


LEHIGH COUNTY

Health & Medicine

Official Publication of The Lehigh County Medical Society



PROTECT YOUR BRAIN THIS WINTER

*Tips to Staying Safe During
Your Favorite Outdoor Activities*

The United Way
PA 2-1-1
CONNECTS
RESIDENTS
*with health and
human services*



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IN THIS ISSUE



BRUCE D. NICHOLSON, MD
Lehigh County Medical Society President

With the Winter Issue we say goodbye to 2018 and welcome in 2019. We hope you have had a chance to read some of our past issues; if not they are available on our website: www.lcmedosc.org/our-publication.

In this issue we will bring you articles on several important health and related topics. We hope you will be interested in our articles on protecting your brain during winter sports, hearing loss, Thyroid nodules, and the flu. Since we are in flu season, this article can help you understand the flu virus, how to prevent it and how to treat it.

Additionally, you will find information on the 2-1-1 service of the United Way of the Greater Lehigh Valley. If you should find yourself needing some help this winter with health care, including mental health services and much more, learn how 2-1-1 can help.

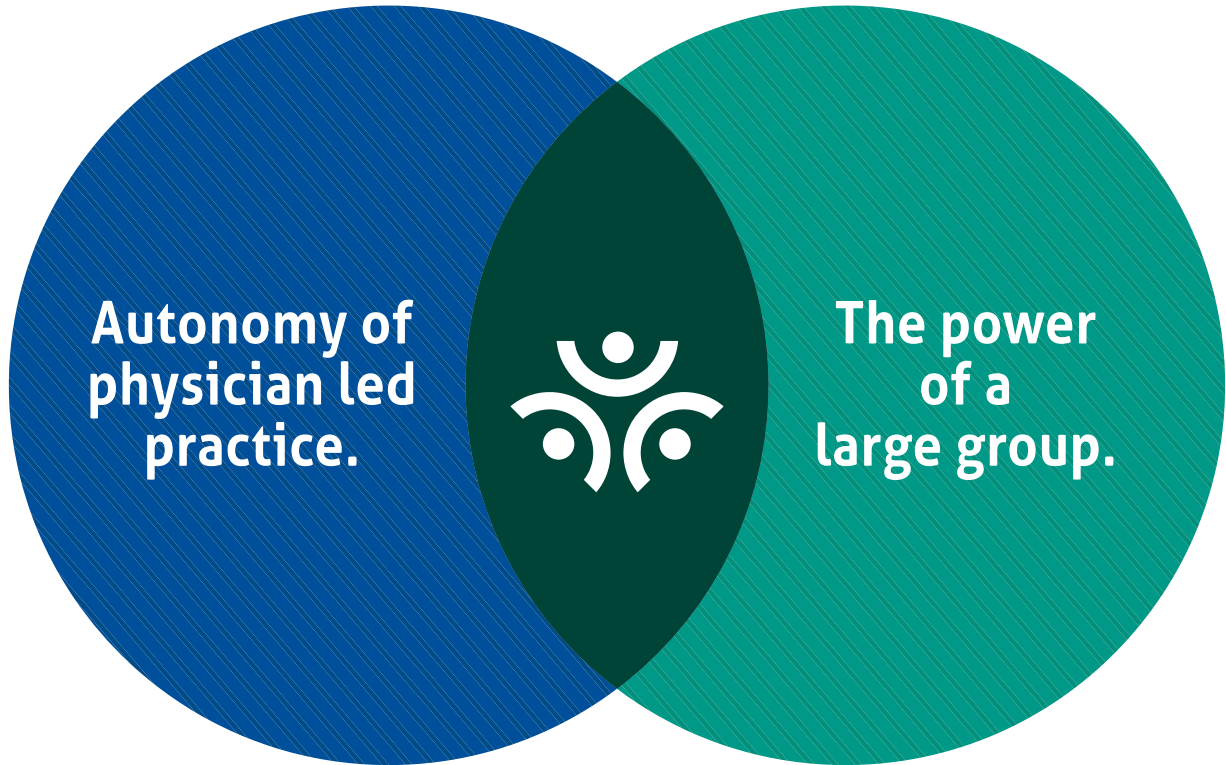
Read up on how Pennsylvania and health insurers in the state have agreed to remove prior authorization for treating substance use disorders. Also check out the follow up piece on Pharmacy Benefit Managers.

Finally, we're showcasing how physicians and their families help our community, aside from delivering health care.

We hope you enjoy this issue and wish you a healthy and happy 2019! +



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PROTECT YOUR BRAIN THIS WINTER

Tips to Staying Safe During Your Favorite Outdoor Activities

BY ASARE CHRISTIAN, MD, MPH
Associate Outpatient Medical Director,
Good Shepherd Rehabilitation Network

As we gear up for the arrival of winter weather, many people look forward to getting outside to enjoy their favorite activities. There is nothing quite like sledding, ice skating, skiing, snowmobiling and snowboarding on a cold winter day.

As a physician who works for a rehabilitation provider, I also see firsthand the potential danger associated with these pastimes. Because many of them involve travelling at high rates of speed on hard and icy conditions, one small mistake can have catastrophic results.

In fact, according to the US Consumer Product Safety Commission, in 2016 alone, almost one quarter of a million people were injured while enjoying winter activities. Here is a quick look at where those injuries occurred:

SNOW SKIING – 88,000 INJURIES

SNOWBOARDING – 61,000 INJURIES

ICE SKATING – 50,000 INJURIES

**SLEDDING/SNOW TUBING/
TOBOGGANING – 47,000 INJURIES**

While the most common injuries are fractures, sprains and dislocations, injuries to the head (traumatic brain injuries) can have lifelong consequences that impact physical, intellectual, emotional, social and vocational performance.

Traumatic brain injuries occur when a sudden movement, such as a blow to the head, shakes the brain. Brain tissue is composed of billions of neural circuits that transmit information necessary for human behavior. When the brain is injured, there is a disruption of the transmission of information caused by a stretching and shearing of these neural circuits. Traumatic brain injuries can range from mild (commonly referred to as concussions) to severe.

Because each person's brain is slightly different, brain injuries will affect each person in a different way. The recovery process after a brain injury depends upon a person's age, the severity of their injury, their pre-injury personality and their level of adjustment. At Good Shepherd, we have a team of physiatrists, therapists and optometrists who specialize in traumatic brain injury diagnosis and customize treatment plans based on the patient's symptoms.

Because of the risks inherently involved in these activities, it is especially important to take extra precautions to minimize the chance of injury and stay safe, including:

Wear the proper safety gear. One of the simplest and most effective ways to prevent and/or minimize a traumatic brain injury is to wear a helmet. Make sure you select one that is designed for the activity, and do not share your helmet with anyone else to ensure it always fits you properly. Replace it periodically,



Vision therapy is often an integral component of rehabilitation for those who have suffered concussions.

especially if you have been involved in an accident.

Drink enough water. If you participate in strenuous exercise, make sure you are well hydrated. You need just as much fluid in cold weather as you do warm weather. Water helps keep your muscles more limber and your mind more focused.

Know – and follow – the boundaries of your sport. For instance, skiers should not venture into areas that are roped off as they usually signal dangerous terrain. In sports like hockey, make sure everyone follows the rules. Do not attempt anything that is beyond your ability.

Be aware of your surroundings at all times. Look ahead to avoid collisions with trees, rocks or other people. Not being aware of your surroundings can expose you to dangerous situations.

Take lessons so you understand proper technique and protocol. Even if you are experienced, a refresher class never hurts.

If you experience a bump to the head, seek medical attention right away. Even if you feel fine or do not experience any symptoms, get yourself checked. Concussion symptoms may not show up for several weeks.

Know how to fall properly. It may sound counterintuitive, but knowing how to fall properly can help prevent injury. +

Be familiar with the signs of a traumatic brain injury. These can include, but are not limited to:

DROWSINESS

HEADACHE

NAUSEA OR VOMITING

**SENSITIVITY TO LIGHT
AND/OR SOUND**

**CHANGES IN REACTION TIME,
BALANCE OR COORDINATION**

**CHANGES IN MEMORY,
JUDGMENT, SPEECH OR SLEEP**

LOSS OF CONSCIOUSNESS

Asave Christian, MD, MPH, is the Associate Outpatient Medical Director at Good Shepherd Rehabilitation Network in Allentown, Pennsylvania. A physiatrist, Dr. Christian specializes in musculoskeletal conditions, spasticity, pain, stroke, spinal cord and traumatic brain injuries.

