

LEHIGH COUNTY

# Health & Medicine

Official Publication of The Lehigh County Medical Society

## **JUST A LITTLE SUGAR**

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**FALL PREVENTION TIPS  
FOR OLDER ADULTS:**

*A Physical Therapist's Perspective*



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**Correction** - We express our sincerest apologies to Dr. Leigh-Anne Piechta for misspelling her name in the byline associated with her article on Peripheral Neuropathy that appeared in our last issue. The correct byline should be Leigh-Anne Piechta, D.O.



### 4 IN THIS ISSUE

#### ON THE COVER

#### 6 JUST A LITTLE SUGAR Can Predict a Big Problem

By Linda M. Famiglio, M.D., F.A.A.P.

#### FEATURES

#### 9 FALL PREVENTION TIPS FOR OLDER ADULTS

A Physical Therapist's Perspective  
By Lynn Gerlach

#### 10 COMPASSIONATE, VALUABLE AND AFFORDABLE HEALTHCARE

By George A. Arangio, M.D.

#### 13 FOLLOW UP ON LEHIGH VALLEY ANTI-HUNGER EFFORT

#### 14 TALK READ SING New Campaign Promotes Brain Development and Literacy Skills Among Babies and Toddlers

By Laura McHugh

#### 17 TRADITIONAL PBM's: What's Behind the Curtain

By Andrew Colvin, PHARM.D., MBA  
Theresa T. Doan, PHARM.D., MS  
Catherine J. Burke, Steven T. Boyd, PHARM.D., BCPS, Suzette Benedick, MBA

#### 20 COMMUNITY HEALTH Does a Doctor's Job End in the Clinic?

By M. Usman Ahmad

#### 23 MINIMALLY INVASIVE LUMBAR DECOMPRESSION

#### 24 THE BENEFITS OF PHYSICAL THERAPY

By Mari Wahlgren, PT, MSPT, ATC, CLT-UE

#### 26 A NEW APPROACH TO BACK PAIN: The Right Treatment with the Right Specialist at the Right Time

#### 28 QUARTERLY LEGISLATIVE UPDATE

#### 30 PENNSYLVANIA'S TOP PHYSICIANS UNDER 40 in Lehigh County

#### 31 LCMS NEWS



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## IN THIS ISSUE



**BRUCE D. NICHOLSON, MD**  
*Lehigh County Medical Society President*

Welcome to our fall issue of the Lehigh County Medical Society magazine, *Lehigh County Health and Medicine*.

Once again, we're offering information on a range of health issues, from diabetes, back pain, and fall prevention tips for seniors, to how to help our youngest residents learn and read.

Our goal is to offer you insightful information, helpful statistics, and tips and tools to consider using in your own lives and practices. The article on diabetes/prediabetes should get you thinking about your own lifestyle and what steps you might want to consider. The article on Pharmacy Benefits Managers (PBMs) describes what these organizations do and suggestions for what to look for in your PBM. Another piece from the United Way of the Greater Lehigh Valley discusses their new program "Talk, Read, Sing," a program they hope will improve literacy skills among babies and toddlers. Two articles on back pain discuss back pain and physical therapy, and an option to deal with Lumbar spinal stenosis.

There are some fascinating opinion pieces in this issue as well. One looks at the politics of medicine; the other by a physician shares his thoughts on the costs of medicine and how we might be able to lower costs without negatively affecting the quality of care.

We hope you enjoy this and past issues as we add to the conversation about how medicine and wellness can help us form strong communities in Lehigh County. If you are interested in back issues, or just want to read *Lehigh County Health and Medicine* online, please visit our website at <https://lcmesoc.org/our-publication>.

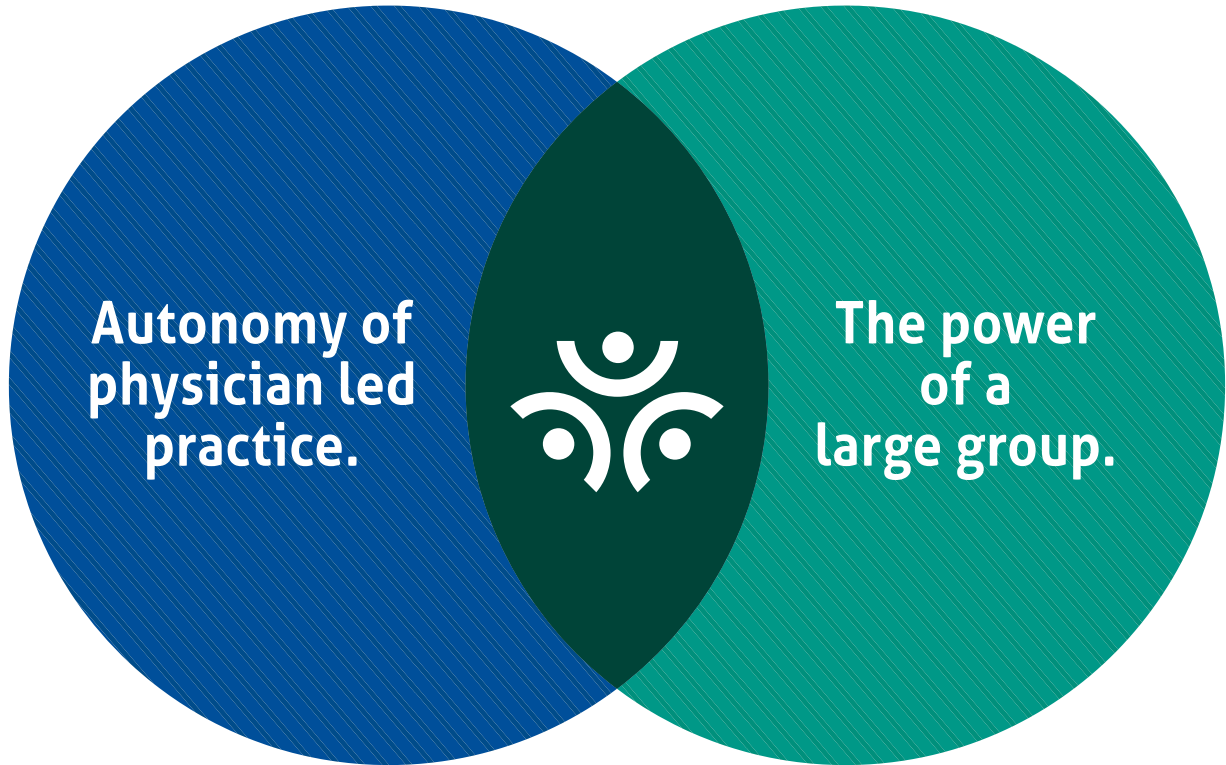
If you have ideas or suggestions for upcoming issues, please consider contacting us. Thank you for reading! +



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# **JUST A LITTLE SUGAR**

can predict a big problem

BY LINDA M. FAMIGLIO, M.D., F.A.A.P.

## Do you know what your patients' fasting plasma glucose is? Maybe.

## Do your patients know their numbers? Probably not.

## Do you know your own? If not, it's time to find out.

There is an epidemic of diabetes in Pennsylvania and throughout the United States, but with the Diabetes Prevention Program (DPP) initiative from the AMA and CDC, it is an epidemic that can be reversed. An estimated 325,000 adult, Pennsylvanians have type 2 diabetes and do not even know it. Even more compelling, one-third of Pennsylvania's adults or 3.5 million people, have prediabetes, diagnosed as a fasting plasma glucose between 100 and 125 mg/dL. Prediabetes is also diagnosed by a blood test finding of hemoglobin A1C between 5.7 and 6.4%. These values are higher than normal but not high enough to diagnose type 2 diabetes; patients in this category have sometimes been told they have "a little sugar." Prediabetes is asymptomatic, so patients are often not aware. In fact, a survey completed by the Centers for Disease Control (CDC) between 2005–2010 found that 9 out of ten adults with prediabetes did not know they had it.

Progression from prediabetes to diabetes is affected by numerous risk factors, and although it is difficult to

predict for any one patient, the AMA initiative to stop this epidemic projects that if left untreated, 15–30% of people with prediabetes will progress on to develop type 2 diabetes in the next 5 years. Those at greatest risk are those with the highest laboratory abnormalities.

When prediabetes is diagnosed, increased physical activity and healthy eating can help patients to reverse some of the risk factors. The landmark paper that described the conditions leading to risk reduction was published in the *New England Journal of Medicine* in 2002. Longitudinal follow up has supported the key findings. The study found that people with prediabetes who followed the structured Diabetes Prevention Program (DPP) reduced their risk of developing type 2 diabetes by 58% compared to placebo at an average of three years follow up. The reduction in risk was even greater for those over 60 years old (71% risk reduction). Even 15 years later, patients with prediabetes who followed a lifestyle change program experienced a 27% reduction in the incidence of diabetes. In those who do go on to develop diabetes, the initiative is estimated to delay the onset of diabetes by a median of 4 years.

