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Contents

WINTER 2016

MCMS Physician is a publication of the Montgomery County Medical Society of Pennsylvania (MCMS). The Montgomery County Medical Society's mission has evolved to represent and serve all physicians of Montgomery County and their patients in order to preserve the doctor-patient relationship, maintain safe and quality care, advance the practice of medicine and enhance the role of medicine and healthcare within the community, Montgomery County and Pennsylvania.

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A Sometimes Inconvenient Truth – *Sleep is Vital to Good Teen Health*

James W. Thomas MD, MBA
MCMS President

Parenting is a blessing filled with many rewards and challenges. We want to protect our children at all cost and provide a better life for them. If there's a problem, it's "SuperParent" to the rescue.

Whether a pediatrician or not, every parent is concerned about their child's optimal health. We see our cranky teenagers getting up at the crack of dawn so that they can get to school on time, often before sunrise. It's hard not to wonder if there is a better alternative.

Why are so many of our children pathologically sleep deprived? Can't schools just start a bit later? Why can't the schedule work more with their bodies instead of against them?

A National Sleep Foundation poll found that 59 percent of 6th through 8th graders and 87 percent of America high school students were getting less than the recommended 8.5 to 9.5 hours of sleep on school nights. It's not because the teenagers won't go to sleep earlier, it's because they may not be able to do so. Adolescent children's biological sleep-wake cycles begin to shift up to two hours later at the start of puberty, making it difficult

for them to fall asleep before 11 p.m. Almost two years ago, the American Academy of Pediatrics (AAP) proposed a solution—align the middle and high schools' start times with the teenagers' sleep cycles, and begin school at 8:30 a.m. or later to allow students the opportunity to get the recommended amount of sleep.

The AAP noted that insufficient sleep can lead to a variety of health problems. Lack of sleep is associated with a number of chronic diseases and conditions—such as diabetes, cardiovascular disease, obesity, and depression—which threaten our nation's health. Additionally, insufficient sleep is also responsible for motor vehicle and machinery-related crashes which cause substantial injury and disability each year.

Last spring, I began communicating with school officials in my district about this national and perhaps local public health crisis, hoping to make some changes in light of the recent studies and concise recommendations. The school officials are just as concerned and bring up additional logistic considerations.

Practical Problems Associated with Delayed School Start Times

Evidently, it is not just a simple matter. Parents and administrators rapidly learned of the varied ramifications of significantly changing start times.

School officials in my children's district said they have had "exploratory discussions" about this concern, but such change would be a massive undertaking. District officials know there is a problem and agree that teens need more sleep. However, they are not convinced that significantly later start times would achieve the desired result. In addition, it seems the logistical and financial hurdles somehow outweigh the potential benefits of having perhaps better rested adolescents.

School officials cite a domino effect of inconveniences that come with a delayed school schedule—childcare for younger children if elementary and middle/high school schedules are switched, the older siblings are not home first, additional time away from classroom instruction, extracurricular activities pushed back, additional transportation costs may result...the list of concerns goes on.

Do the inconveniences or logistical issues outweigh the risks to the health of our children? Such difficult questions! Bottom line, my adolescent children's schedule for 2015-2016 remained the same as the year before, 6:43 a.m. bus stop pickup for 7:30 a.m. school start time and perhaps yours did too. And so the question remains: is this the best we can do for our teenagers?

Right now, the answer is unclear. Perhaps naively, I had personally hoped we could at least push back bus pickups and start times of middle and high schools at least 30 or even 40 minutes uniformly, to 8 a.m. or 8:10 a.m. We all hope for a viable alternative to the status quo, perhaps involving simultaneous changes throughout the county or state.

Continued on page 6

Fixable Public Health Issue

I agree with Dr. Judith Owens, lead author of the policy statement, "School Start Times for Adolescents," published in the September 2014 issue of *Pediatrics*, who believes this is a solvable problem. How each state and school district chooses to implement changes to achieve the desired goal is the challenge. The state of New Jersey signed into law a requirement for their Department of Education to study the matter in October 2015 (S-2484).

"The research is clear that adolescents who get enough sleep have a reduced risk of being overweight or suffering depression, are less likely to be involved in automobile accidents, and have better grades, higher standardized test scores and an overall better quality of life," Dr. Owens said. "Studies have shown that delaying early school start times is one key factor that can help adolescents get the sleep they need to grow and learn."

Research also shows that lack of sleep is associated with an increased risk of injury in adolescent athletes. Many studies are listed at www.startschoollater.net, a comprehensive website that is worth viewing.

Until we figure out a better solution, it is 6 a.m. reveille and perhaps on occasion a bit later, if the teens get driven to school to save a half hour of sleep and school bus time in hopes that a solution may be found …next year.

We say our children are our future. Perhaps a significant portion of our future is a bit too tired and sleepier than necessary.

Warm Regards,
James W. Thomas, MD
MCMS President

"… Sufficient sleep is not a luxury—it is a necessity—and should be thought of as a vital sign of good health."

—Wayne H. Giles, MD, MS, Director, Division of Population Health, National Center for Chronic Disease Prevention and Health Promotion

■

Tuesday, June 7, 2016

Annual Dinner and Installation will be held at the William Penn Inn.
MCMS Physician editor will be installed as president.

Save the Date: Installation Dinner Set June 7 — Join your colleagues for good food and fellowship at the 2016 MCMS Annual Membership Dinner and Installation Tuesday, June 7, William Penn Inn, Route 202 and Sumneytown Pike, Gwynedd. Jay A. Rothkopf, MD, will be installed as the new president, and MCMS will honor 10 physicians who have practiced medicine for 50 years. Husband and wife physicians, Dr. John Eck and Dr. Alieta Eck will share how their political advocacy may change the face of medicine for physicians and their patients. Frustrated by the inadequacy of New Jersey's health insurance system, Drs. Eck founded the Zarephath Free Clinic. The center gives physicians an opportunity to revert back to the old model of donating time each month to care for the poor and uninsured.

Physicians Working Together: An Indomitable Force

The Force Awakens.

Jay Rothkopf, MD
Editor

No, this is not an advertisement for the seventh installment of the Star Wars saga, which by now has probably broken box office records worldwide. I am, however, a lifelong fan, having been raised on the iconic films which are as much a part of American culture as football and apple pie. While too young to have seen the first one in theaters, I do remember attending the premiere of Return of the Jedi back in 1983. It was a warm Saturday in mid-May, and the 309 Cinema in Montgomeryville was packed. The sun was bright, the line for tickets stretched around the corner, and the parking lot was a sea of glinting cars. It was perfect.

I remember the smell of popcorn, the cool air and dim lights of the theater, the fans in costume paying tribute to their fictional heroes. I remember holding my mother's hand as she queried the manager as to why ticket prices had been raised from $1.50 to $1.75 for the matinee show. I don't recall that conversation's outcome, but an accord must've been reached, as we were soon comfortably seated watching Luke Skywalker and Darth Vader do battle for their souls while the evil Emperor Palpatine cackled with glee. It was a wonderful day, filled with the innocence and magic of being both fortunate and young.

A lot has changed since then.

Forces Beyond Our Control Impact Medicine

Not so much on a personal level, no—my life is full of blessings for which I am extremely grateful. Rather, much has changed with the world, and with it, how we comport ourselves as physicians. In a way, the practice of medicine relies on forces, many of which are beyond our control. Many, but not all. Enough, though, to have engendered a sense of helplessness in the profession and the idea that as doctors, we are merely just pawns in someone else's game.

So what are these 'forces'? As a physician, I find myself asking this question often. Is it the insurance industry, the pharmaceutical industry, the political 'forces' that dominate a presidential election year? Is it the seemingly endless wave of regulations that bury physicians like snow in a storm? Or is it the fear of lawsuits, of making a mistake, and the unintended consequences which would likely result?

'Forces'. It's a term that, in many ways, has come to signify a maelstrom, one that is both intimidating and cold. I mean, how can physicians and patients—mere mortals compared to the combined weight of these factors—possibly stand against such Goliaths, or hope to act as agents for change?

Good question. And one for which there isn't an easy solution. I do, however, have a suggestion. If you are a regular reader of this publication, you might find what I am about to say a bit repetitious, but I repeat it because I believe it. Because it helps me deal with the day-to-day pressures of modern practice, of having to not only care for patients, but be pulled in many different directions by multiple stakeholders. Because it brings meaning to the aforementioned sense of helplessness that most doctors have at some point felt.