FEATURE

Powered by United Way

PA 2-1-1 CONNECTS RESIDENTS WITH HEALTH AND HUMAN SERVICES

BY LAURA MCHUGH,
United Way of the Greater Lehigh Valley

United Way • AIRS
2-1-1
Get Connected. Get Answers.



Residents of Lehigh and Northampton counties have an easy-to-use, one-stop resource for health and human services. Powered by United Way, Pennsylvania 2-1-1 East is a free, confidential, non-emergency, comprehensive information and referral service that connects residents with the services they need.

“By calling 2-1-1 or visiting www.pa211east.org, people can find various programs to help them access food, health care, mental health services and much more,” remarked Priscilla Rosado, Assistant Director of Food Access and Emergency Services for United Way of the Greater Lehigh Valley. “When you find yourself in a crisis, it’s hard to know where to start. With one phone call or a few minutes online, PA 2-1-1 can refer you to a full range of services to make sure that you and your loved ones stay safe and healthy.”

Available 24 hours a day, 7 days a week, PA 2-1-1 maintains an expansive database of providers serving Lehigh County residents. The guided health care search online offers resources to find health insurance, preventive care and nearby facilities as well as options for cancer, diabetes and prenatal care.

The latest reports show that calls for assistance to PA 2-1-1 have more than tripled since 2014.

“The good news is that PA 2-1-1 is increasingly looked at as a go-to source for information,” said Jill Pereira, Vice President of Education and Impact, United Way of the Greater Lehigh Valley. “What’s concerning is that the demand for services has steadily increased year after year. We’re specifically seeing increases in the number of people who need homeless services and housing assistance.”

In five years, the total number of calls has increased from approximately 2,800 in 2017 to more than 8,500 calls in 2018:

- **Almost 7% of callers requested utility assistance**
- **More than 15% of callers requested rental payment or deposit assistance**
- **And more than 30% of calls were for Coordinated Entry System homeless services**

United Way has been involved with the Lehigh Valley Regional Homeless Advisory Board since its inception. The Board adopted 2-1-1 for a Coordinated Entry System to provide a collaborative approach to serving people experiencing homelessness in Lehigh and Northampton counties in 2017.

“Before implementing this system, the best estimates showed that less than a thousand people were experiencing homelessness in the

Lehigh Valley. Through PA 2-1-1, we now know that at least 2,822 people have requested services in 2018,” commented Alisa Baratta, Executive Director of Third Street Alliance and Chair of the Regional Homeless Advisory Board. “Coordinated Entry has changed what we know about homelessness in the Lehigh Valley. This system paints a much more accurate picture of how many people need services. With this information, we’re not only better serving the people who need services today, but we’re also really looking at the issue of housing to determine how to use a collective-impact approach to solving this problem in our community.”

Through PA 2-1-1, this coordinated system has created a standardized referral practice for everyone seeking services from the network of providers in both counties. Clients complete an assessment with an intake caseworker, who refers them to the appropriate program. Through this system, agencies track the demand for and availability of homeless services and beds and prioritize requests onto a two-county waiting list.

United Way of the Greater Lehigh Valley has invested \$250,000 into PA 2-1-1 since 2014. 


TO ACCESS 2-1-1:

Dial 2-1-1 from your mobile and landline phone

Text your zipcode to 898211

Or visit www.pa211east.org

**FOR MORE INFORMATION ON PA 2-1-1 OR EMERGENCY SERVICES,
contact Priscilla Rosado at 610-807-5731 or priscillar@unitedwayglv.org.**



SAFE AND EFFECTIVE MANAGEMENT OF CHRONIC PAIN

BY KEVIN MCNEILL, MD

Family Medicine Physician at LVPG Hamburg

A new patient entered my family practice two years ago – a man in his 70s. He had been struggling with chronic pain both in his back and his pelvis for several years, originating from lumbar spinal stenosis and pudendal neuralgia, respectively. The patient was taking opioids prescribed by a former provider, specifically 10 mg of Oxycodone three times a day, but was still experiencing significant pain. He couldn't participate in activities he liked. He spent a lot of time inside the house, avoiding walking and nursing his back.

Continued on page 10

I wanted to help, but there was a lot of information I just didn't know. Was he taking his medication as prescribed? Was he taking other medications besides Oxycodone? Had he turned to illicit drugs since his treatment wasn't adequately controlling the pain? This is a common dilemma shared by health care providers in arriving at reasonable and evidence-based procedures for treating chronic pain with opioids. The Centers for Disease Control and Prevention (CDC) has published guidelines, which are extremely helpful. They outline three steps:

DETERMINING WHEN TO INITIATE OR CONTINUE OPIOIDS FOR CHRONIC PAIN

OPIOID SELECTION, DOSAGE, DURATION, FOLLOW-UP, AND DISCONTINUATION

ASSESSING RISK AND ADDRESSING HARMS OF OPIOID USE

In order to help my patient, these over-arching goals needed to be translated into a workable process for a busy family medicine office.

GETTING A HANDLE ON THE PROBLEM

The system I work with has customized a pain management process based on guidelines created by the CDC, the Pennsylvania Medical Society, and others. It details a thorough assessment to better determine the benefits and risks of opioid prescribing to the individual as well as ongoing monitoring of risk and harm reduction. To begin, we went over the causes of this patient's pain through a review of prior records, being as specific as we could about the type of pain to arrive at a precise diagnosis. We also assessed the adequacy of existing pain relief.

From there, we completed a risk assessment that would tell us if opioids were an appropriate part of the patient's treatment plan and should be continued. Using standardized questionnaires, we gathered information about the patient and his family regarding mental health history, substance abuse history, and any other pertinent factors.

This information would tell us whether the patient was low, medium, or high risk for opioid treatment.

We conducted a urine drug screen to make sure the patient wasn't using other medications that would put him at risk. The patient's information was also run through the prescription drug monitoring program (PDMP) to see if he had received a prescription from someone else. The results all contribute to a determination of whether the patient is safe to use opioid-based medication.

In the case of my patient, we found there was nothing else complicating his care. He was not taking other medications or substances, and was using only one pharmacy. He was classified as low-risk, and an appropriate candidate for pain treatment using opioid medication.

DO WE CONTINUE TREATMENT WITH NARCOTICS?

The next step was to make sure my patient had a clear idea of the risks associated with the medication, and establish realistic expectations for the patient and the provider. This is accomplished through the review and signing of a controlled substance agreement (CSA), which outlines the "rules of the road" in this care plan.

In addition, we would complete an informed consent (IC) document that details the risks and adverse effects of opioid medications. The document we use also details other options the patient has tried for pain, both pharmacologic and non-pharmacologic. This is important because opioids are not considered a first- or even second-line treatment for pain management.

When presenting the CSA and the IC, it's especially important that the health care provider and the patient review these documents together. While this may add extra time to a patient visit, it's essential in ensuring the patient reads and understands the information, and signs the documents with full knowledge of what he or she is signing.

For my patient, who had tried other methods of pain control such as physical therapy and over-the-counter pain relievers, we decided to add other, non-narcotic medications to help with his back pain specifically. I started him on the new medications and then saw him in a month, which is a recommended timeframe. We saw progress, measured not by just pain relief, but also in functional improvement. He was able to spend more time outside walking, which he enjoyed.

FURTHER TREATMENT AND FOLLOW-UP

After referring my patient to an urologist for his pelvic pain, he underwent a surgical procedure, but the procedure did not provide relief. Together, the patient and I decided to increase the dose of the non-narcotic pain medication he was taking. In addition, I added an anti-depressant that is helpful for pain, and a non-narcotic medication for neuropathic pain. The patient saw further improvement and was able to become more physically active without major side effects.

Each month I saw the patient, and later when visits were spaced out to every three months, we completed a functional assessment. Consistent with Pennsylvania legislation, the PDMP was checked with each refill of his narcotic prescription. In addition, a urine drug screen was checked on regular intervals. Close monitoring involving these steps is extremely important in early identification and treatment of potential substance use disorder.