### WHAT CAN PHYSICIANS DO?

#### STEP ONE: CREATE AWARENESS.

We know from the smoking cessation literature that patients are more likely to respond when physicians recommend change. Also, physicians can role model lifestyle changes. Find out about your own risk factors and act on them. Encourage your staff or fellow employees to investigate their own risk factors, too. Participate in wellness programs in your organization.

#### STEP TWO: SCREEN YOUR PATIENTS. DOCUMENTING THE DIAGNOSIS OF PREDIABETES CAN OPEN UP DISCUSSIONS AND PREVENTION OPPORTUNITIES.

Use the CDC prediabetes screening test or the American Diabetes Association Diabetes Risk Test. Arrange for lab testing before patient visits. Engage with your practice managers to use your electronic health record to identify your patients at risk.

#### STEP THREE: EDUCATE YOUR AT-RISK PATIENTS.

The Prevent Diabetes Stat Toolkit includes ready to use downloadable materials for patients, including the risk tools described earlier and motivational sheets in English and Spanish.

#### STEP FOUR: REFER TO AN EVIDENCE-BASED DIABETES PREVENTION PROGRAM.

In the Lehigh Valley programs are available through some pharmacies and employers. For example, Wegmans will be piloting a program with their own employees. St. Luke's University Health System created a similar program for their employees. Also check with the local YMCA; the Bethlehem branch has an approved program. Also, the Neighborhood Health Center of Lehigh Valley offers programs.

#### STEP FIVE: FOLLOW UP.

Plan follow up office visits, ask your patients about their progress, and review the reports from the DPP.

### SUPPORTING PHYSICIANS IN HELPING THEIR PATIENTS

This year Medicare began covering a set of services from the program for eligible beneficiaries with elevated BMI, abnormal screening labs who do not yet have diabetes or end-stage renal disease. Coverage began after a demonstration project conducted by the YMCA of the USA tested the delivery of the DPP and found that it improved health and

*Continued on page 8*

# HEALTH BURDEN OF DIABETES

Compared to people without diabetes, those with diabetes are:



<sup>1</sup> Gilliespie CD, Morone EA, Centers for Disease Control and Prevention (CDC). Prevalence of hypertension and controlled hypertension - United States, 2007-2010. *JAMA*. 2013;309(14):1443-1444.  
<sup>2</sup> Centers for Disease Control and Prevention. *National Diabetes Statistics Report: Estimates of Prevalence and To Burden in the United States, 2014*. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; 2014.

saved Medicare money. Also, there are two qualifying Merit-based Incentive Payment System (MIPS) activities related to DPP: glycemic screening services (IA\_PM\_19) and Chronic Care and Preventative Care Management for Empowered Patients (IA\_PM\_13).

More information about CME credit is available from the steps forward AMA program: [www.stepsforward.org/modules/prevent-type-2-diabetes](http://www.stepsforward.org/modules/prevent-type-2-diabetes).

The time is now to become aware and engage in lifestyle change for our communities as well as our individual patients. The *New England Journal of Medicine* published a Perspectives article “A Road Map for Sustaining Healthy Eating Behavior” August 9, 2018, asking, “So what do we do?” Dr. Bleich calls us to use our medical model of improving care for the patient in front of us simultaneously with our public health measures that take into account the social determinants of heart-healthy food banks, radically altered school lunches, and even soda taxes. This epidemic does have a solution. Screen for elevated fasting plasma glucose, and arm yourself and your patients with the knowledge that altering risk factors can prevent diabetes now. +

## RISK FACTORS FOR PREDIABETES MIRROR THOSE OF DIABETES

- **Overweight or obesity**
- **Increasing age**
- **Family history of type 2 diabetes**
- **Racial/ethnic minorities**
- **Sedentary lifestyle**

## KEY ELEMENTS OF THE DIABETES PREVENTION PROGRAMS

- **Physical activity** (not necessarily exercise) **150 minutes/week**
- **Healthy eating**
- **No specific diet required**
- **Small group meetings**  
Once a week for 6 months then 1-2x/month
- **Lifestyle coach**  
Trained to deliver the CDC curriculum

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Bleich SN A Road Map for Sustaining Healthy Eating. *N Engl J Med*. 2018;379:507-509.

Pennsylvania Medical Society's resource pages: <https://www.pamedsoc.org/advocate/healthy-communities/prevent-diabetes>

The main AMA website for the tool kit and information: <https://assets.ama-assn.org/sub/prevent-diabetes-stat/>

The CDC site including a program locator: <https://www.cdc.gov/diabetes/prevention/index.html>

PA Department of Health information: <https://www.pilot.health.pa.gov/topics/disease/Pages/Diabetes.aspx>

Payment and value based incentive information from Medicare: <https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/2018-Resources.html>



Physical therapy can help older adults prevent falls by improving strength, flexibility, balance, coordination and mobility.

# FALL PREVENTION TIPS FOR OLDER ADULTS:

## *A Physical Therapist's Perspective*

BY LYNN GERLACH,  
Good Shepherd Rehabilitation Network

Falling is a serious problem among our senior population. One in three adults over the age of 65 falls each year, resulting in more than 700,000 hospitalizations due to associated injuries, from hip fractures to brain trauma.

In fact, according to the Centers for Disease Control and Prevention, falls account for 4 out of every 5 injury-related hospitalizations for seniors. Even worse, 20 percent of deaths related to an injury can be traced back to a fall.

“As rehabilitation specialists, we see all kinds of injuries related to falls, including shoulder rotator cuff injuries, elbow and wrist fractures, hip fractures, back, spinal cord and brain injuries,” says Frank Hyland, PT, MS, Executive Director at Good Shepherd Rehabilitation Network. “What might be a simple trip and fall in the bedroom can turn into something needing long-term rehabilitation that can significantly change the patient’s life.”

According to Hyland, there are many obstacles around the house that can contribute to falls, including pets underfoot, clutter, cords and narrow passageways. Clothing, loose footwear, slippery socks, oversized pants, robes and sleepwear can be the culprit, as can climbing on an unsteady step stool or slipping on a wet or icy surface.

For a variety of reasons, seniors are more vulnerable to falls than other age groups. As a whole, seniors are more likely to struggle with health conditions like muscle weakness, vision changes, sensation changes, blood pressure and/or balance problems, inactivity or the improper use of an assistive device, any of which can leave them susceptible to falls.

## SIMPLE TIPS TO REDUCE FALL RISK

Good Shepherd offers the following simple tips to help seniors to reduce their fall risk:

### **Exercise regularly.**

Strength improves balance and coordination.

**Ask your doctor or pharmacist about medicines** that make you dizzy or sleepy to see if any adjustments should be made.

**Get up slowly after sitting or lying down.**

**Wear sturdy shoes with thin, non-slip soles.**

**Use a personal emergency alert system** to call for help in the event of a fall.

**Have regular vision screenings** and wear corrective lenses as prescribed.

**Do not carry too much at once.**

Take an extra trip or use a backpack to keep hands free for hand rails, a cane or walker.

Despite the increased risk, falling is not inevitable, says Hyland.

“There are many things seniors can do to lower their risk of falling, from addressing health issues to implementing safety measures at home,” says Hyland.

There also are simple modifications seniors can make at home to improve safety, says Hyland. He suggests either removing rugs or fastening the edges to the floor, using non-slip mats in the tub or shower and installing grab bars in the bathroom.

While looking at the home environment, a quick clean-up can go a long way to prevent tumbles. Seniors especially should look to reduce clutter, arrange furniture to keep pathways open, ensure thresholds and steps are adequately lit and use pet gates or crates to keep animals out from underfoot.

If you are concerned about your own fall risk or that of a loved one, a physical therapist can help older adults by reviewing their medical history, completing an evaluation and developing an individualized treatment program to improve strength, flexibility, balance, coordination and mobility. A physical therapist can make recommendations for assistive devices, such as a walker or cane, if appropriate, and show older adults how to properly use them.

After a fall, Hyland advises not trying to move the patient on your own. There may be unseen injuries or fractures, which could be worsened by movement. If you are in doubt, call 911 instead, as the patient may need stabilization to prevent further injury. +

OPINION

A close-up photograph of two hands, palms up, holding a bright red, textured heart. The hands are weathered and show signs of age. The heart is the central focus, resting in the center of the palms. The background is a neutral, light gray.

# Compassionate, Valuable and Affordable Healthcare

BY GEORGE A. ARANGIO, M.D.

The 2010 ACA Bill is the law of the land and adds to the healthcare “inefficiencies.” Physicians should be allowed to practice medicine unimpeded by government. Drug companies, insurance companies, the Hospital Association and the American Bar Association have strong lobbies. “The lobbyists spend \$6 billion a year on 532 members of Congress or \$11.2 million per person.”<sup>1</sup> The good news is the Independent Payment Advisory Board (IPAB) has been disbanded.

Healthcare costs rose 4.5% in 2017. In 2018 a Medicare and Medicaid deficit of over \$1 trillion will be added to the National Debt. The Dartmouth Institute for Health and Clinical Practice reports that changing how U.S. healthcare is delivered and managed can save more than \$900 billion a year,<sup>2,3,4</sup> enough to pay for care for all American citizens.