Defend Patient-Physician Relationship with Advocacy Lightsaber

It comes in many forms—local to national, big and small. Now, I'm not suggesting that physicians organize themselves into an armor-clad, lightsaber-wielding fighting force that will magically cure all that ails American medicine (as visually amusing and viscerally satisfying as that would be), but rather, that we continue to organize, to work together, to stand up for the physician-patient relationship. For the past 30 years, we've been force-fed (no pun intended) such phrases as 'change is coming', and 'get on board or get gone' without stopping to realize that there is another way. It has often been said that getting physicians to work together is akin to herding cats, but I disagree. All that is needed is the correct issue, something around which to coalesce, and unity will follow.

An example is SGR. While the MACRA statute which repealed the flawed Medicare payment formula itself has major issues, the story of how it came about laid the foundation for future action by the physician community. From the ground up, we kept the pressure on and results followed. It may not have been perfect, but a point was made: we will play the long game, and we're here to stay.

Nowhere has this been more apparent than with MOC. We have gone from professionals chained to the whim of a private corporation to a force that has led to major change—and more is coming. By standing together, by lifting our voice, we bent the curve on two major issues. Often, the cynics among us will state that we have no real power, that we should leave policies to the experts and politics to the politicians. 'Focus only on the patients', they say, 'and everything else will take care of itself'. I would answer that viewpoint by saying this:

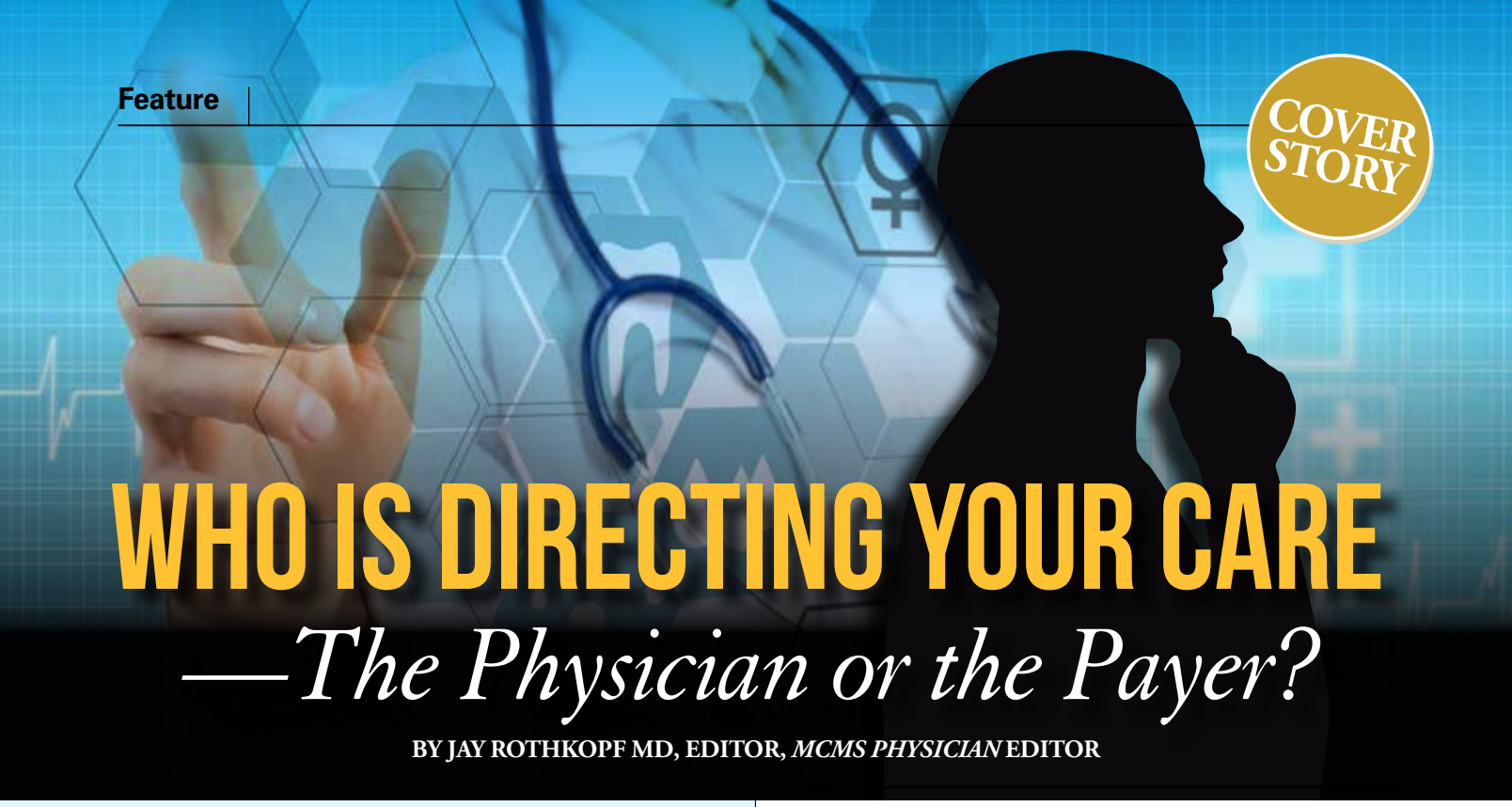
The Right Prescription Includes Advocacy

Advocacy is taking care of our patients. The goal of organized medicine--at every level—is to help Americans live longer, healthier, and more fulfilling lives. By fighting to improve access to care, remove barriers, and defend the physician-patient relationship from unwarranted intrusion, we seek to empower not ourselves, but those who have entrusted us with this sacred responsibility. When doctors feel better about themselves and their work, everyone benefits—especially patients.

We are a force in the lives of the people we care for. A force for hope. A force for good. But we can do more. We can do better. We will move forward to face our challenges. But we must do it together. ■

Jay Rothkopf, MD
Editor

COVER STORY



WHO IS DIRECTING YOUR CARE —*The Physician or the Payer?*

BY JAY ROTHKOPF MD, EDITOR, *MCMS PHYSICIAN* EDITOR

Case Scenario

Mrs. M. has been your patient since you first went into practice. For the past 14 years, you have treated her mostly-stable rheumatoid arthritis with a combination of adalimumab and low-dose methotrexate, with the occasional burst of prednisone for flares. Despite several mild recurrences over the intervening years, she has, for the most part, done fairly well. Then, last week, at her biannual follow-up, she relayed some disquieting news: her insurance company had sent her a letter stating that they would no longer cover payment for her biologic medication. Citing 'recent evidence showing full-dose methotrexate to be non-inferior to anti-TNF therapy', they have determined that her current regimen is unnecessarily aggressive for her level of disease. While she remains free to continue on adalimumab if she chooses, she will now be fully responsible for each dose at cost. With a price tag of up to $2,400 per month, she is facing a painful choice: her mortgage or her meds. Now, sitting across from you in the office, her tear-filled eyes are locked into yours, waiting for not only reassurance, but words of guidance. After promising her you'll look into the situation immediately, you file an appeal with her insurer, only to be rebuffed by their medical director, a colleague who no longer actively sees patients. Despite insisting that in your best judgement, her case is unique, and that unnecessarily altering her regimen will put her at risk, the director refuses to budge. Calling the patient back, you relay the bad news. She breaks down, sobbing on the phone, and asks if there's any other way you can help. What do you do?

Experienced attending or new grad, resident or student, if you're in clinical practice, chances are you've either had this conversation or witnessed it taking place. And while such issues are now commonplace in the practice of medicine, we still have a duty to protect our patients.

So, what do you do? You've filed an appeal, you've spoken to a director, and the answer is still "no." You're convinced that doing what the insurance company dictates—whether it be changing a medication to a less-expensive version or refusing to cover what you feel is a necessary test—is not in the best interest of your patient, yet they hold "the power of the purse." Or do they?

Healthcare Landscape: David vs. Goliath

There is no question that the world of insurance has changed drastically over the past several decades, most notably from the 1980s to today. While once functioning as little more than 'claims processors,' the health insurance industry has grown to a multi-billion-dollar-per-year sector of the U.S. economy. With that level of financial clout has come increased leverage over both state and national policymaking, which has led

to regulations and laws that have not always been favorable to physicians and patients. Much as has occurred with the pharmaceutical industry and the setting of prices, insurers have in many ways become monolithic—and dealing with them can feel like David taking on Goliath.

A sense of mistrust compounds this problem. In a recent poll of 45 states and the District of Columbia, 605 physicians (25% primary care, 75% specialists) found that doctors broadly mistrust health care insurers and believe they interfere with physicians' ability to provide high-quality care. While not all health-insurance companies received the same rating, the biggest factors in physicians' perception of enabling the delivering of good care came down to one issue: more coverage and fewer claims denials versus poor coverage and more claims denials.

Interestingly enough, in this study (the ReviveHealth Payor Trust Index), when asked to assign a justification for a "best" rating from a list of six criteria, five were relationship driven, such as customer service, administration, and clear guidelines, with only one being financial. This would seem to run counter to the argument that physicians dislike insurers due to declining reimbursement and a diminution of earning potential. Conversely, when considering "worse" ratings, the top five criteria were all relationship factors, with payment rates coming in a distant sixth.

