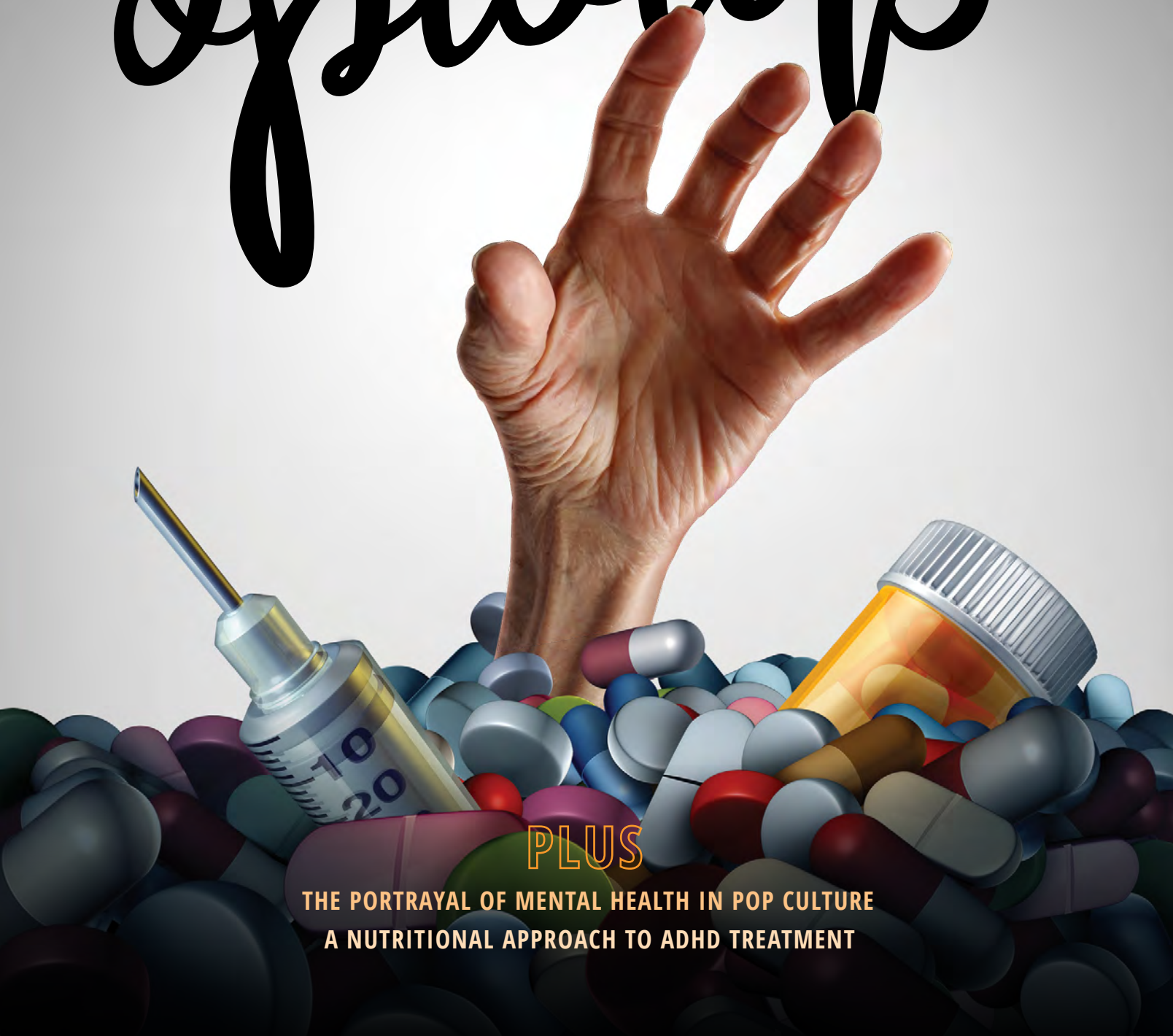


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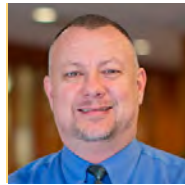
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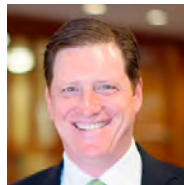
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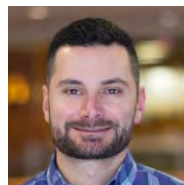
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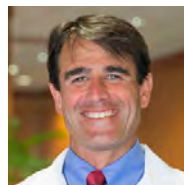
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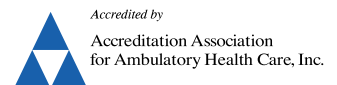
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Health & Medicine



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Welcome to the fall issue of the *Lehigh County Health and Medicine* magazine, brought to you by the Lehigh County Medical Society. We hope you had a safe summer, and we're thrilled to provide this new service to you. We look forward to your responses, ideas, and contributions.

One of the articles I hope you will enjoy is "Rofeh," a simple story of a physician and the relationship between doctor and patient.

One of the themes of this edition of the magazine is nutrition, and specifically micronutrients. Two articles inside will speak on the benefits of diet and your health. Continue reading to see how nutrition is important to skin health. Be sure you are getting the correct amounts of the micronutrients to keep your skin looking healthy.

We also bring you an article on the benefits of diet and its effect on Attention Deficit Hyperactivity Disorder (ADHD). Continue reading to see how micronutrients play an important part in the management of multiple brain functions.

As COVID has affected all our lives, we also see that there has been an increase in substance abuse and drug overdoses. The Allentown Health Department has created opioid education sessions. Learn more about these important sessions inside and perhaps your organization/workplace might be interested in participating. Find out more inside the article.

You may have heard the term "Care Coordination," and wondered what it is. In this edition, you'll see how care coordination can benefit patient care and patient engagement.

Finally, we have all seen movies and television shows that have characters who exhibit mental health issues. In this edition, read the article on how movies, television, and social media have evolved over the years in the way they portray mental health.

We hope you will 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 enjoyed reading this edition, or just wanted to see previous editions of *Lehigh County Health and Medicine* online, please visit our website at <https://lcmedsoc.org/our-publication>.

Thank you for reading!



WOMEN PHYSICIANS SECTION

The Pennsylvania Medical Society is the place physicians in the Commonwealth can go to find support, advocacy and engage in leadership. Important missions include being a resource for physicians on upcoming legislation, providing education and sharing public health concerns. In October 2018 the House of Delegates created the Women Physicians Section (WPS), which was the intended space for female physicians to connect, provide support and allow for discussion of factors that uniquely applied to women practicing medicine. After its inception WPS created leadership roles, including a governing council and district delegates for the 13 districts. The leadership group meets quarterly to discuss regional concerns and brainstorm ideas. It works to support female physicians in pursuing leadership roles. WPS has become vocal in addressing issues such as discrimination and pay disparity. The members bring forward personal experiences of balancing medical practices while raising children. They share stories of both triumphs and frustrations in professional advancement. It has become a place where female physicians can find camaraderie and understanding. It is a place where our unique perspective and experiences can be shared through our presence in the House of Delegates. And above all, it is a place where the female physicians of Pennsylvania can have a voice in advocating on policy issues affecting women and provide advisement.