Four giant medical group purchasing organizations (GPO) lead to shortages and increased prices. This secretive GPO industry shares profits with hospitals and their executives and leads to an estimated 30% increase in costs. In the 1980s Congress exempted GPOs from the anti-“kickback” laws. Today physician associations are calling for a repeal of kickback exemptions.<sup>5</sup>

Concern over high prices of prescription drugs unites Americans and payers are fighting back. Employers in the Healthcare Transformation Alliance (HTA) negotiate to win better contracts from “Big Pharma” and in 2018 the HTA reduced drug cost a median of 15%.<sup>6</sup>

More primary care physicians with sound data can increase efficiency and decrease the cost of U.S. healthcare with better outcomes. This is working in other countries. Healthcare must address pressure from patients to over prescribe, and counsel physicians who profit from drugs and tests they order.<sup>7</sup> Physicians hold the “pen” that spends healthcare dollars.

“According to the CDC, 86% of all healthcare spent in the U.S. is for patients with chronic illness.”<sup>8</sup> “The only interventions that change behaviors are based on financial incentives and face

to face relationships with healthcare coordinators.”<sup>9</sup>

Despite a 12% decrease in opioid prescriptions in 2017<sup>10</sup>, America faces a drug crisis. Primary care physicians address this issue by utilizing Prescription Drug Monitoring Programs and prescribing non-narcotic pain killers and anti-inflammatory drugs. Pharmaceutical companies need to help pay for this national epidemic.<sup>11</sup>

A digital revolution which will transform healthcare is coming. Patients can use smartphones to monitor healthcare. Home care is increasing. Sharing data is creating valuable medical algorithms for diabetes, hypertension, hyperactivity disorder and other problems. Security is a concern but can be overcome.<sup>12</sup>

Over 80 percent of U.S. physicians use electronic medical records. Forty-five percent of hospitals use electronic “record alerts” to guide physicians for back pain imaging, CT scans for head injuries and other treatments. This care may be unnecessary and harmful. Overuse of medicine is “pervasive, harmful and costly.”<sup>13</sup>

The most important step in making a correct diagnosis is “medical history.” Artificial Intelligence (AI) can diagnose faster and more accurately than the physician. When input is comprehensive and accurate, physicians and AI will gather and synthesize opinions and data from multiple treating physicians with better diagnoses.<sup>14</sup>

Physicians receive bundled fees for some specialized procedures. Large corporations like Amazon are evaluating new agreements with healthcare providers such as flat fees for care that will save hundreds of millions of dollars annually.<sup>15</sup>

In 2020, \$207 billion is estimated to be billed to patients for cancer care. In 2015, major cancers passed \$173 million to patients for ads encouraging cancer treatment. Only 18% mention screening and 2% mention risks.<sup>16</sup> Healthcare providers can provide hope and be transparent.

In small and early cancer of the prostate, active surveillance is the safe treatment of

choice. A 2017 report in the *Journal of Urology* said with proper counseling, there was a 30% decrease in “unnecessary curative treatment” among patients.<sup>17</sup>

A 2017 study found in patients with stable angina, stents resulted in no statistical difference compared to medical treatment. Unnecessary insertion of stents fell by 50% between 2010 and 2014.<sup>18,19</sup> Physician and patient discussion of treatment is a teaching opportunity.<sup>20</sup>

Physicians limit Foley catheters to 3 days, then order straight catheterizations each 8 hours or use uro-sheaths. In the elderly, physicians reduce doses and review narcotic prescriptions every 72 hours. After a culture, sterile “needle tip” transfer for wounds, physicians order culture specific antibiotics. These clinical “pearls” of the ’70s are best practice today. Data proves they save lives and decrease complications and cost.

Primary care physicians and specialists can reduce costs for hospitalizations for chronic diseases by eliminating unnecessary prescriptions; prescribing generic drugs; eliminating unnecessary tests and eliminating unnecessary procedures. Hospitals and insurance companies can cut their excessive management positions and salaries.<sup>21</sup> The Centers of Medicare and Medicaid Services and the Government Accounting Office report that eliminating “up-coding” would save \$200 billion a year.<sup>22</sup>

Contrast the situation of excess in the U.S. with the rest of the world where 50 % of people don’t have access to essential health services like HBP checks, basic HIV treatment, tuberculosis and malaria prenatal care. Out of pocket payments are rising worldwide and \$200 billion of \$500 billion is wasted annually.<sup>23</sup> A strong primary care system is an essential precondition for an affordable healthcare system.<sup>24</sup>

We can have affordable, valuable healthcare for all American citizens. We can pay for needed healthcare and new technology by saving more than \$900 billion per year in excess healthcare. Lehigh Valley partnerships plan to save more than \$15 million a year. A Group Purchasing

*Continued on page 12*

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**FEATURE**



Organization in New Jersey and Pennsylvania decreases costs and increases value.

Taxing tax deferred employee healthcare benefits will add \$450 billion of new revenues annually.<sup>25</sup>

Primary Care physicians and healthcare teams can care for the poor and elderly, disabled and the mentally ill. I favor compassionate, valuable and affordable local healthcare for all American citizens.

The elephant in the room is the more than \$900 billion per year of healthcare “inefficiencies.” Physicians hold the “pen” that spends healthcare dollars. We can do better. +

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## *Follow up on* **LEHIGH VALLEY ANTI-HUNGER EFFORT**

**T**his past summer, many community partners joined together to impact hunger and food insecurity among youth in the Lehigh Valley. The Lehigh County Medical Society and the Lehigh Valley Independent Physician Group's donations toward this cause enabled one of the area's 5 new "open" feeding sites to cover startup costs and purchase supplies. This site, the Allentown Health Bureau/Alliance Hall of Allentown, is one of the five offering free meals to area youth aged 18 or under through the Federal Summer Foodservice Program apart from recreational or educational activities. Each site must have a "sponsor" who contracts to prepare the meals for the serving sites. Lehigh Valley Children's Centers sponsored the Alliance Hall site. The site, which opened on July 2nd, served a total of approximately 120 children. About 350 meals were served.

**ALLENTOWN HEALTH BUREAU  
STAFF AND VOLUNTEERS FROM THE  
ALLENTOWN VOLUNTEER MEDICAL  
RESERVE CORPS AND PARTNERING  
ORGANIZATIONS STAFFED THE  
SITE WHICH SERVED MEALS FROM  
1-2PM WEEKDAYS THROUGH  
JULY AND AUGUST.**

In August, Allentown was one of 6 cities nationally to receive an anti-hunger grant from the National League of Cities (NLC) and the Food Research and Action Center (FRAC) to expand after-school and out-of-school meal programs. These grant funds will augment Allentown anti-hunger efforts going forward. +

# Talk Read Sing

New campaign promotes brain development and literacy skills among babies and toddlers

BY LAURA MCHUGH,  
United Way of the Greater  
Lehigh Valley

**R**esearch shows that by the time children of low-income households enter kindergarten, they have heard 30 million fewer words than those in high-income households.

“In the Greater Lehigh Valley, statistics show that two out of every three children are not ready for kindergarten on time,” reported Jill Pereira, Vice President of Education for United Way of the Greater Lehigh Valley. “By the time that they reach third grade, a third of them are not reading on grade level, increasing the likelihood that they’ll drop out of high school. We have a bold goal to ensure all children are reading on grade level by the year 2025. We’re working with partners to level the playing field, so that all kids have the chance to succeed.”

For United Way and its partners, that means an intentional focus on literacy starting at birth.

According to the National Scientific Council on the Developing Child at Harvard University, experiences build brain architecture. While genes provide the basic blueprint, experiences shape the process that determines whether a child’s brain will provide a strong foundation for all future learning, behavior and health.

“By age three, 85% of a child’s core brain structure is already formed. If we’re waiting until kids start school to focus on literacy, we’re too late,” remarked Kelly Berk, MPH, BSN, RN, a member of the United Way-led Early Childhood Coalition, who specializes in maternal-child health as Network Director of Community Care Coordination for St. Luke’s University Health Network.

“We have a great opportunity to impact the success of our young children. We need to work with families to get them talking, reading and singing to their children,” said Berk.

According to the United States Department of Education, disparities in developmental outcomes emerge in infancy and widen in toddlerhood. A child from a low-income household is typically already 12-14 months below national norms in language and pre-reading skills by the time they enter kindergarten. “Quality early learning and parental involvement during a child’s first five years is a key factor affecting their literacy success and puts them on the path to reading on level in third grade,” said Pereira.

## For United Way and its partners, that means an intentional focus on literacy starting at birth.

In late 2018, more than 30 partners in the Early Childhood Coalition will launch a new campaign to promote early literacy skills among babies and toddlers. Adapted from a national program, Talk, Read, Sing includes multi-media messages and environmental prompts to teach parents and caregivers how to advance their children’s literacy skills from the time they’re born.

“Through the use of billboards, public service announcements and posters, Talk, Read, Sing takes everyday situations and turns them into learning opportunities,” said Pereira.