While my patient presented a low-risk scenario, the established treatment protocol is meant to be followed by any physician for any patient. Even if a patient is identified as medium- or high-risk, it doesn't necessarily mean he or she should not be prescribed narcotic medication. What's important is establishing a process for assessment and monitoring in cooperation with the guidelines for opioid prescribing set out by the CDC. Working together with the patient, it is possible to get a handle on the pain – maybe not eradicating it, but offering some improvement. In the context of chronic pain, this is considered a success. +

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THYROID NODULES

Primary Care Edition

**BY ELISA GIUSTO, D.O.,
Family Medicine PGY-1,
PAMPAC Resident Representative**

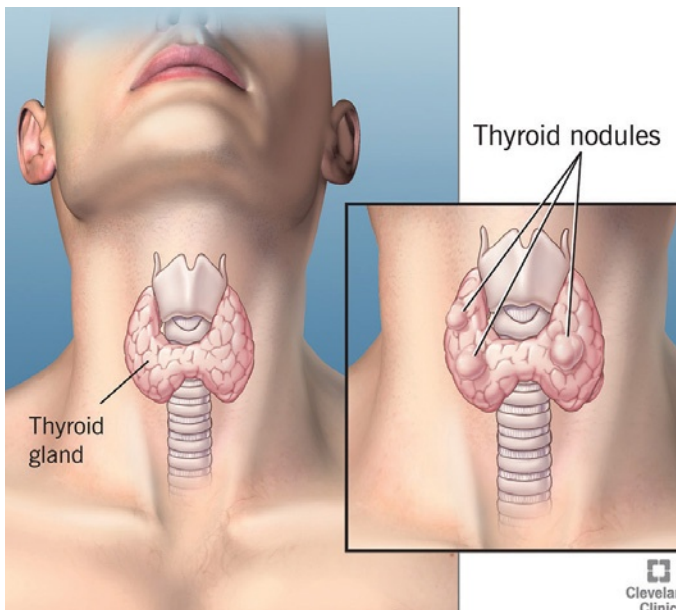
Thyroid nodules come to the attention of the primary care physician when noticed by the patient, found on routine physical exam, or noted as an incidentaloma from a radiographic procedure. Regardless, the role of the primary care physician is to exclude thyroid cancer, which occurs in 4-6.5% of thyroid nodules. It is important to note that nodularity of thyroid tissue is extremely common, however, with several autopsy surveys revealing that 37-57% of patients had thyroid nodules. Nonetheless, initial evaluation in all patients with a thyroid nodule is history and physical exam, thyroid ultrasound, and serum TSH concentration.

History of rapid growth of a neck mass, childhood head and neck irradiation, total body irradiation for bone marrow transplantation, or family history of thyroid cancer increase the likelihood of malignancy. Physical exam findings of a fixed hard mass, obstructive symptoms, cervical lymphadenopathy, or vocal cord paralysis also increase the possibility of thyroid cancer.

Thyroid ultrasound is used to confirm the presence of nodularity and assess for additional nodules and lymphadenopathy. Ultrasonographic features associated with increased risk of thyroid cancer are hypoechoic, microcalcifications, “twinkling” on B-flow imaging, central vascularity, irregular margins, incomplete halo, taller than wide, or documented enlargement of nodule.

If the serum TSH concentration is normal or elevated and the thyroid nodule meets sonographic criteria for sampling, then fine-needle aspiration (FNA) is indicated. If the serum TSH concentration is subnormal, thyroid scintigraphy should be performed. If the nodule is functioning or appears hot, then free T4 and T3 should be tested to determine whether this is overt or subclinical hyperthyroidism. If the nodule is non-functioning or appears cold, FNA of the thyroid nodule should take place if it meets sonographic criteria for sampling.

FNA biopsy is the most accurate method for evaluating thyroid nodules and identifying patients who require surgical resection. FNA should be performed in any size thyroid nodule that has extrathyroidal extension, extrusion through rim calcifications, subcapsular locations adjacent to recurrent laryngeal nerve or trachea, or associated abnormal cervical lymph nodes. FNA should be performed in thyroid nodules >1 cm if they are solid and hypoechoic with any other of these features: irregular margins, microcalcifications, taller than wide, or rim calcifications. Thyroid nodules that do not meet sonographic criteria for FNA should be monitored: 6-12 months for subcentimeter thyroid nodules with suspicious characteristics, 12-24 months for thyroid nodules with low to intermediate suspicion, 2-3 years for very low risk thyroid



nodules. Thyroid nodules that enlarge significantly (> 50% change in volume or 20% increase in at least two thyroid nodule dimensions) should be assessed by FNA and subcentimeter thyroid nodules that grow >1-2 cm require FNA depending upon their size and sonographic characteristics. Bethesda classification categorizes the diagnostic severity of thyroid nodules, with Bethesda V and VI classes needing referral to Surgical Oncology. +

SOURCES:

- <https://www.uptodate.com/contents/overview-of-thyroid-nodule-formation#H2>
- https://www.uptodate.com/contents/diagnostic-approach-to-and-treatment-of-thyroid-nodules?search=thyroid&source=search_result&selectedTitle=4-150&usage_type=default&display_rank=4#H35



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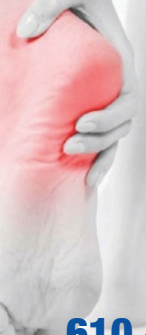
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PHYSICIAN FAMILIES

Making a Difference

BY DONNA BAVER ROVITO



Leaders of the Northampton County Medical Society Alliance and scholarship recipients

Everyone knows that physicians make a difference in the lives of their patients every single day.

Less well known is the economic impact generated by our nation's 736,873 practicing physicians: \$2.3 trillion and 12.6 million jobs, according to the AMA's Economic Impact Study for 2018. Those jobs provide over \$1 trillion in total wages and benefits, all supported by the nation's physicians.

Physician participation in Pennsylvania's economy generates \$3 billion in total state and local tax revenue – or nearly \$87,000 on average per physician.

Then, of course, there is the indirect benefit created when physicians and their families participate in the local and national economy. Health benefits aside, based on economic indicators alone no one would argue that physicians and their families make a HUGE impact on society.

It's a lot more difficult to nail down numbers for the kind of impact physician families have on their communities and the world around them in non-economic ways such as community service or charitable giving. I looked, quite extensively.

Oh, if you search "Physician Charitable Giving" you'll find LOTS of links to charitable foundations or individual links about things

that physician families do to "give back." There are numerous links to physician-related organizations which provide charitable care or which give physician families an opportunity to financially support worthy causes.

But unlike the AMA's Economic Impact report, there is no comprehensive data about the many ways physicians and their families make a difference. Quantification of such information probably isn't even possible – especially since we know that much of the "giving back" done by physician families is done quietly, in ways that don't generate headlines or testimonials or numbers to be tallied up in a report.

A recent issue of the AMA Alliance's publication *Physician Family Magazine* (www.physicianfamilymedia.org) touched on some of the ways that physicians and their families make a difference. (The AMA Alliance, www.amaalliance.org, is the sister organization of the AMA, focused on physician families.) The issue featured articles about valuable work done by national groups like the AMA Alliance and the AMA Foundation to provide awareness about health-related issues, to raise money to improve the nation's health and to benefit the practice of medicine by supporting the physicians of tomorrow. It also included articles about how physician families share their skills in places where health care is virtually unavailable and how they impact national problems like opioid abuse, suicide, lack of school supplies, safety and fitness among disadvantaged youth and

providing safe jobs for people with special needs. Inspirational stories, to be sure, but only a fraction of what physician families contribute to society.

We all know physicians and physician spouses who work hard to support a wide variety of community endeavors, from the arts to free health clinics, from providing for local homeless shelters to comforting victims of domestic abuse, from volunteering in schools to coaching soccer teams. I have always found the physician family community to be particularly concerned about the needs of those less fortunate, eager to roll up sleeves and dirty hands wherever needed.

Here in the Lehigh Valley, in addition to all the things local physician families do as dedicated individual volunteers and supporters of worthy causes, two local AMA Alliance affiliates have provided community service, health education and philanthropy for decades. Both affiliated with their county medical societies, and which began as auxiliaries to those groups, the Lehigh County Medical Society Alliance (LCMSA) and the Northampton County Medical Society Alliance (NCMSA) have a long and proud legacy of community service dating back as far as the 1920s.

Norma Newhart, a past president of the LCMSA, once described rolling bandages with her members for the Red Cross after Pearl Harbor was attacked. Ironically, LCMSA held Norma's 100th birthday

celebration on September 11, 2001 and were together with Norma as the Twin Towers fell.