For all female physicians in northwest Pennsylvania, please consider becoming active in WPS and sharing your stories and experiences. WPS offers educational webinars as well as live presentations addressing concerns. We are always open to proposed topics and work to find appropriate speakers. In addition to dynamic female physician speakers, we have had lawyers, businesswomen and healthcare managers give presentations. Due to COVID we have had to hold meetings virtually, but we are hoping to hold more in-person events and make our section one of the most effective and utilized at PAMED. If there are any questions about WPS, please contact your delegate. You can find your delegate and more information on WPS at <https://www.pamedsoc.org/membership/women-physician-section>.+

The author is Ingrid Renberg, MD, and the Women Physicians Section Communications Committee.

opioids

BY BARB HASSLER
COMMUNITY HEALTH SPECIALIST
ALLENTOWN HEALTH BUREAU



The Allentown Health Bureau is tackling the issue of opioid addiction through funding provided by the PA Department of Health by creating and presenting opioid educational sessions. These presentations are aimed at educating individuals about opioid addiction, how to identify the signs of addiction, and other general information to remove the stigma from addiction as well as promote resources for recovery. These sessions are accompanied by a pre- and post-test/survey, the results of which are collected and analyzed by the University of Pittsburgh.

Starting in the spring of 2021, AHB has given presentations to workforces in the city as well as groups of seniors. Presentations are given either virtually or in-person to seniors in reference to the use of opioids and the current epidemic of overdoses throughout the country and trends in the Lehigh Valley. After the presentations the moderator attempts to facilitate candid discussion on the trends and how it is affecting medical care given moving forward. Discussion topics also revolve around changes in the prescribing of opioids by doctors for pain and the move towards improving patient pain management.

Anecdotally, nearly all participants in the presentations have mentioned they knew someone dealing with opioid use disorder or knew of a family that lost a loved one to addiction or has/had a family member experiencing addiction. Those stories further validate the proposition that this epidemic does indeed cross all income levels and social groups. +

The Allentown Health Bureau is always looking to expand its opioid programming to new people and areas of the city/county. If you would like an opioid educational session for your employees or community group, **please contact the Allentown Health Bureau's Injury Prevention Program at 610-437-7760 x 2831 or email at injuryprevention@allentownpa.gov.**

THE
PORTRAYAL
OF MENTAL
HEALTH
IN POP
CULTURE

BY VIVEK GORIJALA
MEDICAL STUDENT
USF MCOM SELECT PROGRAM

Can anyone who has seen *Rain Man* (1988) forget the extraordinarily skills that allow the character Raymond to count cards perfectly and rig some bets in his favor? The only film with a more unforgettable display of mental illness may be *Fatal Attraction* (1987), which follows the incredibly manipulative machinations of antagonist Alex Forrest. These are hardly the first movies that starred mental health issues, as such films have been coming to life since the dawn of the cinema industry itself. However, these two cinemas, released just a few decades ago, clearly show how media portrayal of psychiatric disorders has long been caricaturized to the point of partial inaccuracy.

Raymond, for example, has autism spectrum disorder and savant syndrome, but his character has led to the common misconception that the rare occurrence of savant syndrome is much more common than it really is in autistic individuals. Similarly, the highly exaggerated depiction of Alex's borderline personality disorder stigmatizes her chaos and violence as part and parcel of her condition, even though the disorder usually presents much more subtly.

That negative stigma against mental health illnesses and those suffering from it was quite a bit stronger at the time of these films' releases than it is in society today. For their ability to showcase a scorned subset of diseases in a relatively fact-based manner, *Rain Man*, *Fatal Attraction*, and several other films should still be applauded.

Even in the late 1980s, there was a much larger proportion of the American population that did not even believe mental illness existed. Although unfortunate, we don't have to stretch our imaginations too far to understand how it is easier to believe in visible medical conditions such as common colds or broken bones, compared to the invisible nature of psychiatric disease. In addition, mental healthcare providers were also treated with an unfavorable bias. It was not uncommon for attending therapy sessions to be seen as admitting weakness,

and for psychiatry and psychology to be dismissed as pseudoscience. In this harsh setting, *Rain Man* and *Fatal Attraction* are two popular films among many others that took successful steps to legitimize psychiatric disorders and their care.

In recent years, society has grown more accepting of mental illness, and media portrayal of mental health disorders has correspondingly grown more nuanced and more accurate. The relatively recent blockbuster release of *Iron Man 3* (2013) sheds light on main character Tony Stark's post-traumatic stress disorder symptoms and his recurrent panic attacks. Before his ailments, Stark had been heavily involved in some fantastically intense battles. His subsequent nightmares and what he dubs

"anxiety attacks" accurately illuminate a very real problem facing our own combat veterans today. In a short quarter-century, an increasingly well-considered media portrayal of mental illness has continued to develop.

This evolution has helped to bring psychiatric care out of the darkest corners of the field of medicine and into the limelight. The improved depictions of mental illness have no doubt helped individuals who were once suffering in silence. The increased nuance present even in commercialized Hollywood films is a testament to the increased acceptance now present in American society. However, despite the rapid expansion of mental health awareness, media versions of psychiatric illness can still be inconsistent when faced with some long-standing concerns.

Commonly in pop culture portrayals of psychiatric disorders, even to this day, the drama of the moment tends to take center stage. It often does not matter whether that portrayal is in a movie, television show, or even an individual social media post. The creator can easily take some creative liberties, bending and twisting the plain facts of how an illness may present, just to further their story. Associations based on stereotype, rather than research data, may pop up. For example, in *The Voices* (2014), the main character Jerry ends up perpetrating several acts of violence against those close to him. This is remarkably reminiscent of Alex Forrest's many violent actions. However, the important distinction that those who suffer from mental health illness are more likely to be victims of violence rather than perpetrators is ignored all the same, in films more than 25 years apart. The only purpose is to heighten the drama and entertainment value of the provided content.

Similarly, rarely do we see characters with mental health disorders seek consistent treatment from the appropriate resources available to them. Unfortunately, in a world where stupendous sums go into ensuring that the commercial and entertainment

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WITH MENTAL
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FROM THE
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AVAILABLE TO
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FEATURE

values of a production are maximized, a straightforward take on successfully controlling mental health illnesses would likely be dull and drab. Instead, a movie trope has flourished that those with mental health illnesses are simply bound to commit atrocious acts due to inadequate or nonexistent care, even though in real life an enormous proportion of psychiatric conditions are successfully managed.