Resources for Patient and Physician

Regardless, physician mistrust of health plans will likely get worse if the consolidation of national insurers into mega-entities is approved by the federal government. Issues such as negotiating power, access to services, and denial of appeals may very well become insurmountable for many practices. In light of this, one might think that advocating for patients will only ever be an uphill battle, but it is not a hopeless one. There are tools that can help. Let's take a look at some of them.

1) Act 68 — while patients can always file not only an appeal, but also a complaint against an insurer, physicians are also not without recourse. Act 68 allows a doctor to file a complaint against an insurer as a "patient advocate." In the case scenario listed above, this would likely be the most suitable course of action. Once filed, the grievance is then reviewed by the Bureau of Managed Care (a division of the state's Department of Health), and a decision made. Historically, outcomes have favored patients 50 percent of the time. While this may sound unimpressive, it is certainly higher than the rate of denials that are reversed upon direct appeal, making this route far from a 'slam dunk' for the insurer.

2) AMA Health Grades — one of the easiest ways for physicians to learn about insurance providers is to study how others have fared when dealing with the same carriers. The American Medical Association offers a "Grades for Plans" service whereby insurers are rated on various metrics such as timeliness in claims processing, frequency of claim editing, and denial-of-

Continued on page 10

claim lines. Patients, via the internet, also have access to information such as customer service, quality of benefits, and ease of navigating administrative burdens (such as appeals). By becoming empowered, physicians and their patients can work together to more successfully weave through regulatory mine fields. In an age where patients are more savvy consumers, a little knowledge can avoid a lot of headache—for everyone involved.

3) New legislation — two pieces of draft legislation that are currently being pondered in Harrisburg aim to not only further protect the physician-patient relationship, but also smooth roadblocks between physicians and insurers. The first of these (pending in the state House), would also address the fictional scenario which opened this article; namely, insurance companies directing care over the wishes of physician and patient. If enacted into law, the bill would prevent a patient receiving treatment plan 'A' from being arbitrarily switched over to plan 'B' for no other reason than to conform to an insurer's 'guidelines'. For example, a patient undergoing a specific treatment suddenly finds their employer has changed insurance carriers. Under the new company's policy, the patient's treatment will not be covered unless they try and fail an older, less expensive treatment first. Currently, a patient in such a situation has to either a) provide evidence of such failure in the past, with no guarantee that the new insurer will change course; b) change to the less expensive treatment and hope for the best; or c) pay for their existing treatment 'out-of-pocket' — all undesirable outcomes. To be fair, every insurer in the country does have an appeals process, but a patient-favorable endpoint is never written in stone. This bill would change that by 'grandfathering' patients whose coverage changes into their current treatments, until and unless their therapy is changed by a physician.

The second of these bills, sponsored by state Rep. Marguerite Quinn (R-Bucks County), focuses on the prior authorization process, something which physicians and patients would both agree is a universal hassle. In its current form, the legislation would enshrine several principles into law: a) all prior authorizations must be electronic, which would both cut down on patient delay times and potentially reduce waste for practices and their managers. Under the bill, all adverse determinations must also be determined electronically using a standardized prior authorization form; b) uniformity and transparency for all insurers in the states (in other words, mandating that different companies all be subject to the same criteria, including consistent response times and processes for said authorizations, adverse determinations, and both internal and external appeals); and c) improving practice efficiency by placing limits on routine medical records requests by insurers in a manner consistent with HIPAA, in addition to excluding treatment utilizing Appropriate Use Criteria, where available, from the prior authorization process.

If passed, these pieces of legislation will hopefully improve the care experience for not only patients, but physicians as well.

4) PAMED — in addition to action on the legislative front, the Pennsylvania Medical Society has also played a key role in facilitating meetings between the physician community and insurance leadership, both in settling disputes between practices and insurers and when concerns have been raised regarding changes to policies. A recent example involved Highmark's decision to cease reimbursement for the anesthesia drug propofol. Used not only in the operating room, but also for a myriad of outpatient procedures requiring conscious sedation, this decision, had it stood, would have been highly disruptive to the practice of medicine for numerous specialties. However, PAMED was instrumental in bringing together all parties involved to help relay physician concerns. After a period of deliberation, Highmark then chose to reverse its decision. On an even broader scale, Novitas, Pennsylvania's state administration of Medicare services, has also changed policies based on PAMED's feedback.

An Ounce of Prevention is Worth a Pound of Cure

While the medical society keeps an eye on both draft legislation and potentially unfavorable policies, it is also important to have 'boots on the ground.' Physicians in

day-to-day practice are encouraged to keep an eye out for, and be aware of, new policies that insurers may have waiting in the wings. Physicians should also take the opportunity to make their concerns known during public comment periods, rather than discovering a new rule has taken effect after-the-fact. To borrow a cliché, 'an ounce of prevention is worth a pound of cure'. Engagement beforehand can avoid problems later, especially when it comes to the complicated maze of insurance rules.

It's a lot to think about. Not everyone may agree with the suggestions that have been laid out, but it is a foundation upon which to build. With further advocacy and effort, the playing field will hopefully become more level, which can only benefit patients and physicians.

Physicians Not Immune in These Battles

On a personal note, I'd like to share something that is germane to this article. On Dec. 9, I received notice that a specialty medication I take for Crohn's disease, Humira, will no longer be subject to a fixed co-pay. Instead, beginning January 1, I will now be assessed for co-insurance as a percentage of the monthly cost. Upon calling the pharmacy vendor for more details, I was told that no information could be given out until the increase took effect. There was no one who could help me, or even provide information on how large a percentage the co-insurance would be. At a yearly retail cost of $52,000, a 20 percent co-insurance would exceed $10,000 per year. While my out-of-pocket expenses are capped at $6,600 annually, the increase from a $5-per-month co-pay to potentially hundreds-of-dollars instead has certainly been an eye-opener. And I'm one of the lucky ones who can afford to pay it. The bigger question is: what about everyone who can't? What happens to them?

I posed that question to my insurance company, who, like the pharmacy vendor, could not give out any information (or even confirm that my co-pay would change, despite the letter that I'd been mailed). It took contacting AbbVie, the pharmaceutical company which developed the drug, to discover that the co-pay assistance card that I currently have is still in effect. As long as the insurer's charge for the drug doesn't exceed $800/month, I will continue to only have a $5 co-pay. To be fair, I am willing to pay more if it means that those without access to lifesaving medication will be able to obtain it, but at the very least, patients should be an active part of that process. Given the choice, I believe that many in a position to help would volunteer to do so. The current system, in which changes are imposed by force, breeds resentment and resistance rather than giving. It is one of the major flaws in our fragmented health care delivery system that I am hoping to see change. Hoping, but the cynic in me knows better.

At the time of this writing, I still have no idea what the new cost-sharing arrangement is going to be, or how it may change from year-to-year. I will post another update in the second article of this series, which will be published in the spring issue of *MCMS Physician*.

Until then, stay tuned. I know I will. ■

Security Risk Analysis is NOT Optional!

BY ANGELA HAAS, CHCO, PMSCO HEALTHCARE CONSULTING

If you haven't done so already, it's time to get your ducks in a row and conduct a security risk analysis. HIPAA and Meaningful Use regulations both require that a security risk analysis be performed or reviewed at least annually as part of the risk management process.

In many HIPAA investigations and Meaningful Use audits, it has been found that the security risk analysis for the practice was either not sufficient or not performed at all. A security risk analysis that does not meet standards upon audit could mean significant fines or the return of incentive payments received, which could be devastating to a practice.

Some things to keep in mind when conducting a security risk analysis:

A checklist is not sufficient. A thorough assessment of potential risks and vulnerabilities to electronic protected health information (ePHI) must be conducted. You will also need to document any deficiencies as well as what action steps will be performed to correct them.

Having a certified EHR system does not mean you are HIPAA compliant or that you don't have to conduct the risk assessment as required by Meaningful Use. EHR vendors are not responsible for making their products HIPAA compliant. Also, there is more to consider than just your EHR system when conducting a risk analysis. You must take into account any equipment, software, or internet-based applications that store, modify, or transmit ePHI. Also, consider who has access to these systems and devices and if sufficient protections are in place.

A risk assessment is not a once and done task. This process must be conducted at least annually, or when changes occur that warrant a review of systems and processes. Meaningful Use requires that the assessment be completed within each attestation period. It is not necessary to start from scratch each time but to review and update the prior analysis for any changes in risks.