The group established Lehigh County Medical Auxiliary's Scholarship and Educational Fund, Inc. (LeCoMASE) in 1968. Through their loan program, 82 medical students received over \$1 million in loans before LeCoMASE partnered with the Foundation of the Pennsylvania Medical Society in 2009 and became the LeCoMASE Scholarship Fund. Scholarships for nursing students were added in 1983, benefiting 71 first-year nursing students. Additionally, dedicated nursing scholarships were created at Lehigh Carbon Community College and DeSales University, respectively, in 2010 and 2013. Over the years, scholarships awarded by LeCoMASE were supported through many fundraising activities of LCMSA and the Lehigh County Medical Society.

Throughout decades of community service, education and philanthropy, LCMSA has also donated funds to a wide variety of health-related organizations such as the Weller Health Education Center, Camelot for Children, the YMCA/YWCA, the Salvation Army, various homeless and domestic abuse shelters, children's fitness and after school programs, hospital-based programs and more. It has also provided educational programs about infection prevention and effective hand washing, school violence, internet safety, diabetes, DES, concussion prevention, organ donation and many more. Its members have delivered Meals on Wheels once a week for over 30 years and advocated in Harrisburg and Washington, DC about legislation which impacts medicine and health care.

The Northampton County Medical Society Alliance (www.NCMSA.org) provides scholarships as well, to eligible medical, nursing and physician assistant students who reside in Northampton County based on academic, financial and community service criteria.

One of NCMSA's longest running projects is Adopt-A-Class; members make monthly visits to a single Northampton County Head Start class to teach children about health and nutrition. October's lesson was "Hands are not for hitting." November is healthy eating month. Pennsylvania Youth Theater visits the classroom in December. January is focused on keeping the body healthy, February is healthy heart month and the five senses are presented in March. Food and fun are always part of the presentation and children look forward to their visits.

NCMSA celebrates Doctor's Day by making monetary donations to local hospitals and organizations, including Lehigh Valley Health Network's Lehigh Valley Cancer Institute, Meals on Wheels on behalf of Coordinated Health, St. Luke's Healthy Kids, the Bright Futures Fund and Two Rivers Health & Wellness Foundation on behalf of Easton Hospital.

Six years ago, NCMSA launched a donation/grant program called the HELP (Health, Education, Literacy Programs) Fund. Non-profit organizations in their area currently conducting or planning a health or education related project can receive up to \$4,000 in funds; NCMSA

donates about \$9,000 per year to different organizations. Funds are generated by a bi-annual fundraiser, Casino Night. Since its inception, Casino Night events have raised over \$85,000 for local grants.

In 2018, NCMSA helped fund St. Luke's University Health Network's dental van services as part of the Adopt-a-School program in Northampton County schools and helped fund Lehigh Valley Children's Centers Spring Garden Summer Program to include swim lessons. They provided support for the YMCA Greater Valley to start a Pickleball program in their childcare programs and Youth Summer Day Camps, Safe Harbor Easton's Peace Garden and Garden Nutrition Program, the Stephen's Place program and One Choice at a Time, a recovery-based health, wellness and nutrition program. They also provide annual support for the Gracedale Nursing Home, Community Services for Children and the YWCA Woman and Teens of the Year Scholarship.

Whether individually or as part of groups like the many medical society alliances throughout the nation, physician families touch the lives of others in big and small ways every single day. Many thanks for the difference YOU make. +

Donna Baver Rovito is a longtime member of the Lehigh County Medical Society Alliance, a member of the Northampton County Medical Society Alliance and serves as editor of Physician Family Magazine for the AMA Alliance. She has been married to general surgeon Peter F. Rovito, MD for 35 years. They have two sons, Peter and Tony.



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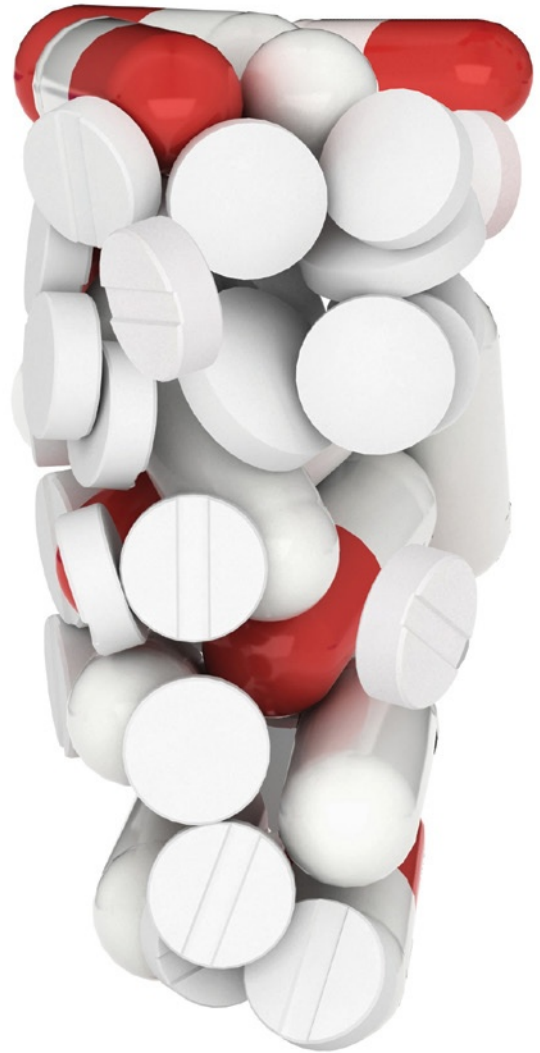
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LANDMARK AGREEMENT REMOVING PRIOR AUTHORIZATION TO TREAT SUBSTANCE USE DISORDERS

The Commonwealth of Pennsylvania and seven major health insurance companies agreed to remove prior authorization requirements for treatment of substance use disorders, a move that has the potential to save thousands of lives, according to the American Medical Association (AMA) and Pennsylvania Medical Society.

In addition to removing this unnecessary restriction on treatment, insurers have also committed to including a comprehensive range of medications to treat substance use disorders on the lowest cost-sharing tier of a health plan's pharmacy benefit as part of this agreement.



“We have long advocated for the removal of prior authorization and other barriers to increase access to medication-assisted treatment (MAT) for substance use disorders,” said AMA President-elect Patrice A. Harris, MD, MA. “The leadership shown by the governor and his administration to reach this agreement should act as a call for all states to demonstrate that they support patients’ access to care over needless administrative burdens.”

“We commend the governor for his leadership in bringing together all major stakeholders in reaching this agreement,” said Pennsylvania Medical Society President Theodore A. Christopher, MD, FACEP. “Today’s agreement will bring much-needed certainty and clarity to physician practices

when we are helping our patients access treatment for a substance use disorder.”

Prior authorization—sometimes called precertification or prior approval—is a health plan process by which patients, physicians or other health care providers must obtain advance approval from a health plan to qualify for payment before a specific service is delivered to the patient. Applying prior authorization to patients with substance use disorders can have deadly consequences if patients are forced to delay care or have that care denied.

MAT is the evidence-based standard for treating people with opioid use disorder to help sustain recovery and save lives. In the past year, nearly 15,000 physicians have become

certified to provide MAT—a 42 percent increase nationwide.+

TO LEARN MORE ABOUT THE PENNSYLVANIA MEDICAL SOCIETY EFFORTS TO HELP REVERSE THE EPIDEMIC, VISIT PAMEDSOC.ORG/OPIOIDRESOURCES

TO LEARN MORE ABOUT THE AMA’S WORK TO END THE NATION’S OPIOID EPIDEMIC, VISIT END-OPIOID-EPIDEMIC.ORG

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Unveiling the Truth Behind **PBM CONTRACTS**

BY THERESA T. DOAN, PHARMD., MS
ANDREW COLVIN, PHARMD., MBA
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Many plan sponsors understand a handful of PBM language and rely heavily on PBMs to manage their prescription drug plan. Plan sponsors sign contracts with their selected PBM and end up unsatisfied due to high drug spending and low savings. Written PBM contracts are commonly known to have vague and ill-defined language which gives PBMs an advantage in taking more money from plan sponsors. To manage prescription costs and increase savings, plan sponsors must understand PBM contract language, effectively negotiate with the PBM and eliminate all contract deficiencies.

In part one, we discussed a few business tactics PBMs commonly use to manipulate revenue streams: (1) retaining drug rebates given by the pharmaceutical manufacturer; (2) charging the plan sponsor more than what they pay the pharmacy for a given prescription, also known as spread pricing, and (3) forcing plan sponsors to utilize mail order pharmacy so PBMs can repackage medications and charge a higher drug cost.