The lasting nature of this generalization likely leads to more interesting avenues for storytelling. In *The Visit* (2015), two institutionalized patients manage to escape a psychiatric facility and murder an elderly couple. Those patients then assume their victims' identities when the couple's estranged grandchildren visit. This scenario provides the thrills a horror film needs. But it could also unintentionally implant some doubts regarding the basic safety of psychiatric facilities and the quality of care provided. Mental health funding can be lacking, and treatment may sometimes be unsuccessful. However, films such as this could easily lead to the mistaken thought that mental health illnesses are rarely treatable, and those who suffer from them should be locked away indefinitely.

Despite these types of creative liberties, it is evident that cinema and other media depictions of mental illness have come a long way since the basic themes that an individual is either sane and functional, or insane and a detriment to society. However, to this day there are still numerous flaws present. So, what should we do when navigating those pitfalls?

The answer, of course, isn't to demand widespread changes in movies, television, and social media. What we can easily do instead is approach any media representation of mental illness with acceptance and empathy, but also a critical eye. We can still accept the character as is, without ruining our enjoyment of a carefully detailed plot arc. We can still feel for a character's mistakes, while enjoying the drama that is sure to ensue. However, when it comes to improving our objective understanding of mental health and all it entails, we should avoid pop culture. Instead, the most reliable resources we have are the unbiased scientific research that continuously propels forward mental health care, and the care providers of all levels who use that research to understand, recognize, and manage mental health illnesses.

Pop culture is exceptional entertainment. But let's be a little careful before we believe every bit of it, too.+



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EAT FOR GOOD SKIN

Micronutrients
and the skin

BY ALI T. KHAN, BS, CHELSEA KESTY, MD,
AND CYNTHIA BARTUS, MD

Vitamins and minerals are micronutrients that maintain our bodies at the cellular level. Without these building blocks of nutrition, often described as ‘essential’ (required as part of a balanced diet), many of the body’s functions become disrupted. An initial warning sign that these micronutrients may be deficient or in excess are visible skin findings. A number of factors put people at higher risk of nutritional deficiency; these include age, pregnancy, and source of nutrition (Mediterranean, vegetarian, vegan diet), as well as social factors like alcohol use, smoking, and socioeconomic class influencing access to nutritious foods. Below is a review of certain micronutrients that may have cutaneous manifestations.

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Vitamin A encompasses a group of fat-soluble vitamins such as retinol. Vitamin A is found in dairy, produce, and meats. It is an integral factor to the immune system, vision, and skin (as part of keratin, a protein found in the skin and hair). Findings of vitamin A deficiency include white spots in the eye (Bitot spots), difficulty seeing in the dark, and ultimately blindness. Skin changes include roughening of the skin (phrynoderma), dry skin, and acne-like lesions.

Vitamin A supplementation at 700-900 mcg daily (2,000-3,000 IU) is recommended with a maximum of 3,000 mcg/d. Toxicity concerns arise with daily doses of approximately 7,000 mcg (25,000 IU) or greater. Vitamin A excess can lead to dizziness, headaches, liver damage, and even death. Excess Vitamin A in pregnant women increases the risk of fetal defects. It is important to correct toxic over-supplementation and monitor patients on systemic Vitamin A retinoids. Cutaneous signs of Vitamin A excess include itchiness, widespread redness, peeling of the palms and soles, and hair loss.

Beta-carotene is a Vitamin A precursor found in colorful fruits and vegetables like tomatoes, carrots, and dark leafy greens. It is converted to retinol after ingestion and also has functions as an antioxidant. Beta-carotene has benefits to the brain, eyes, and skin, and high levels of beta-carotene does not have the negative consequences of excess Vitamin A. However, harmless yellow-orange discoloration, most notably on the palms, soles, and central face, may result from beta-carotene over-supplementation. Once supplementation is discontinued, the skin discoloration gradually resolves.

Vitamin B3, also known as niacin or nicotinamide, is naturally found in meats, fish, fortified cereals, and legumes. Niacin has been shown to increase good cholesterol (high density lipoproteins, or HDL) and decrease fat; as a result, it can be prescribed for those patients with high cholesterol. Skin irritation, redness and/or darkening can result from niacin deficiency, as well as discoloration of the tongue and dandruff of the scalp, skin, and groin. Deficiencies of vitamins B2 and

B6 result in similar skin changes. Pellagra, a consequence of long-term niacin deficiency, is a constellation of symptoms including ulcers around the mouth, skin sensitivity to sun exposure, especially causing a rash of the upper back and neck ('collar rash'), diarrhea, and dementia that can ultimately cause death. Moreover, niacin taken in excess can lead to facial flushing, itchiness, yellowing of the skin (jaundice), and liver damage.

Vitamin B7 is also known as biotin. Biotin is found in many foods, including eggs, beans, and nuts, and deficiency is very rare in individuals who consume a well-balanced diet. Patients with biotin deficiency may present with hair loss, brittle nails, skin irritation around the eyes, nose, and mouth, and, in severe cases, neurologic changes. Biotin is frequently used as a supplement for hair and nail growth, but there is limited data to support this use. However, biotin supplementation, even as low as one dose of 10 mg, may interfere with several lab tests including measures of thyroid disorders and heart disease.

Vitamin B9, known as folate or folic acid, is found in whole grains and leafy green vegetables. Deficiency is more common in people who consume a lot of goat milk in their diets. Common skin findings of folate deficiency include discoloration of the hands, nails, face, palmar creases, and skin folds like the armpits. In addition, individuals with folate deficiency may have their natural hair color replaced by shades of grays and whites (canities). Folate deficiency often coincides with Vitamin B12 deficiency, and the two vitamins are often assessed together.

Vitamin C, otherwise known as ascorbic acid, is a water-soluble compound that is an essential factor for collagen synthesis. The first skin finding of vitamin C deficiency is thickening of the skin (hyperkeratosis). Severe vitamin C deficiency is known as scurvy, and classic symptoms of this condition include damage to the hair follicles (with corkscrew-appearing hairs), swollen, friable gums, and tooth loss. Other symptoms of deficiency include brownish-red skin spots (petechiae), red spots under nails, bruising,

scooped-out appearance of nails (koilonychia), bleeding beneath bones and joints, impaired wound healing, and brittle bones.

