOCIETY QUARTERLY
LEGISLATIVE UPDATE
SEPTEMBER 2017

On June 30, 2017, the General Assembly approved a nearly $32B spending plan. The plan eventually became law without Governor Tom Wolf's signature. What the legislature has yet to accomplish, nearly three months later, is approval of a plan to raise the revenue for the state's budget. Most recently, the Senate rejected a proposal passed by House Republicans that omitted new taxes in favor of a series of one-time special fund transfers to the General Fund. The House bill differs from a previously passed Senate plan that, among other things, levies additional taxes on natural gas producers, a proposal that lacks support in the House.

To reach a compromise between the two plans, the Senate has proposed that both chambers form a conference committee tasked with negotiating a deal for the Governor's desk. Considering the ongoing uncertainty surrounding this year's budget, the rating agency Standard and Poor's recently downgraded the commonwealth's credit rating from AA- to A+.

SB 25 – CRNP Independent Practice (Introduced by Senator Bartolotta)

Since its passage in the Senate this Spring, neither SB 25 nor HB 100 granting independent practice to CRNPs have seen any movement. The legislation remains in the House Professional Licensure Committee. To date, Committee Chairman Mark Mustio has given no indication that he plans to bring the legislation before the committee for consideration.

In August, PAMED leadership met with the Pennsylvania Coalition of Nurse Practitioners to discuss the pending legislation and the opposing organization's goals. Although no major agreement was reached, the discussion allowed both sides to clarify the rationale behind their respective positions.

Prior Authorization Legislation Introduced by Rep. Marguerite Quinn (R-Bucks)

Representative Marguerite Quinn, along with 38 bi-partisan co-sponsors, introduced HB 1293 earlier this session. This legislation will improve transparency, accessibility and the consistent application of prior authorization by including a standard definition. It will also significantly streamline the process by requiring insurers to make available an electronic communications network that permits prior authorization requests to be submitted electronically, and authorizations and adverse determinations to likewise be returned electronically.

Over the past several months, government relations staff has worked closely with Representative Quinn in developing HB 1293 and making improvements over last session's version. Prior to its introduction, staff met with House members to explain the need for the legislation and to secure an adequate number of legislative sponsors.

A significant grassroots effort that asks physicians to engage patients is already underway. The goal of this initiative is for patients to ultimately share their medical challenges with the prior authorization process with their legislators.

HB 1293 has been referred to the House Insurance Committee. PAMED is now arranging direct physician contacts with committee members and continuing the process of educating legislators as to how prior authorization can negatively impact patient care. The next legislative goal is to secure a committee vote on the bill before the end of the year, if not sooner.

Pennsylvania Orders for Life-Sustaining Treatment (POLST)

In early September, House Majority Whip Bryan Cutler introduced House Bill 1196, the Pennsylvania Orders for Life Sustaining Treatment (POLST) Act. The introduction of this legislation, and with such a highly-regarded sponsor, represents a major step forward for a multi-year, collaborative effort that drew on the expertise of twenty-seven health care and patient advocacy organizations. During a press conference this Spring, Senator Gene Yaw also announced his intention to introduce similar legislation in the Senate. He is expected to formally introduce that bill soon.

To prepare for its introduction in the Senate, PAMED's lobbyists recently joined Daniel Kimball, MD, in meeting with Senator Lisa Baker, chairwoman of the Senate Health Committee where the legislation will likely be sent. The meeting was quite productive and the Senator expressed interest in addressing this issue. In the House, the POLST Act has been sent to the Judiciary Committee, but PAMED expects that it may soon be rereferred to the Health Committee.

Credentialing

In cooperation with the Hospital and Health Systems Association (HAP), PAMED was successful in securing the passage of House Bill 125 from the House Health Committee. The legislation was subsequently passed by the full House on May 24, 2017 (190-0). HB 125 will now be considered by the Senate Banking and Insurance Committee, where it will continue to face strong opposition from the insurance industry.

Telemedicine

Last session, legislation was introduced in both the Senate and House of Representatives to provide statutory guidelines related to the practice of telemedicine. As expected, the bills did not move but succeeded in generating discussion among key stakeholders. This session, ongoing efforts, largely taking place in the Senate, to address concerns from all stakeholders has delayed formal introduction of legislation. Two primary issues, guaranteed reimbursement for telemedicine services and a question of mandating the availability of video (PAMED and HAP are opposed to audio only), slowed down the advancement of this issue.

Before the legislature recessed in July, Senator Elder Vogel formally introduced SB 780, a version that has the support of both PAMED and HAP. Representative Marguerite Quinn is expected to introduce a companion bill, with identical language, in the near term.