In part two, we will discuss three PBM contract problems many plan sponsors experience. It will elaborate further in relation to what was discussed in part one of this article.

Brand vs. Generic Drug Definitions

Every PBM contract contains a definition section with core terms such as brand drug, generic drug, specialty products and rebates. It may seem obvious and straightforward on paper, but many PBMs purposely use ambiguous jargon that is open to different meanings and interpretation. Plan sponsors and PBMs must discuss in-detail each definition thoroughly and ensure both parties agree upon its meaning. If not addressed, defective contract definitions will leave plan sponsors with disappointing results and low savings. For example, one PBM may define “generic drug” as a multisource prescription drug supplied by multiple generic drug manufacturers. And, it may define “brand drug” as a prescription drug that is not a generic drug. Questions plan sponsors should ask are:

How does the PBM define multisource drug? Is it more than one generic drug in the market?

How are single-source generics defined and classified? Is the PBM reclassifying single-source generics as a brand drug or as a separate category?

Like multisource drug, how does the PBM define multiple generic drug manufacturers?

What national data file is the PBM using to classify drugs as generics and brands? If a PBM classifies drugs based off the Food and Drug Administration (FDA) or First DataBank,

generic and brand drug definitions are flawed because they do not provide a single field that identifies a drug as a “brand” or a “generic.” Plan sponsors may need to require its PBM to use a reliable source, such as Medi-Span, to define brand and generic drugs because it provides actual indicators.

Vague definitions equip PBMs with an upper-hand advantage in drug pricing, especially if generics are reclassified as brands. Brand drugs are discounted around AWP-12% to -18%, whereas, generic drugs are discounted around AWP-60% to -70%. Thus, if PBMs reclassify generics as brands, such as single-source generics, PBMs can charge a far higher price and not provide the plan sponsor the lowest cost. Air-tight definitions give plan sponsors better control on drug spending and maximize high savings.

Maximum Allowable Cost (MAC) List

Maximum Allowable Cost (MAC) is the PBM’s upper-limit price for generics and brands that have generic versions (multi-source brands). If plan sponsors rely on AWP discounts for generics and multi-source brands, prices would vary drastically because drug manufacturers charge differently on equivalent and interchangeable generics. MAC list plays a key role in establishing an economic alignment between pharmacies and plan sponsors. PBMs want to give pharmacies a reasonable reimbursement while ensuring plan sponsors are charged the lowest possible price.

While a MAC list may sound appealing, it generates big revenue for traditional PBMs and deprives plan sponsors with maximum savings on generics. There are no two similar MAC lists in the market because standardized criteria do not exist in the drug industry. Each PBM has its own method in selecting which generics are included in the list and has their own formula in calculating the maximum allowable cost.

There are a few strategies traditional PBMs can profit from MAC pricing. One, traditional PBMs maintain multiple MAC lists, each with a different generic drug list and pricing. Pharmacies are given a broader and deeper discount list, whereas plan sponsors are given a smaller

list with less aggressive pricing. This is where spread pricing occurs and PBMs can net the difference (please refer to part 1 for additional information on spread pricing). Two, a MAC list may be used for retail pharmacies, but not mail-order pharmacies. Traditional PBMs persuade plan sponsors to use their in-house mail-order pharmacies by waiving or reducing members’ co-pays. But traditional PBMs may apply discounted AWP rather than MAC pricing, therefore plan sponsors are paying significantly more on generics at mail-order pharmacies rather than at retail pharmacies (please refer to part 1 for additional information on mail-order pharmacy). Three, MAC lists are updated frequently within one year and are not disclosed to plan sponsors. Traditional PBMs may state MAC lists are proprietary and will not share any information on their generic drug list and pricing. This leaves plan sponsors with very little information on how much revenue traditional PBMs retain.

A MAC list, however, can be a cost-savings program for plan sponsors if they are prepared to ask the right questions to PBM vendors. By gaining a thorough understanding and more adequate control of MAC lists, plan sponsors can eliminate hidden loopholes, achieve effective savings, and select the right PBM. Some questions to ask are:

Does the PBM allow plan sponsors full access to the MAC list? If so, will they be informed regularly on updates? The PBM may not be in the plan sponsor’s best interest if it refuses to disclose this information.

If a PBM has multiple MAC lists, ask for a rationale on having more than one list.

Discuss and have a clear understanding of how the PBM establishes MAC pricing and what methodology they use to include drugs in the MAC list.

Discuss what pricing formula the PBM uses for drugs excluded in the MAC list.

Continued on page 20

Rebates, Fees and Formulary Management

PBMs are key players responsible for developing and maintaining drug formularies and negotiating rebates with drug manufacturers. PBMs receive rebates in exchange for a favorable position on the formulary list, less restriction and better access for patients (eg, no prior authorization) and better market share performance compared to its competitors. Some PBMs are reluctant to disclose any rebate agreements, while others claim to give a certain percentage or pass 100% rebates back to plan sponsors. But many are not aware of other “fees” drug manufacturers negotiate with PBMs besides rebates. Some are labeled as performance fees, incentive fees, formulary management fees and advertising fees. If PBMs can shift more dollars into the other “fees” bucket, they can increase their revenue stream even though some claim 100% rebates are given back to plan sponsors. Also, PBMs may receive financial benefits from wholesalers and distributors. If the PBM contract does not disclose all payments received from third parties (manufacturers, wholesalers and distributors), plan sponsors will lose dramatic savings. Plan sponsors must request access to third party contracts yielding payments to the PBM. Also, the PBM contract must clearly define and list all financial benefits received by third party companies.

Another concern with rebates is “rebate pumping” or “rebate chasing.” Some PBMs favor more costly brand drugs over generics to increase a rebate percentage and pocket more revenue. PBMs’ goal for formulary management is to promote safe and clinically effective drugs while containing cost. However, if PBMs depend on drug manufacturers’ rebates and fees, this is a concern for bias in formulary decision-making. For example, some PBM companies allow two ridiculously priced brand drugs in the formulary to collect “increased” rebates from the drug manufacturer. Vimovo and Duexis, both drugs that combine two over-the-counter (OTC) products, cost approximately \$2000-\$2500 per month. Vimovo is a combination of naproxen (generic of Aleve) and esomeprazole (generic of Nexium). Duexis is a combination of ibuprofen (generic of Advil) and famotidine (generic of Pepcid). Two OTC products may cost no more than \$25. If the PBM allows ridiculously priced drugs to go through without a prior authorization, is it truly practicing the plan sponsors’ best interest? Another example is drug switching. PBMs request physicians to switch one medication to another that is believed to have a similar therapeutic value and is more cost-effective. However, switching medications may be a purely financial incentive for the PBM, and not in the best interest of the patient and plan sponsors. Regarding formulary management and rebates, plan sponsors can request to customize the PBM’s national formulary by excluding egregious drugs and applying utilization management programs (eg, prior authorization, step therapy and mandatory generic programs) for brand drugs that have generics available in the market.

Conclusion

These are just a few examples of how vague and imprecise PBM contract language can drive up a plan sponsor’s cost. Every PBM contract must eliminate ambiguity so less revenue is in the pockets of PBMs. Plan sponsors should have a strong understanding of PBM

business practices, pay careful attention to the wording of contracts and have strategies and questions ready for PBM vendors.

To achieve lowest net price and maximize savings, plan sponsors should discuss with PBM vendors guaranteed 100% pass-through pricing and rebates, all-inclusive administration fee, customizable formulary, assertive pharmacy discounts, flexibility with integrating cost saving vendors and have a strong clinical management department. Selecting the right PBM partner can better protect the plan sponsor and secure a trusting, long-term and satisfactory relationship. +

References

Cahn, Linda. “Eliminate All PBM Contract Loopholes.” *Benefits Magazine*. 50.10 (2013): 40-46. Print.

Cahn, Linda. “When Is a Brand a Generic? In a Contract With a PBM.” *Managed Care Magazine*, 15 Dec. 2017, www.managedcaremag.com/archives/2010/9/when-brand-generic-contract-pbm.

Calabrese, David. “Comparing Pharmacy Benefit Managers: Moving Well Beyond the Simple Spreadsheet Analysis.” *American Health & Drug Benefits*. (2013): 9-19. Print.