Vitamin D is a fat-soluble compound that is integral in calcium absorption and bone strength. Deficiency is most common in individuals with limited dietary intake and sun exposure, and approximately one billion people in the world are vitamin D deficient. Vitamin D deficiency can disrupt calcium balance and the skin and hair's keratin proteins. Studies have linked a lack of Vitamin D with increased risk of hair loss, eczema, and psoriasis. Vitamin B12 deficiency has also been linked to eczema.

Zinc is an essential mineral with properties important for protection against ultraviolet (UV) radiation damage. Skin changes include impaired wound healing and irritation to the eye, hair, nails, and skin (especially around the mouth, hands, feet, and groin). The classic triad of skin irritation, diarrhea and depression is seen in about 20% of patients, and interactions between zinc and copper deficiency may have a role in psoriasis.

Eating disorders like anorexia and bulimia can cause any of the previously mentioned micronutrient deficiencies and related skin findings. Anorexia may also lead to baby (or lanugo) hairs, especially on the face and arms. Self-induced vomiting in people with bulimia can result in calluses or scars of the knuckles, in addition to enlarged salivary glands and erosion of the tooth enamel.

Nutrition-related skin disease occurs in the setting of either deficiency or excess of essential micronutrients needed to maintain the biology of the body. The vitamins and minerals described in this article play a role in only some of the nutrition-related skin findings. Recognition of these signs can aid in diagnosis of underlying conditions and should be discussed further with licensed medical professionals. +

ADHD

attention deficit

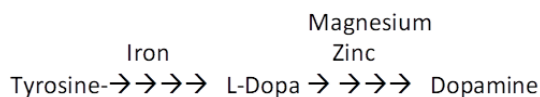
A nutritional approach to ADHD treatment

BY ANGELA CAMASTO, MD

FUNCTIONAL MEDICINE PEDIATRICIAN, PEDIATRIC WHOLE HEALTH, LLC

Although symptoms of Attention Deficit Hyperactivity Disorder (ADHD) were described as far back as the time of Hippocrates, ADHD was first officially described in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-II) in 1968. It was initially called "hyperkinetic reaction of childhood" and in 1980 renamed "Attention Deficit Disorder, with or without hyperactivity." Methylphenidate was created in 1944 by Swiss Chemist Leonadro Panizzon¹ and has been the staple for ADHD treatment ever since. Methylphenidate effects the central nervous system by inhibiting reuptake of neurotransmitters Dopamine and Norepinephrine, thus increasing their concentration in the synaptic cleft. Other stimulants, such as dextroamphetamine, act by increasing the release of dopamine and norepinephrine from the presynaptic neuron. While these medications help millions of people with ADHD every year, there are still up to 30% of those with ADHD that do not respond to stimulants.²⁻³ Others may have undesirable side effects, such as insomnia, weight loss, decreased appetite, mood and/or personality alterations. Additionally, some parents prefer not to use stimulant medication with their children. For these patients, a comprehensive nutritional approach can prove helpful.

When we consider the dopamine pathway, four important nutrients should be highlighted: iron, zinc magnesium, and Omega 3 fats.



Several observational studies have shown that children with ADHD have significantly lower ferritin levels than controls.⁴⁻⁶ One such study in 2004 by Dr. Eric Konofal found that 84% of children with ADHD had serum ferritin less than 30, compared with only 18% of controls.⁷ Within the group of children with ADHD, lower serum ferritin levels correlated with worse scores on ADHD rating scales. Dr. Konofal followed up these findings with a placebo controlled interventional study in 2008.⁸ There was a significant improvement in ADHD behavior in children with a ferritin level below 30 who were treated with iron supplementation. Since iron insufficiency can exist even without overt anemia, a screening ferritin level should be considered for children with ADHD. Target ferritin levels are greater than 30. Children can be at

risk for poor iron status due to processed diets, periods of rapid growth, and/or consuming high amounts of dairy. For some, dairy products can irritate the gut lining leading to microscopic blood loss. Dairy may also inhibit iron absorption due to its calcium content.

Zinc is an essential trace element that assists in the conversion of L-Dopa to Dopamine. It also acts as a coenzyme of the enzyme delta-6 desaturase, which is involved in the formation of the polyunsaturated long chain fatty acids, linolic and linolenic acids. These are important building blocks of neuronal membranes. At least 3 studies have demonstrated that zinc levels are lower in children with ADHD.⁹⁻¹¹ Additionally, two placebo-controlled studies have shown significant benefit of zinc therapy: one using zinc monotherapy alone, and the other adding zinc therapy to methylphenidate treatment.¹²⁻¹³ Potential causes of marginal or low zinc status include: 1) eating a highly processed diet devoid of zinc, 2) having a diet high in foods that impair zinc absorption such as phytates and oxalates, 3) eating high copper foods (copper and zinc metabolism are closely related and their levels have an inverse relationship) and 4) impaired zinc absorption due to inflammation of the gut lining. Short-term zinc supplementation for up to 4-6 months is generally well tolerated with little risk for adverse effects. However, because zinc and copper can compete for absorption, copper levels should be monitored.

Magnesium is a cofactor for over 300 biochemical processes in the body, including aiding in dopamine production, and acting as a GABA receptor agonist. At least 5 studies have shown that children with ADHD have lower levels of magnesium than controls and that giving magnesium supplementation creates improvements in behavior and hyperactivity scores.¹⁴⁻²² Many American children likely have suboptimal magnesium levels due to a few factors: 1) Key nutrients are stripped away from our food during the refining process; 2) Our soil has been depleted of minerals over years of farming and 3) High magnesium foods are not kid friendly (kale, quinoa, pumpkin, chickpeas, spinach, avocado). Checking a RBC magnesium level is preferable to a serum magnesium level as it more accurately reflects whole body magnesium status over the past 3 months. Children may benefit from magnesium supplementation even if frank deficiency is not found, as values on the low end of normal could be suboptimal in those with ADHD symptoms.

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Omega 3 Fatty Acids, such as DHA and EPA, also help optimize the functioning of dopaminergic neurons. Omega 3s, along with Omega 6s and 9s, are essential fats for whole body health and must be taken in through our diet as the body cannot synthesize them de novo. Clinical research indicates that at least a subset of children and adults with ADHD have lower DHA levels. This is not surprising since our standard American diet is woefully deficient in Omega 3 fatty acids compared to Omega 6 fats. A healthy ratio of dietary Omega 6 fats to Omega 3 fats is 2 to 1, but our American Diet provides a ratio of 15 to 1. Most studies supplementing with Omega 3 fatty acids have produced positive results for children with ADHD, including a 2009 randomized, double-blind, placebo-controlled study done on French Canadian youth.²³⁻²⁵ Since most children do not consume significant amounts of high Omega 3 fatty foods in their diet (salmon, flaxseed, hemp seeds, chia seeds), a fish oil supplement that contains both DHA and EPA is advisable.