Talk, Read, Sing shares with parents and caregivers how simple actions — like describing objects seen during a walk or bus ride, singing songs or telling stories — can significantly improve a baby’s ability to learn new words and concepts.

“When parents talk to their children, they teach them vocabulary that enables them to build their stores of knowledge in ever increasingly complex networks that afford them a greater understanding of the world around them. Parents also teach their children how our language works, how sounds go together to form words and words to sentences, and how these all have meaning. These are keys to bringing life to words on a page. And when

all of this happens in a positive, nurturing context of social interaction, parents foster young children’s motivation to learn and positively affect their learning,” reported Robin Hojnoski, Ph. D., Associate Professor in Lehigh University’s College of Education and a member of the Early Childhood Coalition.

“Talk, Read, Sing is particularly promising because of its multi-pronged message — it goes beyond reading to include talking and singing — forms of interaction that some parents might feel more comfortable with or prefer,” added Dr. Hojnoski.

To spread the message, coalition members look to trusted community figures. “It’s been exciting to see how people have already embraced Talk, Read, Sing,” said Megan Radcliff, Kindergarten Readiness Coordinator VISTA at United Way. “Business owners and community leaders are excited to join us. They want to know how they can help, so you’ll see these messages and prompts in a number of community spaces such as churches, health centers, barber shops, grocery stores and laundromats.”

As a result of this campaign, Pereira expects more students to enter kindergarten ready academically, socially and emotionally in the next three to five years. Meanwhile, she hopes moms, dads and family members make new connections with their children. “Through Talk, Read, Sing,” she said, “we hope parents and families recognize their power in the future success of their children.”

Led by United Way of the Greater Lehigh Valley, the Early Childhood Coalition is comprised of educators, community members, parents, and others who work collaboratively to impact the language and literacy development of children, birth to 5 years old. The mission of the Early Childhood Coalition is that all children, birth to 5 years old, will achieve the widely held expectations in the developmental domains of language and literacy. The vision of the Early Childhood Coalition is that each child in the Lehigh Valley is reading on grade level by the end of the third grade. +



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# Traditional PBMs:

*What's Behind the Curtain*



BY ANDREW COLVIN, PHARMD., MBA  
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**W**e have been hearing about “transparency in healthcare” for a decade. However, we have not yet achieved the transparency goal as one of the sectors in the healthcare industry has not pulled back the curtain to reveal the deceptive practices used to place their product in front of the consumer and profits in their pockets. The ACA gave us their version of transparency by regulating data that medical consumers should have to make informed medical decisions. We have access to: hospital safety scores, quality scores, and open payment reporting for physicians. What tools and resources are available to consumers when searching for pharmaceutical transparency?

As pharmaceutical consumers we have been distracted by the dangling carrot called convenience; we have set co-pays, coupons, mail order, and auto-refills at our disposal to ease our ability to obtain medications. However, this convenience comes at a cost to all of us that may appear to border on unethical practices.

A Pharmacy Benefit Manager (PBM) is a third-party administrator that works with commercial and federal insurance to manage prescription drug programs for its clients. The original role of the PBM was to process prescription drug claims; this led to mail-order prescriptions and managing the formulary (the list of approved medications) for your insurance as a means of controlling cost. Our goal in this two-part article is to share with you how some of the PBMs have manipulated the system to create profits for themselves while taking advantage of the consumer adding to the high cost of prescription medications in this country.

*Continued on page 18*



In part one of this article we will focus on manipulative strategies employed by certain PBMs to divert dollars from pharmacies and plan sponsors to bolster their own bottom line. Among these strategies are: rebate retention, spread pricing, and mail order pharmacy mandates.

### **Rebate Retention**

Drug manufacturers offer rebates for many branded medications. These rebates help lower the cost of a given medication and may help a drug company get a favorable position on a PBM formulary. The problem with these rebates is that they are often retained 100% by the PBM instead of being shared with the plan sponsor. Take, for example, Drug X. Drug X has a total cost of \$5,000 and a \$1,000 rebate which SHOULD bring the amount paid by the plan sponsor down to \$4,000. However, given that many traditional PBMs retain the full amount of a manufacturer rebate, the plan sponsor still pays the full amount, \$5,000, while the PBM keeps the \$1,000 rebate.

When reviewing prospective PBMs to design your drug benefit it is imperative that plan sponsors determine if the PBM is passing 100% of your rebates on to you from the manufacturer. Should a plan sponsor decide to contract with a payor that retains even a portion of a drug rebate the sponsor is missing an opportunity to further lower its drug costs. After all, why shouldn't the plan sponsor be allowed to retain the full amount of the rebate? They are the ones ultimately paying for the rebatable drug.

### **Spread Pricing**

Spread pricing is a practice observed by certain PBMs where the PBM charges the plan sponsor a higher price than what the PBM paid the pharmacy for a given prescription. This practice causes the plan sponsor to pay more money for a medication by paying the PBM a higher figure than what it should have been charged. For example, a prescription with a total cost of \$80 would be covered by the PBM and a member's copay.

In this example, the member will pay a \$20 copay and the PBM will cover the

remaining \$60. This \$60 is what the PBM should bill the plan sponsor; however, in spread pricing the PBM will bill the plan sponsor a higher price, let's say \$100. Now there is a situation where the PBM paid the pharmacy \$60 for a medication but is billing the plan sponsor \$100 for the same prescription. This leaves the PBM with a net gain or "spread" of \$40 dollars.

An additional tactic a PBM may use to create a spread is to reclassify a generic medication as a branded drug. This practice centers on a plan's contract with a PBM, specifically the definitions of a brand and generic medication. It is imperative that a plan understand how a PBM defines a brand and a generic medication for many PBMs will use these definitions as an opportunity to reclassify certain medications into distinct categories. In using loose definitions to reclassify a generic drug to a branded drug a PBM can charge a plan a higher price for the medications because branded medications are often associated with a lower Average Wholesale Price (AWP) discount when compared to generic medications. For example, a typical AWP

discount for a branded medication may range between 12% to 18%, whereas most generic discounts are around 70%. By reclassifying a generic drug as a brand when invoicing the client, a PBM can charge a higher price for the medication than they would had the medication kept its generic classification. When contracting with a PBM a plan needs to ensure that all definitions laid out in a contract are airtight and not open to misinterpretation.

### Mail Order Pharmacy

There are many reasons why a PBM may force a plan to utilize its mail order pharmacy. One of these reasons is to allow certain PBMs to mail a medication with a repackaged National Drug Code (NDC). When a mail order pharmacy repackages a medication, it can create a new package size and assign that package size a much higher AWP than the AWP of the traditional package size released by the manufacturer. This new AWP is often unknown to plan sponsors and on the surface, seems attractive due to the fact the discount is lower than what the plan would experience in a traditional pharmacy. These greater price discounts may cause a plan sponsor to sign a contract that forces the utilization of a mail order pharmacy because they perceive the savings to be greater. However, the cheaper alternative would be to avoid the mail-order pharmacy.

For example, a plan sponsor has a member that was recently prescribed drug X. The member has an option to fill drug X at a

traditional retail pharmacy or a mail order pharmacy. The cost of 30 tablets of drug X is \$150 (AWP Price). The traditional pharmacy receives a 15% discount off of the AWP price so the price the patient and plan are responsible for is \$127.50.

The same pricing logic applies when the medication is filled at the mail order pharmacy but this time the pharmacy gets to create a higher AWP because the medication is repackaged. The mail order pharmacy now packages Drug X into a package size of 60 tablets (still only needing to dispense 30) with an AWP of \$450. While the \$225 for 30 tablets is certainly more expensive we remember that the plan sponsor's contract promised better discounts with the mail order pharmacy at 20%. The cost of drug X is now \$225-20% or \$180 to the member and plan sponsor.

To summarize, the cost for a pharmacy to obtain drug X is \$150. It would cost a plan sponsor \$127.50 to fill at a traditional pharmacy but \$180 to fill at a mail order pharmacy that has repackaged the medication.

This is an example of another way to incentivize plans to utilize a mail order pharmacy. The thought of a waived copay is attractive to a plan sponsor as it is a hefty benefit to provide to its employees/members. However, once a plan is locked in to a mail order pharmacy they subject themselves to the many ways that a mail order pharmacy can manipulate claims to charge plans higher prices for medications: See repackaging and the shipping of unneeded medications for examples.

### Conclusion

Rebate retention, spread pricing, and mail order mandates represent a mere fraction of the manipulative revenue streams traditional PBMs utilize to turn a profit. However, these tactics are some of the more commonly seen practices in the managed care sector of health care that prevent plan sponsors from realizing their maximum savings potential regarding drug cost. In part two of this article series we will focus on two additional tactics PBMs use to increase their bottom line, contracting and formulary management pitfalls. When reviewing PBM contracting it is important to understand how core terms of managed care vocabulary are defined within a given contract. While these definitions may appear straightforward, the simplicity of how a topic is defined can leave it open to interpretation of the PBM to create definitions that are rather ambiguous. Consulting the definitions section of the contract will help provide clarity to the specific meaning of topics outlined in a contract with a PBM.+

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COMMUNITY HEALTH

# Does a Doctor's Job End in the Clinic?

BY M. USMAN AHMAD,  
Medical Student

**S**hould doctors limit care for patients with complex comorbidities? As a patient or family member, would you be comfortable if less resources were available for cancer or a genetic disease?