Mattingly, Joey. “Understanding Drug Pricing” *US Pharm*. 2012;37 (Generic Drug Review): 40-45. <https://www.uspharmacist.com/article/understanding-drug-pricing>

“PBM Revenue Streams & Lack of Transparency” *National Association of Chain Drug Stores*. 2011. http://www.ncpanet.org/pdf/leg/nov11/pbm_revenue_streams_lack_transparency.pdf

Siracuse V. Mark; Clark E. Bartholomew; Garis I. Robert. “Undocumented Source of Pharmacy Benefit Manager Revenue” *Am J Health Syst Pharm*. 2008; 65 (6) 552-557.



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the Flu

BY RAVINDER SINGH, MD
Medical Director, MedSurg Urgent Care

Flu also known as influenza is an infection of the respiratory tract caused by influenza virus. It is a highly contagious infection spread by coughing, sneezing, speaking (droplet mechanism) and contact with contaminated surfaces. Spectrum of illness varies from mild disease to severe illness requiring hospitalization and death. Flu usually lasts from 5-7 days but in rare cases especially in high risk patients it can last for weeks.

FLU SYMPTOMS

Flu is a viral illness hence some of the symptoms overlap with common cold but characteristically flu comes on suddenly, usually causes high grade fever (more than 100.4 and in most cases in range of 102-103 F in contrast to low grade fever if any with cold) and causes moderate to severe muscle aches. Other symptoms include chills, fatigue, runny or stuffy nose, sore throat or headache. Some people may experience nausea and vomiting although more common in children than adults.

HIGH RISK PEOPLE

- People age more than 65 and younger than 2 years
- People at any age with pre-existing medical conditions like Asthma, COPD or structural lung disease, Heart disease, kidney disease or diabetes
- Immunocompromised or on cancer treatment

DIAGNOSIS

Flu is usually diagnosed based on the clinical symptoms of the disease. Consult your doctor if you have any of the above symptoms especially if symptoms come on suddenly with high grade fever and body aches. Urgent care centers have been a great source of convenience for these illnesses during the busy time of the year. Your doctor may or may not decide to test you for flu. In most patients seen in outpatient facilities, the doctor may not test for flu as it does not change how you are treated.

Commonly used flu tests called RIDTs (rapid influenza detection tests) have sensitivity in range of 50-70% with specificity of 90-95%. In simple words, it means these tests can miss 30-50% of the patients who have flu and it can misdiagnose 5-10% of patients with flu who in fact do not have flu.

Other tests like Molecular antigen assay or RT-PCR (reverse transcriptase polymerase chain reaction) tests are much more sensitive and specific but more expensive.

TREATMENT

Based on the severity of the symptoms, your risk factors and risk of complications, your doctor may or may not treat you with antiviral medications specifically targeted to fight flu. In many cases flu is a self-limiting illness treated with over the counter fever reducers and pain relievers along with plenty of rest. Avoiding social contact is advised to decrease the risk of transmission of the disease to other healthy individuals. If started within 48 hours of illness, antiviral drugs help to reduce the duration of illness by 1-2 days. In high risk individuals, antiviral drugs can

complications

SEVERE COMPLICATIONS:

PNEUMONIA:

Infection of the lungs which can be primarily flu or secondary infection by bacteria (common among serious infections)

ENCEPHALITIS:

Infection of the brain or spinal cord (Rare)

MYOSITIS/RHABDOMYOLYSIS:

Infection and breakdown of the muscles (rare)

Respiratory Failure/exacerbation of pre-existing respiratory condition like asthma or COPD

KIDNEY FAILURE

MULTIORGAN FAILURE

SEPSIS (BLOOD POISONING)

MILD TO MODERATE COMPLICATIONS

SINUS INFECTION

EAR INFECTION

Exacerbation of pre-existing respiratory condition like asthma or COPD

mean the difference between milder and more serious disease possibly requiring hospital stay.

Oseltamivir (Tamiflu) and Zanamivir (Relenza) are the antiviral drugs approved for influenza season 2018-2019. A newer drug Baloxavir Marboxil (Xofluza) was also approved by FDA on Oct 24, 2018 for 2018-2019 influenza season. Average discounted cost of Oseltamivir and Zanamivir is around \$47 to \$58 and \$ 63-\$67 respectively.

PREVENTION/IMMUNIZATION

There are several different flu vaccines available and CDC does not recommend one over the other.

The vaccine is designed with help of research and data from previous years of influenza infections. It commonly includes three or four common disease-causing influenza virus antigens in the vaccine to mount immunity.

In the best scenario when there is a good match between circulating virus and vaccine, flu vaccine is about 40-60% effective.

CDC recommends a yearly flu vaccine as the first and most important step in protecting against influenza and potential complications.

Avoid close contact with sick people or if you are sick with flu-like illness, avoid any social contact until you are fever free for 24 hours without use of fever reducing medications.

Cover your mouth and nose with a tissue when you cough or sneeze and trash the tissue after use and wash hands with soap and water or an alcohol-based hand sanitizer.

Take antiviral medications if prescribed by your doctor. +

REFERENCES

<https://www.cdc.gov/flu/about/index.html>

<https://www.cdc.gov/flu/professionals/diagnosis/rapidclin.htm#Table1>

<https://www.cdc.gov/flu/about/qa/vaccineeffect.htm>

Physician Shortage

A case of Mismatch

FORWARDED BY AMANDA BROWN, MD

The following was posted by a physician friend of mine in a FB group. This is a personal observation regarding solutions to the plight of unmatched medical students and the need for more physicians in underserved populations, and a subject that we should be addressing in America.

FORWARDED COMMENTARY

I have such a heavy heart today for the plight of the unmatched medical school graduate. I would like to share some of my experiences in the past few years. I know many are peripherally aware that we now have a massive surplus of residency candidates and something like 6000-8000 per year that go unmatched. I still get hints of some degree of skepticism from many, the idea that if one can't match then one must be inherently flawed and perhaps should have known better than to try in the first place. A little "that's too bad" about the time and money they have lost in the process and then back to business. I am a rural family physician providing full scope care in a town of around 8000 in west central Missouri. It's a perfectly good town, no better nor worse than many scattered all over the rural areas of this country. There is nothing about us that is particularly attractive to new recruits. Many of our local sons and daughters who have gone off for medical training have fallen in love and made their lives with someone from somewhere else so they are not all that inclined to return. Recruiting is very difficult and I know that's not just us. I can assure anyone who has bought into the theory that NPs can just fill the void and leave practicing real medicine in the cities to the physicians that nothing could be further from the truth. My patient population does not desire to travel to the city for care, they often

don't have the physical ability or the means to do so, they have complex medical needs and they wish to have high quality local medical care. Many of them seem to know the difference.

Missouri government passed legislation in 2014 to license medical school graduates to be "assistant physicians" and work in a collaborative arrangement to help with primary care in underserved areas. It's no surprise to find the skepticism which has greeted this approach. The first license was issued in July 2017 and there has been some momentum but many of these positions remain volunteer and a few have developed from the assistant physician beginning the practice and hiring the collaborating physician. There is obviously concern for abuse of this system and that concern is well-founded. My business chose to hire one as soon as possible and we muddled through the obstacles of insurance credentialing, liability coverage, hospital privileging and collaborative compensation. Our AP was a great sport and highly motivated. She was fortunately able to match into family medicine and I would say the most likely financial impact from her year with us was a break-even. We honestly didn't pay much because we didn't know how this was going to go. As a small business we don't have the resources to lose lots of money.

I have hired two new assistant physicians, they joined me in June and July. I made sure they understood that my expectation for them was that who would go through the match, not continue in this role for their career. So far this week rejections have come in as much as interview opportunities. These individuals have the intelligence, drive and personality that I would expect from any physician, including my medical school and residency classmates from 20 years ago. What would appear to be minor obstacles might be complete blockades for them.

I spoke today with a faculty member from my alma mater, a community based FM residency in a small midwest city. He agreed to give my APs a second look for me despite the fact that the program has already rejected them in the first round of applications. They have received 500 applications, 160 of them from US grads. They have to find a way to control this and are looking at number of attempts to pass boards and

number of years since med school graduation (as in not more than one). They will interview 72 applicants and match 8 or 9.

I also received an email from AAMC today announcing that there is pending legislation that would grant additional funding for GME. I hope that is true.