The above nutrients should be optimized in concert to maximally support dopaminergic neuronal function. It would also be prudent to simultaneously address potential food sensitivities and blood sugar imbalances.

Our intestinal lining is one cell layer thick and is vulnerable to “wear and tear” from pesticides in our food, medication use, and emotional stress. Increased intestinal permeability (aka “leaky gut”) ensues and allows our immune system to be exposed to food particles in our intestines. This can create immune activation, chronic inflammation, and persistent elevated levels of stress hormones, thereby producing or exacerbating ADHD symptoms. And let’s not forget about the increased number of additives in our processed diet, which by themselves can create ADHD behaviors in vulnerable children. A trial of removing the more common usual offenders like artificial additives, dyes, dairy, and gluten should be considered while observing for behavior improvements.²⁶ Although more work intensive, doing a clinical trial of food elimination gives more accurate results than blood testing for food intolerances.

A typical American breakfast is carbohydrate dense, devoid of protein and healthy fat. Greater insulin spikes from these high glycemic meals will induce hypoglycemic episodes a few hours later. The body responds with a compensatory release of stress hormones, which can create hyperactivity. Even neurotypical students have been shown to have better test performance and less hyperactivity after lower glycemic meals.²⁷⁻²⁸ Admittedly, making diet changes may seem daunting for parents, but there are several cookbooks and websites that have kid-friendly meal ideas and recipes specific to balancing blood sugar.²⁹⁻³¹ Nutritionists are also an underutilized resource for help in this area.

ADHD is a complex condition with multiple causalities. As such, including comprehensive nutritional interventions in an ADHD treatment plan can be a valuable tool for creating better school success, whether used alone or in conjunction with stimulant medication. Research supports the following approach: assessing ferritin, zinc, and magnesium status and optimize where needed; start Omega 3 supplementation; eliminate artificial colors and preservatives in the diet; avoid high glycemic meals and snacks; investigate the possibility of food sensitivities. For further reading on this topic, I direct the reader to a book by pediatrician Dr. Sanford Newmark, *ADHD without drugs: A Guide to the Natural Care of Children with ADHD*.+

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CARE COORDINATION

Enabling Population Health

BY NINA TAGGART, MD, MA, MBA, FAAO

SENIOR MEDICAL DIRECTOR OF ACCOUNTABLE CARE, VALLEY PREFERRED

Throughout 2020, the COVID-19 pandemic showcased the complex dimensions of our health care system and the critical value that care coordination offers as a population health tactic for patients to get high-quality care. When “normal” life was interrupted at the practice, system, and community levels, patients and providers struggled. Practices temporarily closed, procedures were deferred, communities practiced social distancing, and patients struggled financially. As a result, many patients delayed important screenings and maintenance visits, or could not afford care or medications. Medical providers were challenged to keep patients connected and on track with care plans. However, practices that invested in care coordination were better able to maintain quality of care and patient engagement even during the pandemic.

With health care already distributed across multiple settings and providers, managing their health is often overwhelming for the nearly 30 percent of Americans with multiple chronic conditions.¹ Population health-based care delivery is one approach to supporting these patients. Care coordination brings that model to the personal level through individualized care plans and interventions producing high quality, high-value health care.² The goal is to achieve safer and more effective care through better care activity coordination.

Continued on page 16

EXPANDING CARE BEYOND THE PHYSICIAN

At its core, care coordination in the primary care practice enables information sharing among all the providers involved with a patient's care. Each member of the care coordination team works to identify the patient's needs and preferences and communicate them at the right time to the right people, so that information is used to provide safe, appropriate, and effective care to the patient. And everyone works together toward the same end.

In this population health model, providers are paid for maintaining and improving the health of their patient panels. Population health initiatives' clinical and financial results strongly rely on preventing illness progression while continuing to care for patients when illness strikes, therefore, an integrated effort is essential. "Expanding the care team has become more critical than ever before," says Jonathan Burke, DO, CHCQM, Medical Director, Clinical Services with a population health management and data analytics firm. "Physicians can't do it alone and should not be expected to. We all know it takes a village to care for one patient, so a team-based approach is essential."

The "team" typically includes physicians, Advanced Practice Clinicians (APCs), social workers, nurse case managers, and pharmacists who are available to support a patient's plan of care. To understand how the process flows, we'll look at how data sharpens the focus of care coordination, what the team members do, and some results of this work.

ACTING ON DATA

Actionable information about the population under management drives care coordination interventions. In addition to sharing EMR information, these teams rely on data extracted from payers and electronic health records to develop registries that proactively identify patients most in need of care coordination services. They are often patients that have not been to a doctor's office in quite some time! Using integrated claims and clinical data provides a more complete picture of a panel that shows what is, and

TANGIBLE RESULTS

Compared to a matched control group, patients managed by a care coordination team had between 5-8% fewer emergency room visits, 12-15% lower admission rates and 11-13% less readmissions. This resulted in over \$3.9 million dollars in cost avoided for the population.

isn't, happening away from the practice. That helps direct these valuable resources for the greatest impact supplementing the standard work in physicians' practices.

STARTING THE PROCESS

The anchor of the care coordination team is the nurse care manager, who will bring together the resources needed to drive the plan of care. These specially trained nurses follow up with patients discharged from the hospital or emergency department and answer questions about the plan of care and promoting adherence to it. They can often troubleshoot or triage many problems and make sure that urgent issues surface quickly to the provider.

"Our case managers reach out to patients to have a dialogue about their concerns and tailor our outreach to their schedule and communication preferences," says Pamela Fisher, BSN, RN, a care coordination manager. "We use several data-driven tools to complement what we learn to develop an action plan that may address medical management needs, potential gaps in care, barriers to care, health maintenance opportunities, behavioral health needs, social determinants of health, medication management, patient support systems, and health literacy."

Care managers may also liaise with clinical resources in provider, practice, and insurance payer settings, often acting as an advocate. "Nurse care managers are a partner with the patient, their provider, and the patient's health insurance plan to connect patients to services and resources for a variety of

social needs," says Cathryn Kelly, MSN, RN, RD, CCCTM, CMSRN, a care coordination manager. "We use a patient-centric approach and techniques like motivational interviewing, to identify and focus on what personally matters to them. And, in doing so, we enable our patients to find ways to meet their provider's plan of care goals for better health outcomes."

An integrated EMR is also a key communication tool to keep all care team members informed as the patient's needs and circumstances change. The care manager plays a centralized role to help patients be at their physical, functional, and emotional best while managing one or more medical circumstances. "We strive to personalize the care management experience to ensure the highest quality care is provided in an efficient and cost-effective way while putting the patient's quality of life goals at the center," says Kelly.