On July 7th, Seema Verma of the Centers for Medicare & Medicaid Services (CMS), appointed by President Trump, announced suspension of risk adjusted payments to insurance companies. Risk adjusted payments were initially put into effect by the Patient Protection and Affordable Care Act (PPACA) colloquially known as "Obamacare." The regulation helped stabilize the health insurance system by transferring funds from insurance plans with "healthy" patients to plans with "sick" patients. Put simply, this decreased the cost of health insurance premiums for patients with complex diseases. This recent decision was based on ongoing litigation in the state of New Mexico. Judge James O'Browning of the U.S. District Court of New Mexico ruled that the CMS did not have adequate rationale or explanation for its use of the formula used to calculate these payments. The acceptance of this decision by the Trump administration

would have compromised a physician's ability to treat patients with cancer, the elderly, and individuals born with complex diseases.<sup>1</sup>

The American Medical Association (AMA) lead a coalition of 28 organizations that opposed this ruling.<sup>2</sup> In addition, more than 500,000 physicians represented by the American Academy of Family Physicians, American Academy of Pediatrics, American College of Obstetricians and Gynecologists, American College of Physicians, American Osteopathic Association, and American Psychiatric Association released a similar statement.<sup>3</sup> Dr. Robert Murphy, a plastic surgeon in Allentown, PA who has held several professional roles in leadership and advocacy, commented in a recent interview that "Medicine must always be patient centric. When doctors aren't involved at a community, Administrative, or Professional Society level – bad things happen." Nearly every local, state, and federal election has revolved around healthcare issues. Although there have been several unsuccessful reform efforts aimed at the Patient Protection and Affordable Care Act, there are other important issues including ending the National Public Service Loan Forgiveness (NPSLF) program and the opioid epidemic.

### National Public Service Loan Forgiveness

Many public servants including teachers, lawyers, physicians, nurses, pharmacists, dentists, and others use this program to help reduce the high cost of education by committing to employment in government or the non-profit sector for 10 years and making loan payments. Qualified employers include the government, military, and non-profit institutions. Betsy DeVos, Education Secretary, and the Trump administration planned significant reductions to this program. However, consistent advocacy from professional organizations and elected officials including former Republican and current Democrat Senator Elizabeth Warren (D-MA) prevented massive cuts in the 2018 fiscal spending bill. This issue not only affects the availability of health care providers in underserved areas, but also affects a several other professions. As we grapple with the issues of the educational cost, access to services, and competing in a global market, limiting this program may make social mobility a greater challenge for average Americans.

### The Opioid Epidemic

In 2016, there were more than 40,000 deaths related to opioid overdose in the United States.<sup>4</sup> States with the highest rate of deaths include West Virginia, Ohio, New Hampshire, Pennsylvania, and Kentucky. One solution within a multi-faceted approach is to focus on treating addiction as a disease. For example, the leading cause of death in the US is heart disease. Modifiable risk factors are diet, exercise, physical activity, and smoking. However, rather than focusing completely on self-management, we treat heart disease with a variety of drugs, devices, and procedures. Similarly, opioid addiction may be treated by medication assisted treatment (MAT) programs. Recently in Harrisburg, PA, legislation was passed that would license physicians to prescribe buprenorphine, a drug used to help decrease dependence and addiction to opioids. I attended the meeting in Harrisburg and witnessed the debate prior to passing the bill. A major point of contention was charging prescribers \$10,000 in order to register for a license to prescribe. Republican politicians saw this as a funding

source to create a system of oversight and regulation for prescribing. Democratic politicians felt that this measure would severely limit the number of physicians that would take on the cost and risk of licensure. This would decrease the availability of this program to Pennsylvanians. In the end, the licensure fee was negotiated to \$500 dollars and the bill was passed.<sup>5</sup> National efforts via federal organizations such as the Substance Abuse and Mental Health Services Administration (SAMHSA) are also vital to a systematic response to the epidemic.

### The Role of Advocacy

The priorities of American health care are focused on creating an accessible and affordable health system and responding to public health concerns. On July 24th, the ruling by the CMS on ending risk adjustment payments was reversed. As an individual, you may argue whether medical lobbying had an effect on this decision. Although debatable, it is hard to argue that it had no effect. Dr. Alex M. Rosenau, an Emergency Physician in Allentown, PA and past President of the American College of Emergency Physicians, is dedicated to physician advocacy. In a recent interview, Dr. Rosenau spoke on the value of organized medicine: "The resources of the AMA, its position as a convener and leader... [and] its focus on diversity and vulnerable populations all project a positive effect on our communities." Thus, in this case and many others it is vitally important that the medical community considers entering the public sphere for the health of our neighbors, communities, and nation. +

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# Minimally Invasive Lumbar Decompression

**M**any patients with chronic low back pain have asked, “What about that surgery through a one-inch hole that allows me to go home the same day? Am I a candidate for that?” Usually the answer is no. The treatment options left for these patients include one or a combination of the following: injections (epidural, facet or other steroid injections), medications, implantable devices like spinal cord stimulators or intrathecal pumps or surgery.

Lumbar spinal stenosis (LSS) is one of the most common degenerative diseases of the elderly population. The minimally invasive lumbar decompression (MILD) procedure treats a specific segment of this population, namely patients who suffer from neurogenic claudication symptoms where a hypertrophic ligamentum flavum is a cause of the stenosis. Symptoms of neurogenic claudication are numbness, tingling and pain in their back, legs and buttocks when they are upright and active. They report difficulty when walking any significant distance or standing for extended periods of time. Affected patients will have some symptom reduction if they lean forward, sit or lay down. There are cases when these patients responded poorly or fail conservative therapies such as oral analgesics, home exercise programs, or physical therapy.

When selecting patients who may be eligible for the MILD procedure, it is very important

to conduct a thorough clinical evaluation, evaluation of symptoms to identify neurogenic claudication and radiological confirmation of hypertrophic ligamentum in combination with diagnosis of LSS. These patients should also have tried and failed conservative therapy.

LSS patients are usually the first to find a chair in which to sit at the mall or utilize a shopping cart in the grocery store. They spend most of the day sitting and have reduced activities of daily living resulting in a lower quality of life. There is a prevalence of lumbar spinal stenosis in patients over 60 of 10-15%. Ninety-four percent of LSS patients experience some form of neurogenic claudication.

Minimally invasive lumbar decompression procedures utilize a small incision (the size of a baby aspirin), demonstrate the same safety profile of epidural steroid injections and do not require implants, general anesthesia, stitches or overnight hospital stays. It also does not remove the opportunity for the patient to have the option for a further surgery such as a laminectomy or fusion if relief of symptoms is not obtained.

The MILD procedure is FDA approved. Performed in an outpatient setting, through a portal a miniature bone and tissue sculpture are used to remove bone and ligament under direct xray visualization. Once bone and ligament are removed it is likened to

removing a kink in a straw, opening the level of stenosis.

In the ENCORE study post-operatively patients demonstrated an improvement in standing time from 8 to 56 minutes, an increase in walking distance from 246 to 3956 feet and a 53% reduction in pain. MILD does not require general anesthesia and is an outpatient procedure with low risk and no stitches or implants. This procedure allows patients to return to activities of daily living such as cooking meals, walking the dog or even grocery shopping.

Minimally invasive lumbar decompression fills an important gap in the treatment of patients with neurogenic lumbar claudication due to lumbar spinal stenosis and hypertrophy of the ligamentum flavum. Prior to the development of MILD, the only option for patients with symptomatic lumbar spinal stenosis who had failed conservative measures (including epidural steroid injections, or ESIs) was conventional open surgical decompression, or lumbar decompressive laminectomy. While highly effective in roughly 3 out of 4 patients, open surgical decompression carries with it complication rates that range from 5% to 20%.+

*Dr. Robert J. Corba is a surgeon with OAA Orthopaedic Specialists and The Surgery Center of Allentown.*