There is no specific methodology or format that is required when conducting a risk assessment. However, a new tool was recently released by the Office of the National Coordinator of Health Information Technology (ONC) and Office for Civil Rights (OCR) that is designed to help small- and medium-sized practices perform this daunting task for those who want to try and tackle it on their own. The tool is available in an electronic format or in a paper-based version. The tool can be downloaded by visiting www.HealthIT.gov/security-risk-assessment.

The security risk analysis is a critical piece of your HIPAA risk management and Meaningful Use processes. Make sure a detailed analysis is performed regularly so your practice is covered. ■

Angela Haas is president and chief financial officer for PMSCO Healthcare Consulting. She is a Certified HIPAA Compliance Officer (CHCO) who provides HIPAA compliance education and training both internally for PMSCO and externally for PMSCO's clients. You can contact Ms. Haas at ahaas@consultPMSCO.com.

Physician Response Units Ready to Serve Montgomery County Residents

BY VALERIE ARKOOSH, MD, MPH
MONTGOMERY COUNTY COMMISSIONER

As a physician and Montgomery County commissioner, I am keenly aware of the importance of bringing quality emergency medical services directly to those who live and work in Montgomery County. Our commitment to doing exactly that begins the moment someone dials 9-1-1 and continues until the patient has been stabilized and safely transported to the appropriate medical facility.

Our county Department of Public Safety dispatchers handle an average of 2,300 calls a day, about 200 of which are medical emergencies that include traumas, cardiac arrests, overdoses and women in labor. Each receives over 100 hours of emergency medical dispatch training before they take their first call and ongoing training after that.

The police officers and firefighters that may arrive first are trained in advanced first-aid techniques, including CPR/AED. The ambulance that arrives moments later, if not already first on the scene, is staffed with either an EMT and a paramedic or two paramedics. At the Public Safety Department's EMS Institute, the EMTs receive more than 170 hours of basic life support training and the paramedics undergo more than 1,000 hours of advanced life support training.

This past September, Montgomery County added to its arsenal of emergency medical services provided to residents. The Physician Response Unit, a 2016 Ford Explorer equipped with a full complement of Advanced Life Support equipment, is now in service and staffed by one of three volunteer EMS certified physicians: Dr. Ben Usatch, Main Line Health, Lankenau, Dr. Dave Neubert, Jefferson-Abington Health System, and Dr. Alvin Wang, University of Pennsylvania Health Systems. Each is a former paramedic who is now an emergency room doctor certified in Base Medical Station Command.

The Physician Response Unit is equipped with advanced medical equipment and medications that go beyond what paramedics are trained to use, including field amputation equipment and advanced airway gear including a video laryngoscope. Funding for the unit was provided by the Montgomery County Local Emergency Planning Committee.

It will be dispatched when requested by field EMS providers for vehicle or train entrapment where field amputation may be required, structural building collapses, mass causality incident response or chemical, biological, radiological or environmental incidents. The impetus for purchasing and equipping this new unit was a particularly difficult vehicle rescue incident on the Pennsylvania Turnpike on May 27, 2014. The driver of a tractor-trailer was heavily entrapped and his leg had to be amputated to remove him so that life-saving medical care could be provided.

"Thanks to the generous support of the Montgomery County Local Emergency Planning Committee and the County Commissioners, we have enhanced the response capabilities of our jurisdiction with this uniquely equipped and staffed emergency asset," said Dr. Usatch, who also serves as medical director for the Montgomery County EMS Council.

"Our intent is to assist EMS, police and fire units with real-time physician support at the scene including advanced airway and emergency surgical capabilities and a wide array of pharmacologic supplies not available to the paramedic. With this team in operation, Montgomery County continues to lead the way in state of the art public safety responses. We look forward to enhancing our team in the near future with additional physicians, including, emergency physicians and trauma surgeons."

I am extremely proud of our Physician Response Unit and our Department of Public Safety who together work tirelessly in service to our Montgomery County community.

I welcome your feedback and suggestions for this column at val@montcopa.org. ■

Frontline Groups

Join an elite group of practices that are 100 percent committed to the Montgomery County Medical Society and the Pennsylvania Medical Society.

Frontline Practice Groups — three or more physicians in a group — stand on the front line of the medical profession by making a commitment to 100 percent membership to the Montgomery County Medical Society and the Pennsylvania Medical Society (PAMED). Your support helps MCMS and PAMED to advocate on your behalf and provide a forum for physicians to work collectively for the profession, patients and practice.

The Montgomery County Medical Society says thank you.

MCMS Frontline Groups as of ?????? ????

- Abington Medical Specialists
- Abington Memorial Hosp-Div of Cardiothoracic Surgery
- Abington Neurological Associates Ltd.
- Abington Perinatal Associates PC
- Abington Reproductive Medicine
- Academic Urology-Pottstown
- Annesley Flanagan Stefanyszyn & Penne
- Armstrong Colt George Ophthalmology
- Berger/Henry ENT Specialty Group
- Blue Bell Family Practice
- Cardiology Consultants of Phila-Blue Bell
- Cardiology Consultants of Phila-Einstein
- East Norriton Women's Health Care PC
- Endocrine Metabolic Associates PC
- ENT & Facial Plastic Assoc. of Montgomery County
- Gastrointestinal Specialists Inc.
- Green & Seidner Family Practice
- Hatboro Med Associates
- Healthcare for Women Only Division
- King of Prussia Medicine
- LMG Family Practice PC
- Lower Merion Rehab
- Main Line Gastroenterology Associates-Lankenau
- Marc Kress MD & Associates
- Marvin H. Greenbaum MD PC
- Neurological Group of Bucks/Montgomery County
- North Penn Surgical Associates
- North Willow Grove Family Medicine
- Otolaryngology Associates
- Patient First - East Norriton
- Patient First - Montgomeryville
- Pediatric Associates of Plymouth Inc.
- Performance Spine and Sports Physicians PC
- Rheumatic Disease Associates
- Rheumatology Associates Ltd.
- Surgical Care Specialists Inc.
- The Philadelphia Hand Center PC
- Thorp Bailey Weber Eye Associates Inc.
- Total Woman Health & Wellness Ob/Gyn
- TriValley Primary Care/Lower Salford Office
- TriValley Primary Care/Upper Perkiomen
- William J. Lewis MD PC

Through your membership, MCMS Frontline members and practices receive special recognition and benefits that include:

- A 5 percent discount on your county and state dues.
- A certificate of recognition to hang in your office.
- Regional meetings covering topics like risk management, employment law and payer and regulatory matters. These meetings are designed exclusively for member practice managers and office staff, free of charge.
- Additional discounts and services from county and state endorsed vendors.
- Quarterly recognition in *MCMS Physician* magazine.
- Continual recognition on the MCMS web site, www.montmedsoc.com.

For more information on how your practice can become a Frontline practice, e-mail montmedsoc@verizon.net or call (610) 878-9530 or PAMED, (800) 228-7823 or (717) 558-7750.

Meet Your County Medical Society Leaders

Dr. Walter Klein graduated from the University of Pennsylvania Medical Center. He is a surgical pathologist with a subspecialty of dermatopathology and practices at Bryn Mawr Hospital within Main Line Health. Dr. Kline is a Montgomery County Medical Society (MCMS) board member and serves on the Pennsylvania Medical Society (PAMED) Board of Trustees. He is also active in the Pennsylvania Association of Pathologists and the College of American Pathologists.

Name: Walter M. Klein, MD

Specialty: Surgical pathologist with a subspecialty of dermatopathology

Currently Practices: Bryn Mawr, Montgomery County

Medical School: University of Pennsylvania Medical Center

Residency: Johns Hopkins Hospital

Fellowship: Harvard Medical School

Birthplace: Switzerland

Residence: Penn Valley, PA

PROFESSIONAL BACKGROUND

Why I chose a career in medicine:

As a son of a physician, I was interested in science and medicine from an early age. My father, a successful cancer researcher, instilled a curiosity in me from an early age. He took me into his laboratory on weekends and exposed me to the basic science of medicine. I learned early on that diseases are complex, especially cancer. I wanted to learn more about medicine, disease and health. I never even considered another career path.

Describe your job:

I am a surgical pathologist with a subspecialty of dermatopathology and practice at Bryn Mawr Hospital within Main Line Health. Each day I examine and study biopsies and surgical specimens from patients under the microscope. The diagnoses I give ultimately determine how a patient will be cared for and managed.

Most rewarding elements of my career:

Working with a collegial group of pathologists. I am fortunate to be able to openly and freely communicate with referring physicians such as dermatologists, surgeons, and oncologists. To be able to do so, allows me to make the most accurate diagnosis possible for our mutual patients.

Most interesting day in medicine:

There is not a single day in medicine that is not interesting. Each day brings new challenges and surprises. It's what keeps me passionate about my specialty and coming to work each day.