HOW IT WORKS: ADDING ANOTHER LEVEL OF CARE

One case, summarized by Care Manager Pamela Youse, RN, illustrates the partnership between the provider, the patient, and their nurse care manager. The goal is to connect the patient with resources to self-manage their health conditions and be more adherent to their medical management.

"This patient, a middle-aged man with a history of uncontrolled Type 2 diabetes and who is completely blind, was referred to care coordination by his primary care provider. During the pandemic, he and his wife, who is also completely blind, moved from a distant state to live closer to their only living family member. The patient's struggles to adapt to the climate change and navigate his new environment were made harder by other comorbid conditions.

"Due to his blindness, the patient was afraid to use appliances to prepare healthy meals and relied on prepared and fast foods. As a result of these physical and dietary challenges, his HgbA1C continued to climb. He shared with the care manager that since

he could not see or read the results on his glucometer, he was not regularly tracking his blood sugar. With concern for his worsening situation, the patient's PCP intervened to prescribe a glucometer that would provide a verbal reading, but there were insurance coverage barriers.

"The nurse case manager and the PCP communicated daily and successfully set up a peer-to-peer review with the patient's insurance to obtain equipment that will 'talk' to the patient. Since then, the patient is keeping logs of his blood sugars and continues working with care management to review his medications and insulin regimen with his doctor."

MEDICATION MANAGEMENT

Pharmacists also play an outside role in care coordination. Medication reviews can identify duplicate medications or those no longer appropriate, improving safety and cutting out-of-pocket costs for patients. Simplified regimens can lead to better compliance and better outcomes for diabetes, hypertension, depression, and other chronic conditions. Reminders and pill packaging along with mail order can be part of the plan to get the right medication to the patient every time. Those practices that don't have access to a pharmacist can turn to community pharmacists. One group found that its higher risk patients visited their pharmacy 35 times a year – far more often than the three times they saw their primary care provider.³

Local physician John Stoeckle, MD, CHQS, shared an example: "One patient with a deep venous thrombosis did not have insurance coverage. This is not a patient for which I would have felt comfortable prescribing warfarin due to reliability issues. Our care manager was able to work with him both on the process for getting insurance and in getting him affordable coverage for an anticoagulant."

BRIDGING THE GAPS IN MENTAL HEALTH

Managing one's chronic conditions and medications during the pandemic adds stress

to an already stressful situation. A recent Kaiser Family Foundation survey found that during this pandemic, about four in 10 adults in the United States reported symptoms of anxiety or depression, up from one in 10 adults who reported these symptoms in the first half of 2019.⁴ Many of the more expensive patients in any population have a behavioral health diagnosis.⁵ Being able to access a counselor allows timely interventions, and even bridging to psychiatry if needed. Understanding what is going on with those conditions certainly impacts the overall care plan and treatment choices.

Social workers are also helpful in obtaining access to community resources to assist with getting care at home, transportation, supplemental nutrition, or medication assistance. A common starting point is United Way's 211, a confidential helpline for finding food, and assistance with mental health and health care expenses. Another is the Resource Information and Services Platform for Pennsylvania (RISE PA) platform built using Aunt Bertha, America's leading search and referral platform of social service organizations. This is an interactive statewide resource and referral tool provided by the Department of Human Services to help close the loop with community-based organizations.

Meeting the needs of growing numbers of patients through distributed care in a personalized way means adopting population health with individualized care coordination. Whether physicians and health care providers access a virtual team or have key team members in the office, data-driven care coordination will help deliver on the commitment to patients even as physicians feel that they are increasingly doing more with less.

Care coordination reaches across the continuum; A case study bridging the PCP with psychiatry and a clinical health coach:

Ms. Smith is a 65-year-old grandmother with a 15-year history of Type 2 diabetes complicated by elevated blood pressure and recurrent episodes of major depression. Ms.

Smith has a BMI of 38 and has struggled with her weight since childhood. At a doctor's visit, she was found to have an HbA1c of 8.9%, a blood pressure of 148/88 and PHQ-9 score suggesting minor depression. Her primary care doctor (PCP) worked with the social workers in care coordination to refer Ms. Smith to a psychiatrist. In collaboration with her doctors, Ms. Smith was introduced to a clinical health coach and the entire care team stayed connected through care coordination's electronic patient portal.

Ms. Smith missed the first appointment with her psychiatrist, which was picked up by the charting system. The clinical health coach called Ms. Smith to set up another appointment. During the subsequent first visit, the psychiatrist adjusted her depression medication, but also found that her blood pressure was elevated. Ms. Smith also complained of headache and fatigue, so care coordination alerted her PCP, who then adjusted her anti-hypertensive medications. Shortly after, the clinical coach followed up to make sure Ms. Smith knew how to take her medication and was taking it as directed. The clinical coach suggested Ms. Smith check her blood pressure every other day, which she did. Ms. Smith slowly began to feel less depressed, and her BP slowly reduced to target levels with one more medication adjustment. +

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PARTNERS UNITE

to Provide Fresh, Healthy Food to Lehigh Valley Families

BY LAURA MCHUGH, UNITED WAY OF THE GREATER LEHIGH VALLEY

When the COVID-19 pandemic gripped the Greater Lehigh Valley, the adverse health effects became immediately apparent. Many found themselves unexpectedly out of work and facing serious choices with limited resources. Would they pay the electric bill or buy diapers? Could they afford the rent and food for their families?

“In our food pantry, we went from serving 800 households to serving 3,000,” said Victoria Montero, Executive Director of Hispanic Center Lehigh Valley located in South Bethlehem.

Food pantries across the region reported similar increases. At the height of the pandemic, the demand for emergency food increased by at least 50%, and in many cases,

much more. Although that initial spike has plateaued, recent research from United Way of Pennsylvania shows that feeding their families remains a top concern among Pennsylvanians living paycheck to paycheck.

“Food insecurity is on the rise for Greater Lehigh Valley residents and children in particular. Maintaining access to healthy, affordable food is critical to community stabilization. Although recovery is underway, the need for improved food access will continue,” said David Lewis, President, United Way of the Greater Lehigh Valley.

“Meeting those needs takes a UNITED approach. With new partnerships such as the Air Products Fresh Food Promise and Full Cart Virtual Food Pantry, we’re more committed than ever to addressing the issue



of food access in the Greater Lehigh Valley,” added Lewis.

AIR PRODUCTS FRESH FOOD PROMISE

One in 10 Lehigh Valley residents faces food insecurity, including one in six children, according to the latest data from Feeding America. That means they do not have reliable access to affordable, healthy food and may not know when or where they’ll get their next meal.