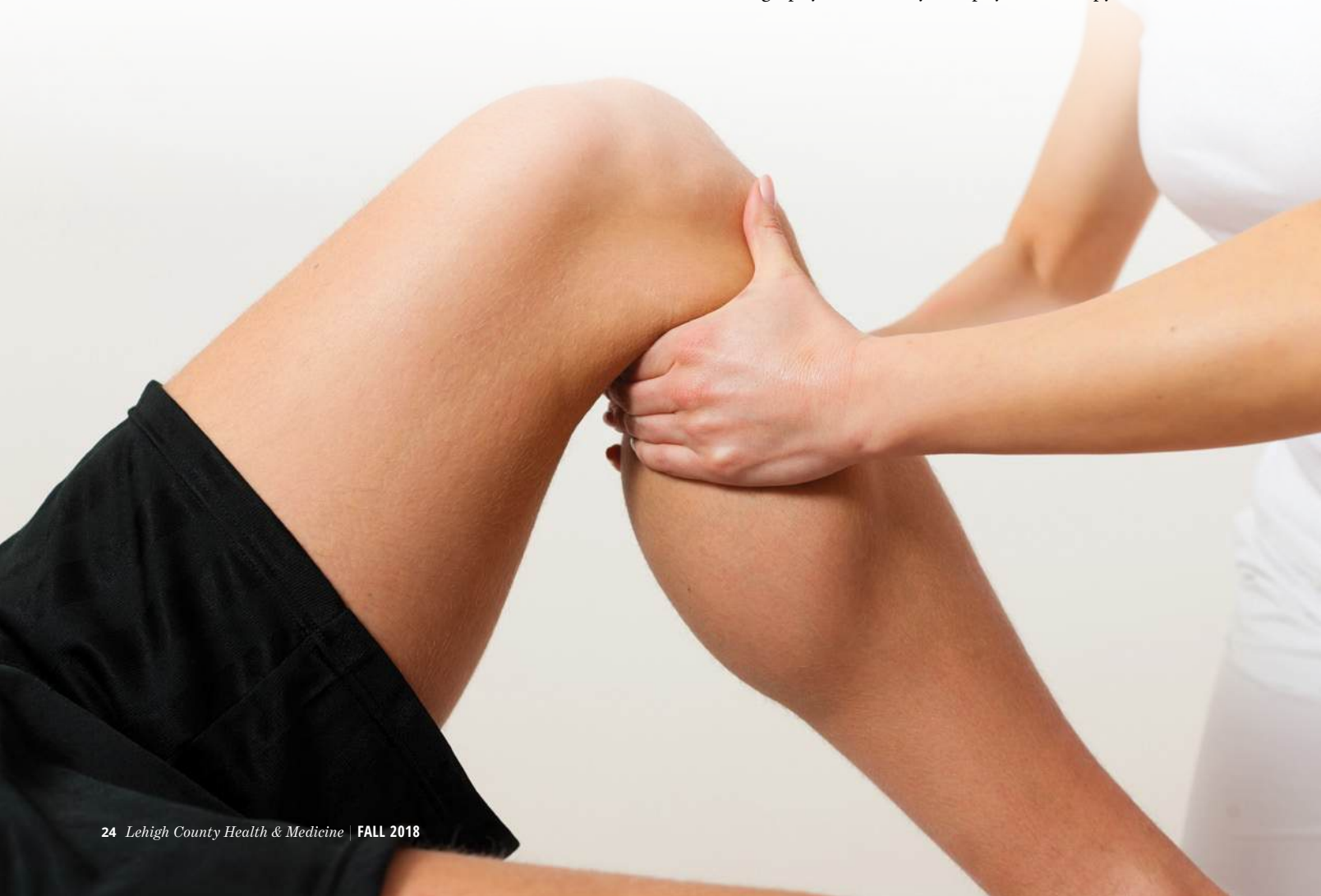
# THE BENEFITS OF PHYSICAL THERAPY

## *and Physical Activity in the Prevention and Treatment of Lymphedema*

BY MARI WAHLGREN, PT, MSPT, ATC, CLT-UE  
Physical Therapy at St. Luke's

Each year, 1 in 8 women are diagnosed with breast cancer. Due to advances in medical treatment of the disease, many women are surviving and thriving. However, many side effects of treatment still exist. While physicians are successful at treating a woman's cancer, there is still a lack of knowledge regarding the prevention of lymphedema among patients and survivors.

Lymphedema is a build-up of lymphatic fluid in an affected limb. It is a long-term chronic and progressive adverse effect of cancer treatment which develops when lymph nodes are removed during surgery or damaged during radiation treatment. It is estimated that even with the newer surgical techniques such as sentinel node biopsy, up to 40% of breast cancer survivors could be at risk for breast cancer related lymphedema (BCRL) due to surgery, radiation and chemotherapy. Some patients successfully manage symptoms of lymphedema through physical activity and physical therapy.





Older guidelines regarding lymphedema and physical activity are based on anecdote(s) and assumptions. Many patients were told not to lift more than 15lbs for the remainder of their lives which led to patients not using their affected arm. This could lead to shoulder pain, arm weakness and even frozen shoulder. Many patients believed that if they performed any type of exercise with that arm they would develop lymphedema. These beliefs led to a culture of fear and inactivity for decades.

Early research on exercise and the lymphatic system revealed that the body was able to regenerate some of the deep lymphatic vessels in 8 days. It is now considered to be best to limit rigorous activity of the affected arm for 10 days but to then initiate controlled activity to return the arm to normal range of motion and strength. The lymphatic system is able to tolerate small amounts of stress which, when applied in appropriate doses, can increase its tolerance to activity, thereby allowing patients to return to their regular daily functional tasks such as lifting, carrying and exercising.

A large research study performed in Philadelphia in 2010, known as the PAL study (physical activity and lymphedema), specifically looked at women who were at risk for developing lymphedema as well as women who had lymphedema and how they tolerated a weight lifting program. Survivors participated in two 90-min. exercise sessions per week over a 12-week period which included stretching, cardiovascular warm ups, abdominal exercises and strength training. The women performed two sets of 10 repetitions of a variety of exercises which were progressed to 3 sets of 10 as tolerated. Resistance was increased after 2 sessions if no symptoms appeared. They compared the exercise group to a control group. Results indicated that women who performed the exercise program developed lymphedema at a decreased rate vs the control group. Women who had more than

5 lymph nodes removed and did not exercise had an increase in lymphedema by 22% vs 7% in the exercising group.

When the same exercise program was tested in women who already had lymphedema, these patients had no increase in swelling or infections over a 3-month period. Weight lifting actually decreased the severity of arm and hand symptoms by half.

This study and others indicate that it is safe to participate in supervised physical activity, such as physical therapy, during and after treatment for cancer and may actually help reduce the incidence of lymphedema. If lymphedema is already present, exercise may reduce the incidence of exacerbation.

While some patients' bodies can develop new pathways to redirect the lymph fluid, others cannot. There are no tests that can be performed to determine who may be able to do so and who may not, therefore, a slow, controlled increase in stress is best for every patient.

## THESE ARE SOME GUIDELINES TO FOLLOW WHEN INITIATING A NEW EXERCISE PROGRAM

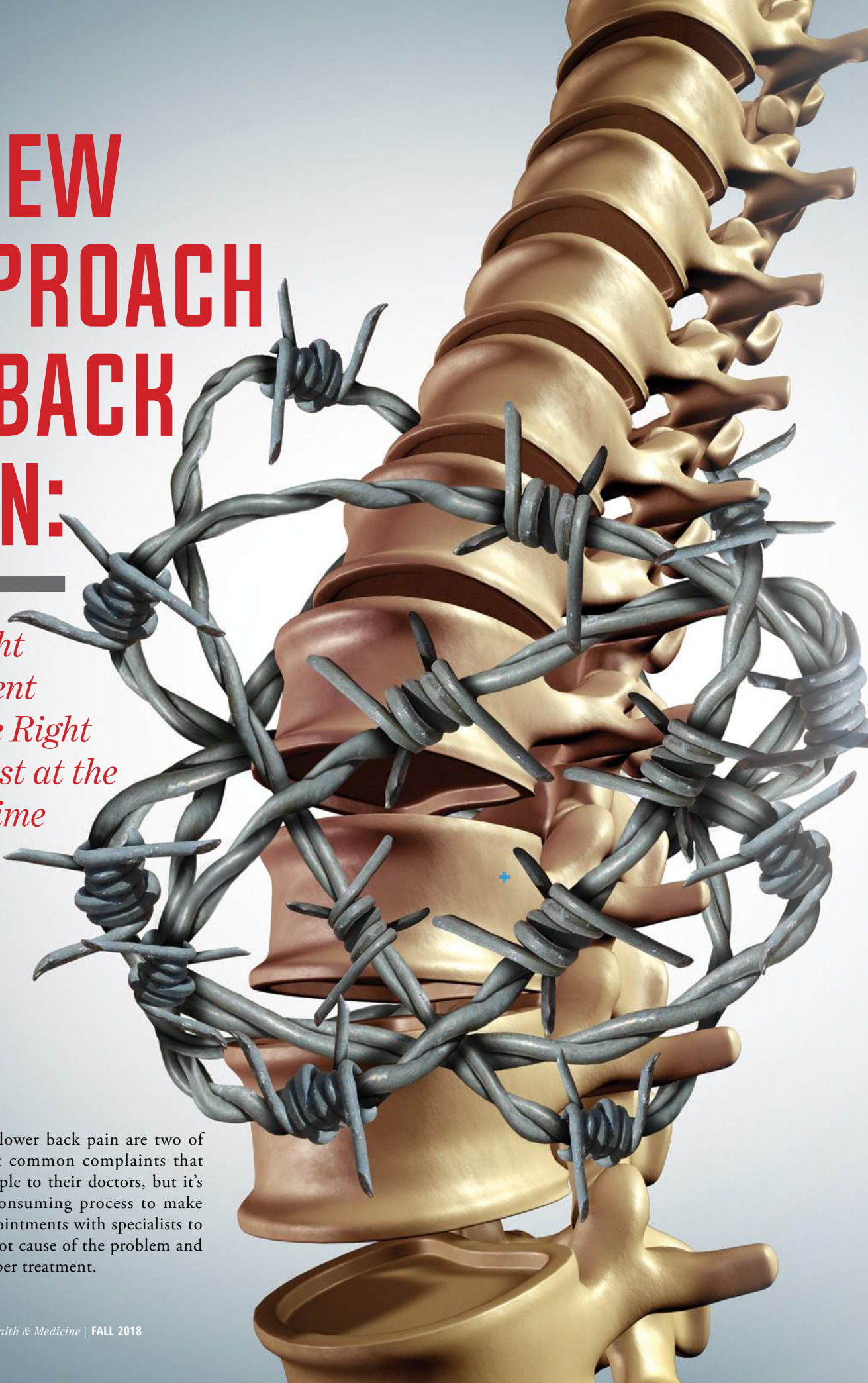
- Always get approval of your physician whenever you initiate a physical fitness program.
- Wear compression garments with activities that increase heart rate and blood flow to the affected region for greater than 15 minutes.
- If an already swollen region becomes larger or there are increased symptoms of fullness or heaviness during or after the activity, reduce the intensity.
- Slowly increase your sets, repetitions and intensity as long as you do not observe an increase in symptoms.
- Aim to exercise 150 minutes per week.
- Include strength training exercises at least 2 days a week.
- Do not avoid trying new activities.