Interesting childhood fact:

I have two younger brothers. All three of us were born in different countries. I was born in Switzerland and my two younger brothers were born in Argentina and the United States.

How did I end up practicing in Montgomery County:

I grew up in Montgomery County and am very close with my family who still lives in the area. Coming back to the area after residency and fellowship was important to me.

What interests me outside medicine:

I enjoy spending time outdoors with my wife and two young, active sons. We also enjoy traveling, and we haven't let our two young sons stop us from doing it!

If I could be anything other than a physician:

I have been homebrewing beer for more than 15 years. I had a distant relative in Germany who was a master brewer in the 1800s. So I probably had it in me to be a professional brewer.

My family:

I have a wonderful wife, also a pathologist, whom I met during my residency at Johns Hopkins. We have two young boys, ages two and five, who keep us on our toes all day long.

I greatly admire:

My wife. Her living with a chronic illness and still being able to do what she does is hard to put into words. She is able to manage a busy, unpredictable daily schedule, raise two young, active boys, and do the best she can to stay active and healthy. She is truly a super mom and wife. I am lucky and blessed to have her in my life.

Most interesting moment in medicine:

I had several publications in peer-reviewed medical journals during residency and fellowship; two of them, the very first and the very last one, were co-authored with my father.

You may not know:

I am the first person in my family to attend and graduate from an American university. Both my parents emigrated from Argentina to the U.S. in 1978.

Why I stay involved in organized medicine:

I realized early on in my career that we need a constant and powerful voice to speak up about the issues that affect physicians. If we don't, who will? In addition to MCMS and PAMED, I am also very active in the Pennsylvania Association of Pathologists and the College of American Pathologists.

Advice to young physicians:

Pursue your dreams and don't be discouraged by the rapidly changing healthcare environment. Embrace the opportunities that come your way. ■

Does Your Financial Health Include Life Insurance? That Depends

BY CARL H. MANSTEIN, MD, MBA, CPE

If you have a genetic history where early mortality is part of the family legacy, then insurance policies become an important part of the financial structure.

Physicians are familiar with insurance, from Medicare and HMOs, to malpractice insurance. They also should consider life insurance as they evaluate their financial health.

Life Insurance

Life insurance falls into two main categories, term and whole life (sometimes called permanent insurance). For term insurance, the individual buys it for a defined period or term, usually 10-30 years. The premium paid is a set amount for the defined period; and at the end of the period, the policy can be renewed for a new period of time but at a higher premium.

Whole life insurance covers an individual until death, pays a defined death benefit, builds up some cash value; and has a stable premium regardless of the advancing age of the purchaser. So what is the difference between the two? Generally at any given age, term is cheaper than whole life. However, after the term policy expires, the renewal premium may be quite expensive.

Which is Better – Term or Whole?

If you are single without any dependents and have very little debt, then do not buy any insurance. Insurance is designed to pay off your debts or future obligations (like children's education tuitions) and pay funeral expenses. No kids, no spouse, no need for insurance.

However, if you do have children, then insurance is an important aspect of your financial planning. Until such time as either the children graduate or you have accumulated enough money that you are able to cover all their expenses and feel confident that your spouse will have some level of life-style comfort, one needs insurance.

How Much Insurance Do You Need?

One common formula used tells us that a death benefit should equal about 10 times your income. If you make $250,000 a year, you should buy a policy with a death benefit worth about $2.5 million. As you get older, and you accumulate and save more wealth, the need for such a death benefit presumably should decrease. Hopefully, by the time you are ready to retire, your retirement account is full enough so that you need only minimum, if any life insurance.

Term Life Insurance

A term policy is designed when an individual needs a large death benefit for a limited period of time. For physicians, this is usually from age 30-60. This is why I personally recommend that most physicians buy only term-life insurance and buy as long a term-period as possible. Insurance is usually cheaper the younger you are; but it is never too late to buy insurance if you need it. If it is too expensive to buy the policy all at once, "ladder" the policies. For example, suppose you need a $1,000,000 policy but at age 30 you can only afford a $500,000 policy. Buy a 20- or 30-year term for the $500,000, and then five or ten years later, when you are more financially solvent, buy another $500,000. This requires a great deal of discipline but it is one strategy to consider.

Whole Life Insurance

Generally speaking, I am not a fan of whole life insurance. The selling feature that it accumulates cash is grossly over-valued. Insurance should never be considered as an investment and one would be better off investing the difference in premiums from term and whole life into the stock market (which is what the insurance companies do anyway). If you are planning on bequeathing money to your children, you are far better off giving it to them when you are alive. It is also cheaper.

Whole life insurance policies also come with all sorts of riders, add-ons, disability policies, and on and on. Insurance agents are more than happy to sell them. Remember that life insurance is designed for one purpose, to provide for your family when and if your death precedes the financial stability that you hope for them to have.

This is why discipline for retirement savings becomes important. Presumably by age 65, there should be enough money saved that life insurance is almost unnecessary. But let's be realistic. Unfortunately, another dose of realism is that physicians are notorious poor savers, so the need for life insurance may extend beyond age 65 or 70.

In the next issue, I will address disability insurance and long-term care policies. ■

Carl H. Manstein, MD, MBA, CPE, is a graduate of Abington High School, Amherst College, Temple University School of Medicine and LaSalle School of Business. He completed his plastic surgery residency at Duke University and is certified by the American Board of Plastic Surgery.

MORE PEOPLE DIE FROM DRUG OVERDOSES THAN IN CAR ACCIDENTS IN PA

THE PROBLEM: Opioid abuse, misuse, and overdoses are increasing, both in Pennsylvania and nationally.

While some requests for pain medication are legitimate, others are likely to be from pill scammers who have become addicted to opioids.

THE SOLUTION: A multi-pronged approach that includes physicians, patients, and health care organizations like the Pennsylvania Medical Society (PAMED) working collaboratively to address this growing epidemic.

To help prescribers combat this problem, PAMED, in collaboration with the Pennsylvania Department of Health and 11 other health care associations, is creating a comprehensive online educational resource for prescribers.

"Addressing Pennsylvania's Opioid Crisis: What Health Care Teams Need to Know" is a four-part course that examines all the tools prescribers can use to identify patients with addiction issues and get them help.

The first session of the course addresses how prescribers can use the statewide voluntary opioid prescribing guidelines, and the second session takes a deeper look into the state's naloxone law. Both are available at www.pamedsoc.org/opioidresources.

Upcoming sessions (Parts 3 and 4) will address the controlled substances database and the warm hand-off.

This educational series features:

- Videos and interviews with physicians, other prescribers, and state officials working on the front lines of the crisis
- The latest statistics and data
- Details on how to use opioid prescribing guidelines for physicians, emergency departments, and other providers
- Scenario-based learning to help implement the lessons into daily practice

This crisis spans nearly every state in the U.S., but has hit Pennsylvania particularly hard. Nearly 2,500 deaths were reported in Pennsylvania as a result of drug overdoses in 2014, and more people die from drug overdoses than in car accidents.

No one disputes the magnitude of the prescription drug abuse crisis in Pennsylvania and the nation at large. The question is, how do we combat the problem?

"I think that we have to understand that this is a public health crisis and we all have a role to play in terms of solving this," said PAMED member and Pennsylvania Physician General Rachel Levine, MD.

"We need to get past the idea that these are somehow just drug abusers that are miscreants and throwaway members of our society," Dr. Levine said. "The substance use problem and opioid problem touch all of the families in our state and in the country."

PAMED's education seeks to address the many layers and complexities of the crisis. Learn more and get CME credit by visiting www.pamedsoc.org/opioidresources.

FOUR WAYS TO INCREASE YOUR CONFIDENCE IN MANAGING OPIOID THERAPY

- Familiarize yourself with these state-endorsed, voluntary guidelines for opioid prescribers in Pennsylvania:
  - Guidelines on the Use of Opioids to Treat Chronic Non-Cancer Pain
  - Emergency Department Pain Treatment Guidelines
  - Prescribing Guidelines for Dentists
- Get involved with grassroots advocacy and initiatives by having a discussion with the physicians in your county or region. Call PAMED's Speakers Bureau at (800) 228-7823, ext. 2620 for details.
- Have a conversation with your chronic pain patients using PAMED's Opioid Prescription Checklist to help facilitate the pain-management discussion.
- Access even more PAMED opioid education and receive patient safety and risk management CME credits. Take PAMED's six-part, online course designed to educate physicians and other health care providers on the appropriate use of long-acting and extended-release opioids.

Visit www.pamedsoc.org/opioidresources to access these resources and more. ■

Feature

Zzzzs
Teens Not Getting Enough

Teen Sleep Habits: What Should You Do?