“Air Products and United Way believe that no one should wonder where their next meal is coming from and families should not have to worry about food insecurity. That’s why we’ve launched the Air Products Fresh Food Promise,” remarked Laurie Gostley Hackett, Director of Community Relations and Philanthropy for Air Products and 2021 campaign chair for United Way of the Greater Lehigh Valley.

With a goal to expand access to healthy food for thousands of local children, families and older adults, Air Products Foundation will make an additional contribution to provide fresh, nutritious food in honor of every new donor during United Way’s 2021 fundraising campaign.

“With the Air Products Fresh Food Promise, we encourage and invite everyone in our community to step up and make a difference by contributing at any level. Food insecurity is a major challenge facing our community, and when we invest in United Way, all of us become part of the solution,” added Hackett.

Air Products Fresh Food Promise applies to all new donations made by March 31, 2022.

FULL CART VIRTUAL FOOD PANTRY

One of the region’s newest emergency food solutions is Full Cart Virtual Food Pantry. Through a pilot program launched earlier this year, 250 Lehigh Valley families are receiving boxes of food delivered directly to their homes. Each box contains shelf-stable food options that will serve a family of four for about ten days or a single person for about six weeks.

“Hunger is most often linked to poverty, and the COVID-19 pandemic illuminated and magnified the non-economic barriers to food access that impact food security for many individuals,” said Susan Dalandan, Coordinator of the Lehigh Valley Food Policy Council. “Those non-economic barriers include transportation,

health and well-being, time, availability and opportunity as well as cultural and social customs.”

The Full Cart pilot program is a collaboration of United Way of the Greater Lehigh Valley, the Lehigh Valley Food Policy Council and U.S. Hunger and is made possible with funding from BSI Corporate Benefits, the Baker Foundation, City of Allentown CHAMPS grant, Roberta “Robin” Barnes and her husband Clark Chandler, as well as individual United Way donors.

“There is no business more important than supporting the most vulnerable in our communities that struggle with food insecurity,” said Anthony (Tony) DaRe, CEO of BSI Corporate Benefits. “Our BSI team is committed to doing whatever it takes to support United Way and the Full Cart program at this most critical time of need. +

To donate or learn more, visit
www.unitedwayglv.org/fresh or
 text “FRESH” to 40403.

Rofeh

SUBMITTED BY GENE H. GINSBERG, M.D.

After more than thirty years in medicine, I have finally learned what it really means to be a doctor.

Leon Friedman (name changed for this essay) became my patient several years ago. He was a Holocaust survivor who wrestled with his memories. Yes, he suffered depression, and what some would call “survivor’s guilt.” After all, he had lost his whole family and endured an amazing odyssey of hiding places, brutal work prisons and finally, concentration camps. As he aged, several medical conditions plagued him. I saw him frequently for one problem or another; sometimes I thought he just wanted to talk.

His visits often challenged my diagnostic skills. Some of his complaints were clearly psychosomatic, and at times, it was difficult to sort out the pathologic from the emotional. He was cordial to me and my staff and he seemed to take comfort in my reassurance. I respected him, too. Not only did he survive unspeakable horrors; he was able to build a life in America, establishing a sheet metal business, sustaining a happy marriage which produced three loving and intelligent children.

I enjoyed speaking with Leon about his interests in politics and religion. He could find a religious reference for almost any situation. When my own parents died, I

frequently attended the evening services at the Orthodox Temple where he was a member. He would greet me and call me his “rofeh,” the Hebrew term for physician. He explained that Jews all over the world pray everyday for “rofuah shlemah,” healing of the sick.

And then when Leon had a persistent cough, I ordered a chest xray. Although there was no evidence of pneumonia, the film showed new shadows. A followup CAT scan confirmed my suspicions of possible lymphoma. Because of his advanced age, and because the condition was causing no symptoms, Leon and I agreed to a course of observation. An oncologist concurred.

But after about a year, Leon complained of increasing fatigue and malaise. We were able to get a biopsy of a cervical lymph node which, as I expected, confirmed the diagnosis of lymphoma. We talked about the options. At first, he was very despondent and wanted nothing done. But after consultation with the oncologist and his family, he agreed to try chemotherapy.

The treatments were rough. He got weaker. Was it the lymphoma, I thought, or was it depression? Soon enough, I got my answer. Leon developed a sudden, raging fever and was admitted to the hospital for suspected sepsis.

To my dismay, my primary hospital had no available beds, an all too frequent occurrence, so Leon was transported across town to another facility. I knew he would receive excellent care; I knew the hospital and I knew the other physicians on his case. But I was still out of the treatment loop.

Then, I received a distressing call from Leon's son, who was planning to come in from Chicago. He seemed to be angry with me for not assuring the continuity of care. I tried to explain that I was not a member of the other hospital's staff, that I had received some reports, but that I could not be involved in the day to day care of his father. Furthermore, I explained to him, I felt confident in his doctors and that they could call me at anytime.

He really did not seem satisfied. Then he said, "at least you could have called." My mind was numb. I can't visit every sick patient who ends up in another hospital. What was he saying? I should call all of my patients in the hospital? Leon was a loyal patient, a nice man, but he wasn't my good friend. He wasn't a relative.

I was torn, upset, but I held my tongue. I thought to myself that the son was just emotionally distraught because his father was so ill, and probably dying. I had an unsettled feeling. The experience continued to nag the inner recesses of my mind. I had conflicting emotions: anger, anxiety and even guilt.

Finally, that night I decided to call the oncologist. I learned that he was unable to pinpoint the source of infection. His blood counts were low. He was deteriorating and hope was fading. I called Leon's wife and went over the whole situation with her on the phone. She seemed satisfied with my explanations. She thanked me for the call.

Next week was a hectic one, busy with office and nursing home patients, hospital emergencies and the usual annoyances that physicians face every day, such as paperwork, irritating calls from insurance companies and the like. Somehow, I found the time to dash across town, fielding several phone calls in the process, and was still able to visit Leon in his room. The visit was brief, but he seemed very pleased. I left feeling comfortable that I had helped to lift his sagging spirits.

Then a few days later, the oncologist called to tell me that a bone marrow biopsy showed that the chemotherapy failed miserably. His marrow was filled with lymphoma. The fever was caused by the malignancy. I called his wife again, but reached one his daughters. I answered questions truthfully and clearly. We talked about possible Hospice care. I felt that I was involved in Leon's care at this time to the best of my ability, even though I was relegated to the sidelines by his being in another hospital.

That night, on the Jewish Sabbath, Leon died.