If you are at risk for developing lymphedema, or have lymphedema and are unsure where to begin, do not hesitate to schedule a pre-exercise assessment with a specially certified physical therapist. They can perform girth measurements for a compression sleeve, L dex testing to assess your fluid levels, and develop a program specifically tailored for your needs. +

# A NEW APPROACH TO BACK PAIN:

*The Right  
Treatment  
with the Right  
Specialist at the  
Right Time*

**N**eck and lower back pain are two of the most common complaints that send people to their doctors, but it's a time-consuming process to make secondary appointments with specialists to evaluate the root cause of the problem and determine proper treatment.



Physical therapists are perfectly positioned to diagnose and treat these conditions, and St. Luke's University Health Network has recognized that fact. More than 50 physical therapists have been specially trained for St. Luke's new program called Comprehensive Spine that offers near-immediate diagnosis and treatment.

According to the National Institutes for Health, "[t]he majority of acute lower back pain is mechanical in nature, meaning that there is a disruption in the way components of the back ... fit together and move."

Patients experiencing acute neck or lower back pain can call in on a special hotline, which debuted this summer, to speak with trained nurses who screen the callers for symptoms and conditions. Referral appointments are set within 48 hours of the call.

"Often times, imaging isn't necessary, especially to treat an acute issue," explained Dennis McGorry, MD, a primary care physician with St. Luke's. "If it's trauma-related or cancer-related, you will need some type of imaging, but most acute spine pain is a sprain or strain, conditions which are absent in imaging."

The Comprehensive Spine program is designed so that the physical therapists work with patients suffering from acute pain in order to rehabilitate and strengthen affected areas while increasing the range of motion. Learning the actual source of the pain not only deals with the acute issue, but helps it from becoming a chronic issue.

"Once a patient presents for 4-6 weeks, you go from being an acute pain patient to a chronic pain patient, at which point imaging, seeing pain management or other specialists may become appropriate," said Dr. McGorry.

## BY CHOOSING PHYSICAL THERAPY AS THE FIRST OPTION FOR TREATING BACK AND NECK PAIN, PATIENTS CAN AVOID UNNECESSARY SURGERY OR IMAGING, REDUCE THE NEED FOR DRUG THERAPIES AND PROVIDE FOR A BETTER PATIENT OUTCOME AND EXPERIENCE.

According to research conducted by St. Luke's, just 15 percent of the people need to be referred immediately to an advanced specialist. But, the remaining 85 percent can be referred directly to physical therapy for assessment and rehabilitation.

"Our physical therapists are trained specifically to do this, as primary care physical therapists, to triage them faster," said Giovanni Stracco, DPT, spine program director at Physical Therapy at St. Luke's. "If a patient comes in to see me and I think they would be better served by pain management, I can write a referral directly so that they're seen much faster than trying to schedule it on their own. It expedites their treatment."

McGorry said there are often multiple elements involved with pain generated from the spine, and they could be muscular in nature, joint-related, ligament issues or even disc and facet issues.

"Sometimes it's not as simple as fixing one particular problem," McGorry said. "A physical therapist helps the patient learn how to move through the process they're having issues with. A physical therapist can increase a patient's awareness of where the pain is actually coming from, help them increase their strength, flexibility and movement in dealing with it."

By choosing physical therapy as the first option for treating back and neck pain, patients can avoid unnecessary surgery or imaging, reduce the need for drug therapies and provide for a better patient outcome and experience. It also greatly lowers the overall cost of treatment.

Stracco said that physical therapists are training in recognizing the signs and symptoms that would indicate a referral to pain management, an orthopedic surgeon, neurosurgeon or physiatrist.

The physical therapists often use manual therapy in treating conditions.

"There are different type and styles of manual therapy," Stracco said, "but we use it with neck and spine issues and it's one of the therapies available to restore normal motion and function of the spine."

When the physical therapists document that their therapies aren't working, they can reassess the rehabilitation modalities. If it's evident the situation is becoming chronic, patients get immediate referrals to advanced specialists.

"Our goal is simple," said Jason M. Erickson, DO, an interventional pain physician at St. Luke's Spine and Pain Associates. "Provide the right treatment with the right specialist at the right time. We want patients returning to function and meaningful activities, whether it's spending time with their families, getting back to their jobs or returning to the activities that are important to them." +

**FOR MORE INFORMATION CALL 1-866-STLUKES (OPTION 6) OR VISIT SLUHN.ORG/SPINE**



## *Pennsylvania Medical Society* QUARTERLY LEGISLATIVE UPDATE

### PRIOR AUTHORIZATION REFORM

#### *Background*

The Pennsylvania Medical Society (PAMED) is seeking a legislative fix to the prior authorization process to address patient care issues. HB 1293 was introduced in May 2017 by Rep. Marguerite Quinn (R-Bucks), and it is supported by a coalition of more than 50 patient and medical advocacy groups.

#### *Current Status*

A call to action to physicians across the state took place in late April. Blast emails from PAMED to House Insurance Committee Members took place in May, urging them to address the issue of prior authorization reform.

#### *Next Steps*

PAMED is seeking to advance the legislation by working with medical specialty organizations and House Insurance Committee staff members to get consideration before the end of the year.

### INFORMED CONSENT

#### *Background*

In a June 2017 ruling, the Pennsylvania Supreme Court held that, under the MCARE Act, a physician's duty to obtain a patient's informed consent is a non-delegable duty. Under the MCARE Act, except for emergencies, physicians must obtain

informed consent from their patients, or their authorized representative, prior to conducting the following procedures:

- Performing surgeries (including the related administration of anesthesia)
- Administering radiation or chemotherapy
- Administering a blood transfusion
- Inserting a surgical device or appliance
- Administering an experimental medication

#### *Current Status*

PAMED's legal and government relations teams have been working with the Hospital and Healthsystem Association of Pennsylvania (HAP) to draft legislation that aims to address physician and hospital concerns with this ruling.

#### *Next Steps*

A co-sponsorship memo has been drafted and PAMED has asked Speaker Turzai to review. We will continue to stay in touch with his office to monitor progress.

### TEAM-BASED CARE AND SCOPE OF PRACTICE

#### *Background*

On April 26, 2017, passage of SB 25 occurred in the Senate and the bill is awaiting consideration by the House Professional Licensure Committee, as is HB 100. Both SB 25 and HB 100 would grant independent

practice to certified registered nurse practitioners (CRNPs).

#### *Current Status*

A multi-level communications campaign started in April to generate awareness regarding this issue. Engagement on social media regarding this topic was steady and stats showed that from April 1–25, 2,099 people liked, shared, commented, or clicked on a link in the posts.

#### *Next Steps*

PAMED strongly opposes any legislation that does not keep physicians as the leader of the health care team. The PAMED government relations team continues to educate legislators in the House Professional Licensure Committee and the public regarding our concerns with this legislation.

### TELEMEDICINE

#### *Background*

Two bills – SB 780 and HB 1648 – would establish a statutory definition for telemedicine, mandate that telemedicine services are reimbursed, and prohibit “audio only” services (video must be available if either the patient or provider requests it).

#### *Current Status*

SB 780 was recently unanimously approved

by the Senate. PAMED is pleased with the vote and looks forward to supporting this legislation as it moves through the House of Representatives. PAMED would especially like to thank Sen. Elder Vogel (R-Beaver) for his leadership on this issue. The vote is a positive first step in the process of getting the bill to the governor's desk.

#### *Next Steps*

SB 780 has been sent to the House Professional Licensure Committee. As telemedicine moves through the next chamber, the House of Representatives, PAMED will rely heavily on its members to respond to calls to action on this topic.