I'd like to end this missive with a few "asks."
1. Please be cautious about these new medical schools and increased medical student positions that seem to be popping up everywhere. There don't seem to be more residency positions to go with them. Am I alone in not realizing during medical school that I could possibly have a degree and no use for it due to not enough residency positions? I don't really think that existed 20 years ago but it certainly never occurred to me as a possibility.

2. Actively support the development of new residency positions. I have a special place in my heart for rural primary care but it is my observation that the available nearby supply of many specialists appears to also be limited. Government funding has been the bottleneck. Can some of these enormous healthcare networks also take the lead on any of this? Perhaps with guaranteed employment after graduation and commitment from the residents. If there is legislation that will increase the government funding then please support it. Contact elected officials by email or letter, lobby, go meet with people.

3. Please do not dismiss the plight of this massive group of medical school graduates who are desperate for a residency opportunity. Understand that they have worked hard, sacrificed and gone into substantial debt and are just absolutely stuck even though they have the potential to be great physicians. Please don't assume they are flawed. They might be but probably aren't.

MATCH DAY 2018

There are a total of 30,232 residency positions currently available.

American Medical Grads MD seniors: 19312 applicants, only 17740 matched (1,572 unmatched, 91% match rate)

AMG DO schools: 6054 applicants, only 3771 matched (2,283 unmatched)

AMG MD schools: 1788 PGY1 reapplicants, only 662 matched (1,126 unmatched)
 US Citizen FMGs: 6986 applicants, only 2900 matched (4,086 unmatched)

GRAND TOTALS FOR AMERICAN CITIZEN MEDICAL GRADUATES:

34,140 applied for 30,232 available residency positions. Only 25,073 matched. This is a 73% match rate.

9,067 Americans did not match. Approximately 27% of medical doctors failed to match. This number is INCREASED when compared with 2017 data which is included below.

Source 2018 NRMP

<http://www.nrmp.org/wp-content/uploads/2018/03/Advance-Data-Tables-2018.pdf>

MATCH DAY 2017

AMG MD seniors: 18539 active applicants, only 17,480 matched (1,059 unmatched, 94% match rate)

Previous graduates of US allopathic schools: 1472 active applicants - match rate 46% = 795 unmatched

AMG DO school: 3,590 active applicants - match rate 81% = 675 unmatched

US citizen/IMG: 5069 active applicants - match rate 54% = 2292 unmatched

non-us citizen/ IMG: 7284 active applicants - match rate 52% = 3470 unmatched

There were 35969 active applicants for the NRMP match in 2017, 8281 (~ 25%) failed to match. If you account for the SOAP that leaves close to 7200 applicants without residency positions in 2017.

All from NRMP data, page 15, table 4:

<http://www.nrmp.org/wp-content/uploads/2017/06/Main-Match-Results-and-Data-2017.pdf>

Thank you for reading to the end. I'd love to participate in some dialogue about this with those who are interested. ✚



WHAT?!?

BY ANDREW J. PESTCOE, D.O., F.A.O.C.O.

Do you feel that you have to often ask “What?” when conversing with others? Are you avoiding conversations for fear of answering inappropriately due to your hearing loss? Approximately 20% of Americans (48 million) report some form of hearing loss. Based on the degree of loss, it can have a significant impact on the quality of your life. It is important to understand that, based on the type of hearing loss, treatment is not just limited to amplifying devices such as hearing aids.

Hearing loss can be divided into three categories, nerve loss, conductive loss or mixed (combination of nerve and conductive loss). Nerve hearing loss root cause lies in the inner ear, where the cochlea (sensory organ) and the auditory nerve are located. Conductive hearing loss would indicate a problem with the external ear, including the ear canal, ear drum or the middle ear, where the ossicles (three small bones) are located. The type of hearing loss is determined by an audiogram (hearing test).

Conductive hearing loss can have multiple causes, including cerumen impaction, scarring or perforations involving the ear drum, fluid in the middle ear or ear infections of the ear canal or middle ear. Another cause for conductive hearing loss can be due to a cholesteatoma. Cholesteatomas can form secondary to skin cells migrating through a perforation of the eardrum, often after repeated middle ear infections, forming a cyst. These cysts erode through the ossicles and expand through the mastoid bone, causing a significant hearing loss, and potentially balance disturbances and facial weakness. Treatment for cholesteatomas require surgical removal, and in many cases require reconstruction of the ossicles in order to restore hearing.

Otosclerosis is yet another cause for conductive hearing loss. This condition occurs when the stapes, the third of the series of three ossicles in the middle ear, becomes stuck in place. Many cases of otosclerosis can run in families, with middle aged women at higher risk. There is no medical therapy for this, and a stapedectomy is often recommended to improve hearing. A stapedectomy involves replacing the stapes with a synthetic prosthetic, allowing for sound vibrations to once again travel to the inner ear.

Trauma to the ear can have a have a significant impact on conductive hearing loss. In fact, the leading cause of traumatic ear drum perforations is due to cotton tip applicators (ie Q-tips) (JAMA Otolaryngol Head Neck Surg. 2018;144(2):136-139. doi:10.1001/jamaoto.2017.2550). Although these perforations may heal spontaneously, surgical repair may be necessary. This form of trauma may potentially fracture or separate the ossicles, also requiring surgery for hearing restoration.

If you have hearing loss, or if you know someone who is affected with hearing loss, it is recommended that you discuss this with your Ears, Nose and Throat doctor. Once the cause of the loss is determined, treatment options can then be discussed. Understanding the causes and treatments for hearing loss will hopefully make the process less daunting. +

Dr. Pestcoe is a Board Certified Otorhinolaryngologist and has been in practice in the Lehigh Valley for over 25 years. His practice is located at The Head and Neck Center in Bethlehem, PA



STRUCTURAL HEART DISEASE

and the Latest Tech to Provide Next Level Care

The heart is one of the five vital organs essential for survival. The heart's functionality impacts all the other systems of the body, so it makes sense that the doctors trained to heal and protect the heart are particularly adept at working collaboratively, just as the heart does. "Working well together is vital for any type of patient care, but it's especially important for cardiac physicians - the crossover and continuum is very important," says Raymond Durkin, MD, chairman of cardiovascular medicine for St. Luke's University Health Network.

Cardiovascular disease is the leading cause of death for men and women in the United States and within Pennsylvania, affects more than 25 percent of residents each year. Cardiovascular disease is the broad term used for a variety of heart and blood vessel diseases. It encompasses a wide range of conditions with many impacted by lifestyle choices.

In a team approach, patients are assured that their care is well coordinated among an entire team of cardiac specialists, knowing they have access to the most comprehensive care from minimally-invasive procedures to the latest, high-tech, innovations. "It's important for the entire treatment team to get to know each patient and treat him or her like family, assuring the best treatment in a personalized way," shares Jay Fisher, MD, vascular surgeon. "Sometimes treatment is diet, exercise and medication, sometimes it's minimally invasive and sometimes it requires an open operation, but, in a team approach, the treatment will always be tailored to their disease process and the individual."

WHO IS IMPACTED BY HEART DISEASE?

"Regardless of treatment needs and procedures, patient care is a team process," says Stephen Olenchok, DO, St. Luke's Cardiovascular Surgical Associates, chief of cardiovascular surgery, "where everyone contributes to the care of patients, and focuses on a common goal - restoring the patient and the family to good health."

Treatment can be for a variety of conditions that cause chest pain or discomfort occurring in any area of the heart muscle including the common afflictions like Afib, coronary artery disease, heart failure and heart valve disease. While heart and vascular disease, blockages and heart attacks are more prevalent in older patients, issues like rhythm disorder can strike younger patients too.

INNOVATIVE TREATMENTS

"The first angioplasty in the United States was done in 1978, and since that time the field has evolved rapidly and continues to progress," says Dr. Durkin.

The transcatheter aortic valve replacement (TAVR), the MitraClip mitral valve repair apparatus, the Micra Pacemaker, called the world's smallest pacemaker, and Abbott's dissolvable stent are among the most innovative treatments available today. Because of new medications and advancements like these, heart conditions that once caused stroke or proved fatal are now very treatable.

TAVR

TAVR is a catheter-based procedure for patients with severe symptomatic aortic stenosis. It's best for those patients who are not candidates for more invasive open heart surgery because the risk of an open heart procedure would be too great. Benefits of TAVR include a shorter hospital stay, less anesthesia, less risk of infection and a faster recovery. With the new valve in place, blood flow occurs immediately.