I went to the funeral. It was a frigid wintry day, snowing, and the attendance was small. After all, other than the children and grandchildren, there were no other living relatives. Most of the friends were members of the Orthodox temple. I listened to Leon's son deliver a stirring eulogy, and I learned more anecdotes about his life. Then the Rabbi spoke. He compared Leon to the burning bush in Exodus, the bush that was consumed, yet would not die. He spoke about the bush not being just a sign of God, a revelation for Moses, but he also spoke about the bush as a symbol of the durability and strength of the Jewish people. And Leon

was the perfect example of a man who was wrought with adversities, but somehow was able to survive, and go on and establish a new and fruitful life.

Then the Rabbi said something that hit me like a dart. He said that Leon had the uncanny and admirable ability to see the good in others. That comment stayed with me: the ability to see the good in others.

I wrestled with the Rabbi's observation. For weeks this thought and the telephone experience with Leon's son gnawed my consciousness.

Gradually, my thoughts became more lucid. I began to understand that maybe Leon's son knew that his father had great respect for me and that he depended on me, and yes, may have even REVERED me as his physician. To Leon, I was not just his physician in the sense of a person he went to see when he didn't feel well. I was his friend, advisor, confidante. I was a "healer," a "rofeh." This man, who was so good at seeing the goodness in others, felt so comforted by my interventions and by my very presence. How ironic that he saw the goodness in me that I was unable to see in myself.

Physicians get so "caught up" in the trivialities of medical practice, worry incessantly about lawsuits, fret about antagonistic patients and families. We forget so often that our patients respect us, hang on to every word we say, and depend on our advice and expertise. And many patients even revere us.

I am now determined to approach each patient in a different way. Since my patients look to me as one who heals, teaches, advises and gives comfort, I owe it to my patients to respond to them as one who appreciates the goodness that they see in me.

Thank you, Leon, for teaching me this lesson. Your Rofeh wishes you everlasting peace. ✚

Quarterly Legislative Update from the Pennsylvania Medical Society Legislature Recesses Early for the Summer

Pennsylvania lawmakers have historically waited until the very last minute to approve the state budget. This year, the General Assembly exceeded all expectations by approving a nearly 40.8 billion-dollar budget on June 25...five days before the constitutional deadline. The frenzy of legislative activity, immediately prior to the budget deadline, often results in “legislative surprises” where bills that had otherwise languished for one reason or another suddenly make it across the finish line. This year was no exception.

For the Pennsylvania Medical Society (PAMED), legislation to address the process by which physicians obtain informed consent from patients passed both chambers and was signed by the Governor on June 30, 2021, as Act 61. The measure, formerly Senate Bill 425, had originally been introduced several sessions ago after a state Supreme Court ruling materially changed the informed consent process, no longer allowing physicians to delegate that authority. The change significantly disrupted patient flow in hospitals often leading to surgical delays. Physicians will once again have the authority to delegate informed consent to another colleague or other qualified individual.

Members can learn more in PAMED’s Quick Consult on Act 61 at www.pamedsoc.org/QuickConsult.

Other PAMED supported bills were advanced in the legislative process prior to the summer recess.

THESE INCLUDED:

- **Senate Bill 225 (PAMED supports)** – Legislation to reform the prior authorization process. Approved by the Senate Banking and Insurance Committee.

- **Senate Bill 705 (PAMED supports)** – A telemedicine measure that will, among other things, mandate insurers to pay for telemedicine. The bill was approved by the Senate Banking and Insurance Committee.

- **House Bill 681 (PAMED supports)** – A measure to limit restricted covenants in physician contracts was approved by the House Health Committee and awaits final consideration by the full House.

- **House Bill 1280 (PAMED supports)** – Legislation changing the process by which patients are informed about the results of imaging studies. The bill was recently approved by the House Health Committee.

- **Senate Bill 416 (PAMED supports)** – This legislation officially recognizes certified registered nurse anesthetists (CRNAs) in the Commonwealth of Pennsylvania as well as outlining requirements for certification of CRNAs. PAMED followed the anesthesiologists’ lead in supporting this effort. The bill was signed into law by the Governor on June 30 as Act 60.

- **House Bill 1420 (PAMED supports)** – The Health Care Heroes Act will establish a public awareness campaign to provide information regarding the programs and services available for first responders, health care workers, and other workers suffering from mental health issues related to COVID-19.

- **House Bills 1700-1701 (PAMED supports)** – Newly Introduced – Disclosure of disingenuous physician complaints. This bill would no longer require physicians to acknowledge the existence of a complaint filed against their medical or osteopathic license if the case were closed without any formal action. PAMED supports this effort and will advocate to advance these bills. This legislation has been referred to the House Professional Licensure Committee.

While the advancement of legislation listed above positively reflects PAMED’s legislative efforts and the efforts of engaged physicians, there are several bills that we continue to oppose and actively monitor. It is important for legislators to hear from their physician constituents on all of these pieces of legislation to either

thank them or explain why specific legislation is not in the best interest of patient care.

PAMED is closely monitoring and engaging in the following:

- **Senate Bill 25 (PAMED opposes)** – The bill, introduced in this same form since 2015, would grant CRNPs independent practice authority. PAMED has long opposed these efforts and will continue to do so. This bill was recently voted out of the Senate Consumer Protection and Professional Licensure Committee.

- **Senate Bills 397-398 (PAMED opposes in current form)** – Since late 2019, PAMED has been working with representatives of physician assistants (PAs) to reach an agreement on several changes to the existing rules governing the physician supervision. Legislation introduced this session, Senate Bills 397-398 were approved by the full Senate before the summer recess. PAMED, working with our physician coalition, is seeking critical changes to the bill that would ensure appropriate oversight of newly graduated PAs in addition to those who are changing from one specialty to another. PAMED is seeking to improve physician workflow related to PAs, while at the same time ensuring appropriate supervision and state oversight of the process.

Over the summer recess, PAMED encourages physicians to set aside time to reach out to their local legislators and begin to develop a personal relationship. For those who already know their representative or senator, it is a good time to simply touch base. The first lesson in effective advocacy is to avoid your first meeting with lawmakers to be the one where you are asking for help.

Physicians interested in engaging in the issues above, or on any legislative proposal, are encouraged to reach out to PAMED’s Governmental Relations staff for assistance at 800-228-7823.✚



LCMS NEWS

NEW MEMBERS

William James Bonner, MD (PM)

Claudia F Busse, MD (PD)

Thomas George Donkar, DO (GS)

Genesis V Hines, MD (Resident – OBG)

Douglas Lundy, MD (OTR)

Roberto Rosario (Medical Student)

Behrang Saminejad, MD (N)

Clarke Garrett Stoltzfus (Medical Student)

Sagar Rohit Vadhar, DO (Resident – IM)

RE-INSTATED MEMBER

Jennifer Christine Rovella, DO (PUD-CCM)



Adam Sadler, DO
Chinenye Nwachuku, MD
Jennifer Banzhof, DO

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