Federal Medical Liability Legislation

HR 1215 has cleared both the House Judiciary and the House Energy and Commerce committees. PAMED had previously sent a letter to the House delegation from PA as well as key congressional staff urging support for HR 1215. The bill may come up for a vote soon but because it is identified as health care reform, it could be delayed. ✚

LCMS NEWS

Upcoming Meetings

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.

APRIL 17, 2018

Recognizing and Responding to Children at Risk - Suspected Child Abuse & Neglect (SCAN) Education for Physicians

SCAN is a program of the PA Chapter, American Academy of Pediatrics and is approved for Act 31.

The Pennsylvania Medical Society designates this live activity for a maximum of 2.0 AMA PRA Category 1 Credit(s)™. Physicians should only claim credit commensurate with the extent of their participation in the educational activity.

MAY 5, 2018

Annual Social at Lehigh Country Club

NEW MEMBERSHIP

M. Usman Ahmad
(Medical Student)

Tatiana Arolli, DO (IM),
2545 Schoenersville Rd., Fl. 2, Bethlehem;

Melissa Ann Brodsky, MD (AN)
4905 W Tilghman St, Ste 250, Allentown;

Francis Burt, MD (IM-CD)
1469 8th Ave, Bethlehem

Victoria I. Chen, DO (ISM)
LVH-Graduate Medical Education, Allentown

Fan Cheng, MD (FP)
1545 Broadway, Bethlehem

Emily Du (Medical Student)

Michael C. Engels, MD (GE)
1501 N Cedar Crest Blvd., Ste 110A, Allentown

Kelly M Freed, MD (R)
1255 S. Cedar Crest Blvd., Ste 2500, Allentown

Christin M. Gillier, MD (OBG)
2200 St. Luke's Blvd, Ste 403, Easton

Jeffrey Phillip Gordon, MD (ICE-CD)
1250 S Cedar Crest Blvd., Ste 300, Allentown

Lauren Nicole Hibshman
(Medical Student)

Haoli Jin, MD (AI-PD)
3178 W Tilghman St., Allentown

Sean R. Lacey, MD (GE)
3131 College Heights Blvd., Ste 1200, Allentown

Sean J. Lewis, DO (FM)
4520 Park View Dr., Schnecksville

Yee Cheng Low, MD (PS)
1243 S Cedar Crest Blvd., Ste 301, Allentown

Craig Mackaness, DO (NEP-IM)
1230 S Cedar Crest Blvd., Ste 301, Allentown

James Marco, MD (AN)
4905 W Tilghman St., Ste 250, Allentown

Sharon E. Maynard, MD (NEP)
1230 S Cedar Crest Blvd., Ste 301, Allentown

Anuj Mehta (Medical Student)

Michael D Misbin, MD (AN)
4905 W Tilghman St., Ste 250, Allentown

Shairko Missouri, MD (AN-APM),
4905 W. Tilghman St., Ste 250, Allentown

Kyra Munzenmaier (Medical Student)

Aedan S.A. Olaso, MD (NEP)
1230 S Cedar Crest Blvd., Ste 301, Allentown

Leigh-Anne Piechta, DO (PM)
1255 S Cedar Crest Blvd., Ste 2100, Allentown

David Christopher Roy, MD (ORS),
St Luke's Orthopedic Surgery Residency,
801 Ostrum St., Bethlehem

Harinder Kaur Singh, MD (NEP-IM)
1230 S. Cedar Crest Blvd., Ste 301, Allentown

Megan Joy Wuebber, DO (EM)
Lehigh Valley Health Network-EM Residency,
2545 Schoenersville Rd., Bethlehem

Karl N Yaeger, MD (DR)
95 Highland Ave., Ste 130, Bethlehem

Shawn Terrence Yeazell, MD (ORS-Res.)
1021 Park Ave., Quakertown

REINSTATED MEMBERSHIP

Ravindra Bollu, MD (NEP)
1230 S Cedar Crest Blvd., Ste 301, Allentown

Shawn M Hazlett, DO (NEP)
1230 S Cedar Crest Blvd., Ste 301, Allentown

Jillian Faith Paprota, DO (IM)
1243 S Cedar Crest Blvd., Ste 2200, Allentown

James P. Reichart, II, MD (NEP-IM)
1230 S Cedar Crest Blvd., Ste 301, Allentown

Migdalia Resto, MD (NPM)
PO Box 7017, 17th & Chew St, 1200 S. Cedar Crest Blvd., Allentown

Rohit Sharma, MD (GS)
1240 S. Cedar Crest Blvd., Ste. 205, Allentown

Joseph L. Yozviak, DO (IM)
1627 Chew St., 3rd Flr., Allentown

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