MITRACLIP

Patients with mitral valve disease, or patients that have a leaky mitral valve, can now have the condition repaired with the MitraClip, a medically implanted device that stops or reduces the blood leakage in the mitral valve. It allows doctors to clip or staple the front and back parts of the leaflet in the heart so they no longer leak. "The physician and his or her team can then view an echocardiogram to confirm the valve isn't leaking anymore, and patients go home the next day," explains Dr. Olenchok.

WATCHMAN

The Watchman is available for patients with AFib, who can be five times more likely to have a stroke because the condition puts a severe strain on the heart and blood vessels, and can cause blood clots that cut off the blood supply to the brain. It's a one-time procedure that can effectively reduce a patient's likelihood of stroke with a 95 percent success rate. The Watchman device, about the size of a quarter, blocks off the left atrial appendage, reducing stroke risk and eliminating the need for blood thinners.

"Heart disease kills more adults in the United States than any other medical condition, yet it is often preventable and treatable," says Dr. Durkin. **+**

PHYSICIAN ADVOCACY IN ACTION

PAMED LEADERS DEBATE HEALTH POLICY AT 2018 HOUSE OF DELEGATES



Physician advocacy is alive and well in Pennsylvania, as more than 200 physician and medical student delegates came together for the 2018 House of Delegates (HOD) meeting in Hershey, Pa. on Oct. 26-28. Pennsylvania Medical Society (PAMED) delegates representing counties, specialties, and member sections engaged in spirited debate on many of the pressing issues affecting health care today.

Danae Powers, MD, was inaugurated as PAMED president on Oct. 27.

The HOD approved a breadth of resolutions, including ones that addressed rising prescription drug prices, reaffirmed PAMED's support for the physician-patient relationship, and called for PAMED to support a repeal of the Merit-based Incentive Payment System (MIPS).

Here's a look at some of the resolutions that physicians either adopted or directed PAMED's Board to study further. (Important Note: This is not an exhaustive list. PAMED will soon share final versions of the 2018 resolutions adopted or recommended for further study online, and we will provide monthly updates on progress concerning each resolution.)

HEALTH CARE LEGISLATION & REGULATIONS

In their daily practice, Pennsylvania physicians must navigate an ever-growing number of laws, policies, and regulations. Delegates addressed legislative and policy issues such as:

Defending the Physician-Patient Relationship – PAMED will continue to recognize, support, and lobby for the need for physician oversight, whether by direct supervision or a written collaborative agreement, of all non-physician practitioners who deliver care as part of a physician-led care team.

Maintenance of Certification (MOC) – PAMED will strongly encourage organizations such as hospitals, network employers, and insurance companies to recognize multiple qualified board organizations when credentialing physicians. Further, at the HOD's direction, PAMED will share more information from a September 2018 Department of Justice letter containing MOC guidance.

Clarifying State Legislation on Ambulatory Surgery Centers (ASCs) – The Pa. Dept. of Health has ruled that a 2017 state law intended to increase the allowable time of care in ASCs to 23 hours, 59 minutes did not specifically address Pennsylvania code which prohibits overnight stays. As a result, current Pa. code

prevents care in an ASC to last up to 24 hours except in "extreme circumstances." The delegates voted to work with stakeholders to ensure that the intent of the law is executed and, if necessary, seek a legislative remedy.

Maternity Leave Equity – The delegates directed PAMED to support the elimination of punitive salary policies on the career opportunities of women physicians who become mothers, and, with guidance from the Women Physicians Caucus, develop best practice guidelines for physician employers.

School Resource Officer (SRO) Training – In light of the multiple incidents of school violence, PAMED will advocate for legislative initiatives to implement minimum standards of training for SROs to include topics like conflict resolution and cultural competency.

PAMED Support of Local Legislative Efforts – PAMED's Board will study ways to increase the grassroots involvement of physicians statewide. They will explore whether to create a council or committee that would coordinate advocacy initiatives at the state and county level.

PUBLIC HEALTH & EDUCATION

Delegates explored issues that affect the health and well-being of Pennsylvania patients, including:

Improving Health Care in Correctional Institutions – The delegates directed PAMED to address a range of public health issues in the U.S. prison system. They approved resolutions on issues affecting individuals in the prison system including: improving treatment of depression in older adults, support of medication-assisted treatment (MAT), health education programming, and prevention of hygiene-associated and sexually-transmitted infections. The PAMED Board is directed to study the issue of funding for disease prevention programs, including vaccinations, in the prison system.

Immunization – PAMED will promote American Academy of Family Physicians and/or Pennsylvania Academy of Family Physicians outreach campaigns to educate health care providers about immunization platform visits at 16 years of age that can enhance the well-being of older adolescents.

Firearms Safety Education for Physicians – The delegates directed PAMED to explore partnerships with other stakeholders to provide physicians with comprehensive educational resources on firearms safety.

Promote Substance Abuse and Mental Health Services Administration (SAMHSA) Treatment Referral Helpline – PAMED will continue to promote awareness of the SAMHSA national helpline, 1-800-662-HELP (4357).

Social Determinants of Health (SDOH) – PAMED will support addressing SDOH to provide comprehensive care to patients. We will also encourage primary care providers to recognize the correlation between adverse childhood experiences and chronic disease to appropriately tailor care to the patient.

PRACTICE ISSUES & REIMBURSEMENT

Skyrocketing drug prices, the accelerating transition to value-based payment models, and patient access to care are major concerns for all Pennsylvania physicians. Delegates addressed practice and reimbursement issues such as:

Out of Network Balance Billing – PAMED will support state legislation to get patients out of the middle of billing disputes between

insurers and providers that result from “surprise” insurance gaps, out of network emergency services, or other situations where patients do not have the ability to select their provider. We will also oppose initiatives that base the benchmark or default payment rate for non-contracted physician services on Medicare rates.

Support for Repeal of Merit-based Incentive Payment System (MIPS) – PAMED will support the repeal of MIPS and petition the American Medical Association (AMA) to support the repeal and to oppose any federal efforts to implement pay-for-performance programs unless they do not add significant regulatory or paperwork burdens to the practice of medicine and have been shown by evidence-based research to improve quality of care.

Corporate Practice of Medicine – PAMED will commission a study to determine the current extent of corporate ownership of physician practices in the state, which will include physician and patient feedback.

Health Insurance Parity – The delegates directed PAMED to advocate for essential health benefits, seek legislation to ensure Pa. consumers are protected, and ask the Pa. Insurance Department to provide resources to consumers seeking comprehensive health insurance.

Physician Credentialing – PAMED will advocate that physician credentialing by insurance companies be based on professional training and licensure rather than solely on employment status or hospital affiliation. We will also advocate to payers that, once credentialed, physicians be listed as equal-tiered providers to those employed by the hospital or health insurer.

Drug Shortages and Drug Prices – Delegates voted to direct PAMED to support evidence-based policy to address drug shortages and drug prices, advocate for increases to supply chain transparency and pharmacy choice, and advocate for effective implementation of pharmacist gag clause legislation. Additionally, PAMED will provide member education on the safe harbor exemption to the anti-kickback statute.

PAMED MEMBERSHIP

The delegates in attendance discussed numerous strategies to strengthen state and county medical societies and enhance the member experience:

Find Methods to Increase Communication and Transparency – The HOD recommended a variety of strategies to effectively communicate with members. One such strategy recommended by delegates is an “Ask the Board Chair” website providing members and opportunity to submit questions for physician leadership. This new feature will be available soon. Note that PAMED members can currently access Board of Trustee and Executive Committee meeting minutes here.

Role of County Medical Societies – The HOD reaffirmed that county medical societies are integral components of the state medical society.

Update to PAMED’s Bylaws – The HOD adopted several bylaws amendments that will (1) clarify dues for medical staff coordinators, (2) give county medical societies increased flexibility in setting their own dues, (3) streamline PAMED’s membership categories, (4) update provisions regarding the Early Career Physicians and Medical Student Sections, and (5) create a new Women Physicians Section and Board of Trustees seat.

Regionalization of County Medical Societies – PAMED will form a task force to create a grant process through which county medical societies who wish to participate in the process of regionalization can apply for assistance.

PAMED’s Care Centered Collaborative – The Collaborative, PAMED’s for-profit subsidiary, will continue to share information about its activities to PAMED members on a regular basis. You can find the Collaborative’s quarterly reports at www.pamedsoc.org/CCC.

Explore Options for Making the HOD Virtual – A task force will be created to explore the incremental virtualization of the HOD as a means to increase member participation and engagement. +

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