### **OPIOID CRISIS**

#### *Background*

More than 25 pieces of legislation regarding opioids have been introduced. Legislation ranges from Prescription Drug Monitoring Program (PDMP) requirements to prescribing limits.

#### *Current Status*

Though there are quite a few pieces of legislation regarding opioids, PAMED is highlighting SB 655, which would mandate that physicians follow guidelines such as the current voluntary guidelines when prescribing opioids. This legislation has the potential to saddle physicians with a “no win” decision: follow the mandated guidelines knowing it's potentially not the best course of treatment for their patient or break the law in the interest of appropriate patient care.

#### *Next Steps*

A call to action was sent to physicians across the state in mid-June. Unfortunately, SB 655 passed the Senate unanimously. PAMED plans to monitor this legislation closely and if it is determined that this legislation will be voted on in committee or on the House floor, PAMED will rely heavily on its members to respond to calls to action.

### **DRUG FORMULARIES**

#### *Background*

Under current law, insurers are not required to provide practitioners with drug alternatives when a drug prescribed is denied for not being in the patient's insurance drug formulary.

#### *Current Status*

Practitioners must expend time and resources

to figure out what alternatives are available as part of a patient's insurance coverage. PAMED recognizes the burden and is aiming to make headway with lawmakers so that the process is more transparent.

#### *Next Steps*

PAMED's government relations staff are continuing to educate lawmakers on the topic in an effort to identify sponsors or co-sponsors of legislation that would reform the drug formulary process.

### **MAINTENANCE OF CERTIFICATION (MOC)**

#### *Background*

Per House of Delegates (HOD) policy, PAMED continues to work toward improvement of the MOC process and ultimately seeks to introduce legislation which makes certain MOC cannot be used as criteria for credentialing by insurers or hospitals. PAMED also seeks to prohibit physician licensing boards from using MOC as a condition of licensure.

#### *Current Status*

PAMED hosted a gathering at the 2018 AMA Annual Meeting of the House of Delegates in Chicago to discuss the MOC process. Scott Shapiro, MD, Chair of the Pennsylvania Delegation and PAMED Past President, facilitated the meeting, which was held on June 11, 2018.

In May 2018, two medical specialty boards announced changes to their MOC programs. Both the American Board of Anesthesiology (ABA) and the American Board of Obstetrics and Gynecology (ABOG) announced that their MOC pilot programs will become permanent. Earlier this year, another specialty board – the American Board of Pediatrics (ABP) – also announced that, starting in 2019, it is making changes to its MOC process.

#### *Next Steps*

The American Board of Medical Specialties (ABMS) recently launched its “Vision for the Future” initiative to review the MOC process for physicians. PAMED Past President Charles Cutler, MD, MACP, is one of 26 members chosen to participate in the initiative's Vision for the Future Commission. The commission's goal

is to provide a set of recommendations about the future of continuing board certification for consideration by ABMS. Stay up to date at [www.pamedsoc.org/MOC](http://www.pamedsoc.org/MOC).

### **THE BUDGET**

Gov. Tom Wolf approved the \$32.7 billion state budget on June 22, 2018. While much of the attention on this year's budget centered around increased spending for education and workforce development, the final budget does affect health care as well. Notably, a proposed three percent tax on Ambulatory Surgery Center (ASC) Net Patient Revenue is not included in the final bill. PAMED supported several specialty societies and their efforts to oppose the assessment.

The new budget includes funding for a wide variety of health-care related items such as:

**Opioid Use Disorder Treatment** – The budget includes \$4.5 million to provide home-visiting services for families affected by opioid use disorder, plus an additional \$800,000 in increased rates to home-visiting providers.

**Lyme Disease Prevention and Awareness** – \$2.5 million will go toward implementing Lyme disease prevention, education, awareness, and surveillance activities.

**Prescription Drug Monitoring Program (PDMP) Funding** – The state will maintain its funding for the PDMP, allocating more than \$3 million toward the program.

**Community HealthChoices (CHC)** – Pennsylvania has budgeted more than \$662,000 toward CHC, Pennsylvania's new long-term care initiative. CHC is a managed care program intended to increase opportunities for older Pennsylvanians and individuals with physical disabilities to remain in their homes while receiving services.

**Loan Forgiveness** – Money was once again included for programs that forgives loans for physicians choosing to practice in a rural or underserved area of the Commonwealth. +

Stay up to date on PAMED's legislative priorities at  
[www.pamedsoc.org/Advocacy](http://www.pamedsoc.org/Advocacy)

# Pennsylvania's TOP PHYSICIANS UNDER 40 in Lehigh County

Jeff Wirick, Pennsylvania Medical Society, (717) 909-2651

**(HARRISBURG, Pa. – 6/27/18)** This year's Pennsylvania Medical Society Top Physicians Under 40 winners come from a diverse range of backgrounds.

This select group has demonstrated a significant amount of success early in their medical careers, said Theodore Christopher, MD, president of the Pennsylvania Medical Society.

"As these physicians have shown, the future of Pennsylvania medicine is very promising," said Dr. Christopher. "We're excited to recognize them for their outstanding contributions to the practice of medicine and the delivery of patient care."

Winners were nominated by colleagues and ultimately selected by a statewide committee of Pennsylvania Medical Society member physicians.

The 38 physicians on this year's list represent 19 different medical specialties and live in 18 different cities. They include 20 women and 18 men who work in practice settings that range from large health systems to smaller medical practices.

*Here are this year's winners:*



#### LEIGH-ANNE PIECHTA, DO, ALLENTOWN

Physiatrist Leigh-Anne Piechta has opened three acute inpatient rehabilitation units on behalf of Lehigh Valley Health Network, serving as Medical Director of the units. She has helped her organization to increase the community's access to the resources they need to recover from strokes, spinal cord injuries, and other debilitating injuries and illnesses. Her leadership and team-building skills have provided a strong foundation of practice for many clinicians.



#### KARINA REED, MD, ALLENTOWN

Dr. Reed is an OB/GYN with Lehigh Valley Physician Group (LVPG) Obstetrics and Gynecology. She serves as assistant practice leader where she works to implement innovative ideas to provide better and more efficient patient care. One of her initiatives involves helping to develop and support the expansion of LVPG's midwifery program. She is also the obstetrics rotation leader for her organization's OB/GYN residency and co-directs its obstetrics simulation curriculum.+

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# LCMS NEWS

## NEW MEMBERSHIP

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**Hassan H. Amhaz, MD**

**Timothy John Batchelor, MD**  
EM - Resident, LVHN - Graduate Medical Education, Allentown

**Amulia Chari, DO**  
Resident, 801 Ostrum St, Bethlehem

**Alan R. Cherney, MD**  
2545 Schoenersville Rd, Bethlehem

**Joseph F. Ciecko, DO**  
3691 Crescent Ct E Ste 201, Whitehall

**Brian Fuller** Resident

**Andrew Hamarich DO**  
Cedar Crest & I-78, Allentown

**Sarah Iqbal** Medical Student

**James A. James III**

**Beth S. Jennings, MD** Retired

**Kathryn Clare Kelley, MD**  
SLHN - Graduate Medical Education  
1021 Park Ave, Quakertown

**Alexander Michael Kowal, MD**  
1255 S Cedar Crest Blvd., Ste 2500, Allentown

**Bret J. Kricun, MD**  
1255 S Cedar Crest Blvd Ste 2500  
Allentown

**Eunice Lee, MD**  
1665 Valley Center Pkwy Ste 130, Bethlehem

**Tara Morrison, MD**  
N 1240 S Cedar Crest Blvd Ste 401, Allentown

**Diep Dinh Nguyen, DO**  
3100 Emrick Blvd, Bethlehem

**Osama Osman, MD**  
Resident, Graduate Medical Education, Allentown

**Adam Paul, DO**  
1210 S Cedar Crest Blvd Ste 2400, Allentown

**Virginia C. Phipps, DO**

**Joanne N Quinones, MD**  
3900 Hamilton Blvd, Ste 201, Allentown

**Robin Sperduto Schroeder, MD**  
1243 S Cedar Crest Blvd, Ste 2200, Allentown

**Ravinder Singh, MD**  
1808 Swamp Pike, Ste 200, Gilbertsville

**Shrita Marie Smith, MD**  
3435 Winchester Rd Fl 2, Allentown

**Jennifer Stockhausen, DO**  
3691 Crescent Ct E Ste 201, Whitehall

**Anuraj Mambazhathu Sudhakaran, MD**  
Resident, LVHN-Graduate Medical Education,  
Allentown

**Dieynaba M. Toure, DO** Resident

**Ali R. Yazdanyar, DO**  
225 N Main St, Coopersburg

**Matthew S. Yoder, MD** Resident

**Susan K. Yaege, MD**

**Steven John Zanders, DO**

**Kenneth J. Zemanek, MD**  
1251 S Cedar Crest Blvd 202A, Allentown

## REINSTATED MEMBER

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**Louis W. Hansrote, MD**  
1605 N Cedar Crest Blvd., Ste 119, Allentown

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