Almost 70 percent of high school students are not getting the recommended hours of sleep on school nights, according to a study by the Centers for Disease Control and Prevention. Researchers found insufficient sleep (less than 8 hours on an average school night) to be associated with a number of unhealthy activities such as:

- Drinking soda or pop one or more times per day (not including diet soda or diet pop)
- Not participating in 60 minutes of physical activity on five or more days in a given week
- Using computers three or more hours each day
- Being in a physical fight one or more times
- Cigarette use
- Alcohol use
- Marijuana use
- Current sexual activity
- Feeling sad or hopeless
- Seriously considering attempting suicide

Adolescents not getting sufficient sleep each night may be due to changes in the sleep/wake-cycle as well as everyday activities, such as employment, recreational activities, academic pressures, early school start times and access to technology.

The National Sleep Foundation recommends that teenagers receive between 8.5 hours and 9.25 hours each night.

Are You Getting Enough Zzzzzzzs?

Age	Recommended Amount of Sleep
Newborns	16–18 hours a day
Preschool-aged children	11–12 hours a day
School-aged children	At least 10 hours a day
Teens	9–10 hours a day
Adults (including the elderly)	7–8 hours a day

Sleep guidelines provided by the National Heart, Lung and Blood Institute.

The following sleep health tips are recommended by the National Sleep Foundation:

- Go to bed at the same time each night and rise at the same time each morning.
- Make sure your bedroom is a quiet, dark, and relaxing environment, which is neither too hot or too cold.
- Make sure your bed is comfortable and use it only for sleeping and not for other activities, such as reading, watching TV, or listening to music. Remove all TVs, computers, and other "gadgets" from the bedroom.
- Avoid large meals a few hours before bedtime.

If your sleep problems persist or if they interfere with how you feel or function during the day, you should seek the assistance of a physician or other health professional. Before visiting your physician, consider keeping a diary of your sleep habits for about 10 days to discuss at the visit.

Include the following in your sleep diary, when you:

- Go to bed.
- Go to sleep.
- Wake up.
- Get out of bed.
- Take naps.
- Exercise.
- Consume alcohol and how much.
- Consume caffeinated beverages and how much.

An example of a sleep diary can be found at http://yoursleep.aasmnet.org/pdf/sleepdiary.pdf

More information on sleep and sleep disorders can be found at http://www.cdc.gov/sleep/about_sleep/index.htm

For further information—and a more comprehensive listing of recommended hours of sleep for different age groups— please see the National Sleep Foundation web site at http://www.sleepfoundation.org/site ■

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Pennsylvania Physicians Have Access to Free Child Abuse CME That Meets State Licensure Requirements

Pennsylvania physicians now have access to free child abuse continuing medical education (CME) that meets the state's licensure requirements.

Under the amended Child Protective Services Law (CPSL), all physicians must complete approved training on child abuse recognition and reporting as a condition of licensure.

INITIAL LICENSE – Physicians must complete three hours of approved training to obtain an initial license to practice in Pennsylvania.

LICENSE RENEWAL – Physicians must obtain two hours of approved training each cycle to renew their license.

This CME activity, developed by the Pennsylvania Medical Society (PAMED) and approved by the state Department of Human Services to meet licensure requirements, includes three parts:

Part 1 – Online interactive training that provides an overview of child abuse reporting in Pennsylvania and related matters, including:

- What is child abuse
- Who must report child abuse
- When a report must be made
- How to make a report
- Investigation of reports
- Protections given to reporters, and
- Penalties for failing to make a mandated report

Part 2 – Online interactive training during which you will:

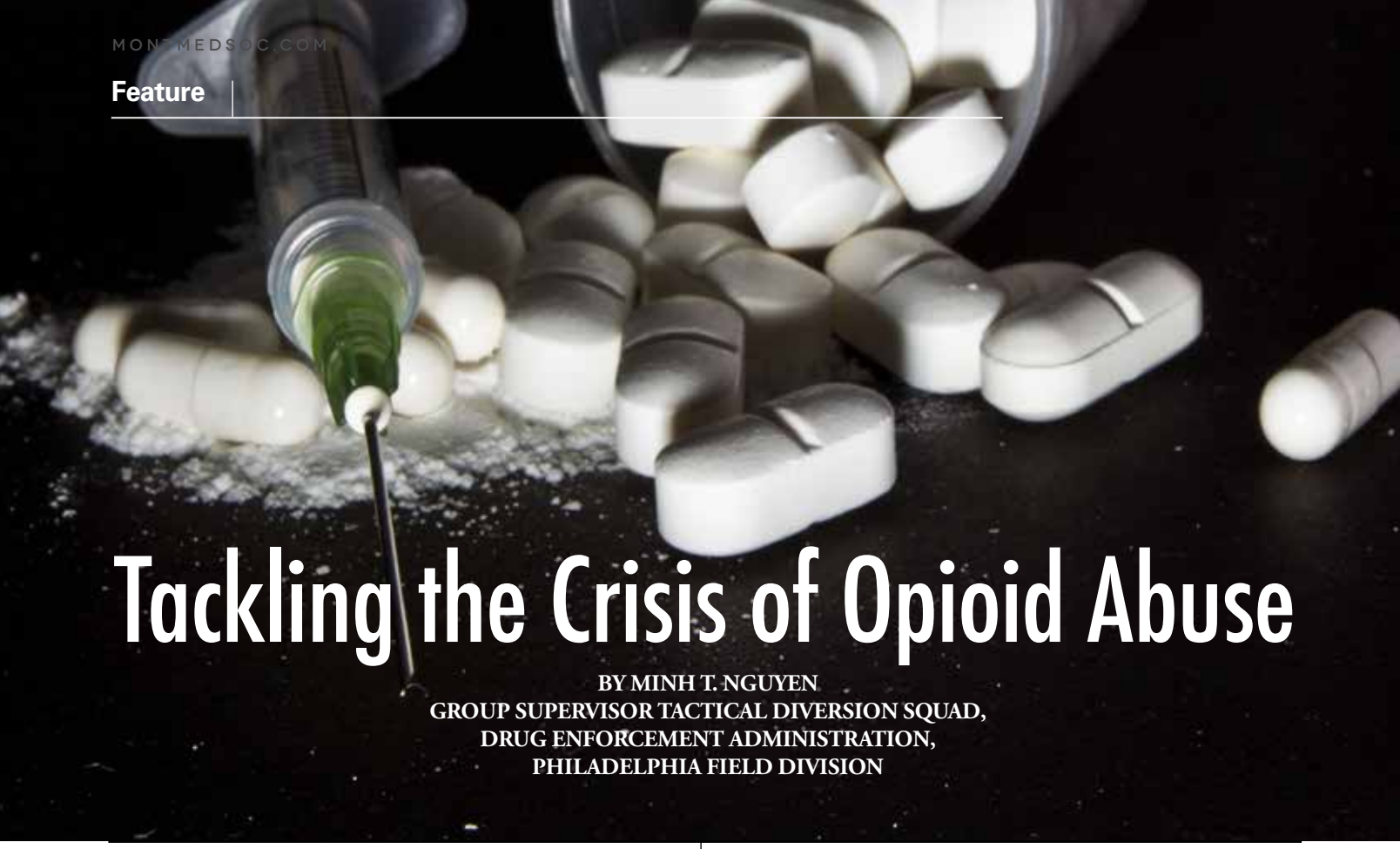
- Review the signs and symptoms of child abuse, and
- Learn through interactive case studies

Part 3 – Written material from PAMED's child abuse Quick Consult series that provides more in-depth understanding of the topics covered in this webinar.

Physicians who complete Parts 1 and 2 and pass an assessment will receive two hours of CME/approved training. This is required for license renewal. If applying for an initial license, you must also complete Part 3 to obtain an additional hour of CME/approved training.

PAMED has a suite of resources at http://www.pamedsoc.org/childabuselaws to help physicians and physician practices understand their responsibilities under the CPSL. PAMED members who have questions on the reporting requirements can contact PAMED's Practice Support Team at (717) DOC-HELP, that's (717) 362-4357. ■

Reprinted with permission from the Pennsylvania Medical Society. Don't face the challenges of practicing medicine alone. Learn more about PAMED and Montgomery County Medical Society membership at www.pamedsoc.org/join or by calling 855-PAMED4U.



Tackling the Crisis of Opioid Abuse

BY MINH T. NGUYEN
GROUP SUPERVISOR TACTICAL DIVERSION SQUAD,
DRUG ENFORCEMENT ADMINISTRATION,
PHILADELPHIA FIELD DIVISION

The Issue

Over the last decade, the non-medical use of prescription drugs has emerged as an increasingly serious health and safety concern in the United States. Drug poisoning, to include pharmaceutical controlled substances, has become the leading cause of accidental death in the U.S., even surpassing auto accidents.[1] The diversion of controlled pharmaceuticals has also contributed to increased rates of addiction, overdoses, and crime nationwide. The Centers for Disease Control estimates that people who are addicted to prescription opioid painkillers are 40 times more likely to be addicted to heroin.[2]

Specific to Pennsylvania, information from the law enforcement, public health, treatment, and regulatory communities indicate that various types of diverted pharmaceutical drugs are readily available on the illicit market in both retail and wholesale quantities. The lucrative illicit market, coupled with the relative ease by which these substances are seemingly obtained, and Pennsylvania's currently limited prescription monitoring program, serve as incentives for the continued diversion of controlled pharmaceutical substances within the Commonwealth. The drug categories of opioids and benzodiazepines are of concern for abuse and overdose potential.

While the medicine cabinet of a friend or relative is often the source of potentially addictive controlled pharmaceutical substances for some users (especially the young), medical community professionals and/or their office staff are the greatest sources of supply of pharmaceuticals for drug trafficking organizations (DTOs) and long-term individual abusers. DTOs often operate organized "smurfing rings" wherein large numbers of pseudo "patients" are recruited and paid to visit doctors in order to obtain prescriptions for substances in demand on the illicit market. Additional tactics used by DTOs or individual abusers include "doctor shopping" and forged or fraudulent prescriptions, as well as robberies or burglaries of pharmacies or other sites. In some instances, persons employed by DEA registrants have also been reported to be complicit in the schemes.

DEA's Philadelphia Field Division Addressing the Issue

To combat this burgeoning threat, the DEA Philadelphia Division has three Tactical Diversion Squads (TDS) located in Philadelphia, Pittsburgh, and Wilmington, DE. Each TDS vigorously pursues and targets individuals and organizations involved in the illegal diversion of licit pharmaceuticals in Pennsylvania and Delaware.

1 Centers for Disease Control and Prevention, National Center for Injury Prevention and Control
Note: calendar year 2013 represents the most recent data available
2 Source: National Survey on Drug Use and Health (NSDUH) 2011-2013

This calendar year, DEA reinstituted its "Take Back" initiative to assist with the collection and destruction of unwanted or expired drugs turned into local collection sites by the public. During a September 2015 "Take Back" event, approximately 15,995 pounds of drugs were collected in Pennsylvania.

In November 2015, DEA announced that Pittsburgh would serve as the pilot city for a comprehensive law enforcement and prevention initiative to help cities dealing with the heroin and prescription drug abuse epidemic and associated violent crime. The short-term goal of the "360 Strategy" is to provide as much information as possible in many different forms to reach young people. Officials will work to form a "Community Alliance" comprised of key leaders from law enforcement, prevention, treatment, the judicial system, education, business, government, civic organizations, faith communities, media, social services and others, to form the core of a long-term group that will cross disciplines to help carry the prevention and treatment messages to the local population during the critical post-operation timeframe. In the future, DEA and its partners also plan to host multi-day summits to bring community leaders together to look for sustainable, impactful efforts to address drug abuse, addiction, trafficking and the violence that accompanies it.

Resources Available to All to Report Abuses

The DEA's Philadelphia Field Division (PFD) was one of the first field divisions to implement the Tip411 text tip service. This program allows the public to submit tips anonymously, and the system allows for two-way communication between the tipster and DEA. The system provides an opportunity for the public to provide information related to illicit prescription drug suppliers and organizations. To use the system, tipsters send a text to: TIP411 and include keyword RXTIP in their message.

In addition, you can submit tips through the DEA's website, www.dea.gov.

We are in the midst of an epidemic of pharmaceutical abuse in our region. As such, DEA will continue to focus on examining the efficacy of current strategies designed to curtail non-medical prescription drug use and diversion in Pennsylvania and Delaware. Additionally, the DEA will continue to collaborate with our partners in education and the public health community to design and implement effective strategies. ■

Drug Threat Rankings for the Philadelphia Field Division, January - June 2015

RANK	DRUG
1	Heroin
2	Pharmaceuticals
3	Cocaine
4	Crack Cocaine
5	Marijuana

Source: DEA Philadelphia Field Division (PFD)

The Drug Enforcement Administration (DEA) PFD Intelligence Program conducted a bi-annual assessment of the drug threats to the PFD, comprised of the states of Pennsylvania and Delaware. Pennsylvania has a population of over 13 million people; the city of Philadelphia is part of the sixth largest Metropolitan Statistical Area (MSA) in the country. The determination of the ranking of drug threats to the PFD as a whole, and within each reporting area of responsibility, is determined by a variety of factors, to include: availability, threat to public health, community impact, attendant crime, enforcement activity, seizures, drug abuse and treatment statistics, and propensity for abuse. Analysis of each of these areas, as evidenced by investigative reporting, sources of information, liaison, and open source data.

Feature

A PHYSICIAN'S DIARY: DR. HIRAM CORSON

Dr. Hiram Corson, an 1828 graduate of the University of Pennsylvania, made his first diary entry March 31, 1827, while he was still a medical student. His last entry was dated Jan. 31, 1896. He died March 4, 1896. He was well-known nationally and was highly respected by such illuminati as Sir William Osler.

The diaries of Dr. Hiram Corson give many insights into the man, the society and times in which he lived, the Civil War, and most especially into medical education and the medical profession of the 19th century. More than any other man in America, Dr. Corson was responsible for women physicians gaining recognition and being accepted into the medical profession. Undaunted by reprisals or scorn, he was an outspoken abolitionist. His sense of justice caused him to respond to many issues. His public awareness throughout his long life is reflected in his diaries, which contain a treasure of information. For more than 30 years he worked for better care for the mentally ill. In 1877, Pennsylvania Gov. John F. Hartranft appointed Dr. Corson to the Board of Trustees of the State Lunatic Asylum at Harrisburg "in recognition of his life-long interest and zealous efforts in behalf of the insane."

Dr. Louis Meier transcribed, edited and annotated Dr. Corson's diaries and shared them with the Medical Heritage Library earlier this year. The library holds three volumes of Dr. Corson's diaries that you can view at www.medicalheritage.org.

November 19: Sunday.

Robt. Rodgers' son John, a student of med. at the University, came here with Edward last night to stay till Monday morning. He seems a fine young man. I was much pleased to see him. His father and I were very intimate while at lectures. I took him to board with me at Woglom's the 2nd winter. Young Rodgers & I rode together all this forenoon.

November 22: Wednesday.

Have practiced the last 3 days very steadily. Had a consultation with Dr. Jno. L. Foulke, in Jane Scott's case last Monday morning. I am in very good health now.

November 29: Wednesday.

Several large failures have occurred since this day last week, which have produced much distress among our people. Reeses Buck & Co. have gone. These were the largest operations in iron perhaps in the state. Their indebtedness is 1 ½ million. Their property is said to be more than sufficient to pay.

Samuel & Washington Jacoby, "marble men," also stopped payment yesterday. Confidence is fast being destroyed. Business men have been extending until they have become entirely too much involved. Extravagance is ruining thousands.

December 25: Monday.

Christmas morning. Fine morning. All well. December has been very cold thus far. Two weeks since there was a very drifted snow, which has continued on the ground. Saturday last there was a sleet. Yesterday morning every tree was hung with icicles & walking almost impossible, but it thawed much through the day. This morning it is frozen again. The children are all at home but Franny. She is living at her grandmother's at Gwynedd. Edward & Joseph came up from the city on Saturday evening & will remain until Tuesday morning.

Last Saturday week, I was present with several others at an operation by Dr. Washington Atlee[xliv] on Dorothy, a maiden lady of about 45 years of age, for the removal of an ovarian tumor. He had drawn off 14 pints of fluid about 10 days before and today he took off two more. There were no adhesions. The sac was removed, and the patient has done very well since. I do hope very much she will get well as I was consulted in a case on Saturday last, and the patient will not likely have anything done unless this Dorothy succeeds in getting along. There is to be a meeting of the friends of Temperance in Norristown today in which measures are to be adopted for executing laws against men who are selling liquor in defiance of the laws. I shall go up. The boys and girls will go to Gwynedd.

December 26: Tuesday.

Attended the meeting yesterday.

1855

January 1: Monday.

Snow on the ground for three weeks past, but no sleighing more than a day or

69

1855

two. This is a beautiful morning. Joseph & Edward came from Philad. on Saturday to spend yesterday with us. Joseph left here for town again this morning, but as there are no lectures at the Medical College today, Edward will not go down until evening. Practiced much today and warned out many of my tenants. I have 14 of them. Edward went down in the car. (It is now 10 P.M.). Bertha & Mary have been poorly today with a renewal of the whooping cough.

January 6: Saturday.

Weather has been very mild all this week, quite like spring. Several interesting cases of disease on hand. Have practiced much since Monday.

January 8: Monday.

Daylight. Edward & Joseph have left for the city. They have been up since Saturday evening. They enjoy themselves much in those weekly visits, and they are very pleasant to us. Weather was as mild yesterday as the middle of April. It did not freeze last night.

January 15: Monday.

Weather mild during the last 7 days.

January 16: Tuesday.

Pollock[xlv] inaugurated today as governor of the state. Very busy in practice all along.

January 17: Wednesday.

A spring day. Practiced much. Have 4 men digging on by the day, 5 men digging by the ton, 4 men digging stone by the perch. I get $2.50 per ton for the ore at the Conshohocken Furnace. It costs 50cts. to have it hauled. What is dug by the ton costs me 87 ½ cts. per ton for digging, and 50 cts. for hauling, so that I have $1.12 per ton clear profit. The stones cost me 25 cts. per perch for digging and get sixty cents per perch on the ground, having therefore 35 cts. per perch clear profit.

January 18: Thursday.

Warm, beautiful, dry as I crossed the Schuylkill at Spring Mill with Osborne Conard, who introduced me to two persons with him, Mr. Shefferdecker,[xlvi] the hydropathic doctor, and a young man under his care. Dr. Shefferdecker is about to take the Old Spring Mill Tavern for a hydropathic establishment. He has purchased from Geo. Culp the spring on top of the hill, along the road, for $500. He can conduct the water all over the house.

I have pasted here the beautiful poem by Thomas Buchanan Read, a first cousin to my brother-in-law, Thomas Read. This young man possesses rare genius. He is a fine painter and ranks high as a poet.

Editor's note: It can be clearly seen where the poem was pasted into the diary. Unfortunately it is missing from the diary.

Continued on page 24

1855

January 27: Saturday.

Attended the Medical Society meeting of our county at Norristown. Had a pleasant time. In the evening Robt. Corson took Miss Rebecca Foulke & Caroline &, I think, Nancy up to Norristown to hear Miss Greenfield, commonly called the Black Swan Sing[er]. She sung very well, all say. She is a large black woman and has for several years sung in the chief towns of the Northern states and made a tour through England, singing before the most fashionable audience and gotten up under the patronage of Lords, Dukes, Duchesses, &c. She was aided last evening by a pianist & a violinist. Powell Child's wife is to be buried tomorrow. I wrote an obituary for her this evening.

February 5: Monday.

Intensely cold. Some snow on the ground.

February 6: Tuesday.

Thermometer at 3 degrees at sunrise, at 5 degrees at 1 P.M., at 2 degrees at sunset.

February 7: Wednesday.

At 1 degree below zero at sunrise. Beginning to snow.

February 8: Thursday.

Snowed all day yesterday & all night. Thermometer at 15 degrees this morning, snow about 8 inches, a sheet [of ice] on top, and still sleeting. Practiced much this cold weather.

Follen & myself started to go a long trip this morning; had an old York-wagon-top on runners upset, broke the top, and if the beast had not been very quiet, I surely would have been much hurt, as I was fast under the top, which lay upon my legs almost to my body. I ought here to mention an escape that I made about a week ago. I was standing at an iron-ore-hole while the men were raising a large lump of ore by a windless. When they had raised it to the top, I stepped back about 2 feet, to get a plank to put under it, when my foot, as I made the second step, seemed to step into a hole. I looked behind to see what was the matter, and Lo! I was standing on the very brink of another hole about 8 ft. square & 50 ft. deep. Half a step more and I would have fallen on my head & shoulders a distance of 50 feet. I was horror stricken at the peril I had just escaped. This was at the quarry between Spr. Mill & Jeremiah Comfort on the road side.

April 1: Sunday.

Edward has returned from lectures and is aiding me in the practice. My nephew, Dr. Lewis Read, conceived a desire a month since, to enter the Russian Army as a surgeon. Last month when he was nearly ready to start, news arrived that "Nicholas The Czar of all the Russians" was deceased. He died after a very short illness. The siege of Sevastopol by the British & French had been going on for several months. The Battle of Eupatoria[xlvii] had just been fought & lost by the Russians, and it is supposed that the intense mental labour of the Emperor took his life. Notwithstanding the news of his death, Doctor Read persists in going and sailed from New York in the ship Herman for Bremen at noon on the 24th day of March. His friends in Norristown & elsewhere

manifested much warm feeling for him previous to his sailing, and three gentlemen accompanied him to N. York and saw him sail.

I have had a most laborious practice now for weeks. The news from the seat of war shows a dreadful destruction of men and horses. The Russians often repelled. Bombs are flying in all directions. Disease, exposure, bullets and all other means of destruction combine to destroy life. Dead men and horses lie scattered all over the region of strife.

April 8: Sunday.

Easter. The children & their mother all eating breakfast. Little Frannie is absent at Gwynedd and is quite sick, fever, sore mouth, &c. All our small children have had it within a few weeks. Times are very pressing on the poor. Wheat is $2.50, flour is $12.00 per barrel, potatoes $1.50, while wages are only $1.00 per day for men in the iron ore & marble & lime stone quarries. I am much engaged daily. Yesterday had two consultations with Doctor Smith at Chestnut Hill in the case of Jno. Hildebrand's child, the other with Doctor Poley at Norristown in the case of Sheriff Boyer.

April 14: Saturday.

Have had a consultation with Dr. Smith every day this week and on Friday one also in the Sheriff's case, and one with William also, in Esq. Ramsay's case. My brother Wm. came near his death this week. While examining the body of Judge Evans, he made a slight puncture of his finger. This inflamed, swelled very much. Vomiting, pain in back, &c., came on. By opening finger, taking opium, &c., he was relieved. We have had quite a sick house this past week.

Nancy has been very sick with a violent infl[ammation] in the ear. It has been discharging bloody water & matter for several days. She has not been able to be up since last Sunday. Is still very poorly. Miss Rider also has been ill with erysipelas of the face & head since last Monday, but is now convalescent. I have done very [much] practice since the first of the month, & indeed a long time before.

The Liquor Law has passed & received the signature of the Governor. We have had a long & desperate struggle. On the first day of April the law goes into effect that shuts up all Taverns on Sunday, & now comes the Liquor Law, to go into effect on the first day of July. The rum selling is by it utterly prevented everywhere by the small. A few persons are to be licensed to sell it for medicinal, chemical & sacramental purposes.

May 27: Sunday.

Mrs. Corson is very sick today and it is now nearly five weeks that she has been almost entirely confined to her room, and much of the time to her bed. She was taken with a violent pain through the left eye, which was very severe for two days, then shifted to the left ear and side of the neck just below the ear. As she had suffered severely some years ago from neuralgia of that side of the face and head, she thought this was the same thing and so only took some anodynes to relieve it, but having had pains in the ear for two days, matter flowed freely from the ear with partial relief of the symptoms. It has continued to discharge ever since, and she has suffered so much from neuralgic pain as to compel her to resort often to "Incepticum." Her stomach is, even in health, so delicate

MCMS Physician will continue to share the words of Dr. Corson in future issues of the publication. Until then, you can learn more about 19th century medicine, www.www.medicalheritage.org.

Feature

Legislative Update

BY HANNAH L. WALSH, ASSOCIATE DIRECTOR, LEGISLATIVE AFFAIRS, PAMED

On Dec. 29, 2015, Gov. Wolf signed a partial $23.4 billion budget for 2015-2016, selectively vetoing portions of the $30-plus billion spending plan that the General Assembly sent him a week prior. The partial budget released some much-needed funding to schools and social service agencies, and a number of programs of interest to physicians.

Included in the enacted budget was $4.671 million in funding for the Primary Care Practitioner Program, the umbrella program under the Department of Health which provides educational loan repayment for physicians and residency programs. Funding was also released for the state's new prescription monitoring program, known as ABC-MAP (Achieving Better Care by Monitoring All Prescriptions), which is expected to be up and running later in 2016. The Pennsylvania Health Care Cost Containment Council, or PHC4, received a $2.71 million appropriation, equal to the previous year.

The legislature has yet to reach final agreement on the remaining budget items that the governor reduced or vetoed. The line-item veto included funding for several health care related items, such as regional cancer institutes, diabetes programs, regional poison control centers, and Medical Assistance critical access hospitals, hospital-based burn centers, and obstetrics and neonatal services, among others.

In the midst of the ongoing budget standoff, there have also been developments on a few measures of importance to physicians and patients over the last few months. Below are a few highlights on that legislative activity.

Public Hearing Held on CRNP Independent Licensure

Last October, the House Professional Licensure Committee held a public hearing on House Bill 765, sponsored by Rep. Jesse Topper (R-Bedford County). HB 765 would allow certified registered nurse practitioners (CRNPs) to practice independently and eliminate the current requirement that CRNPs have a collaborative agreement with a physician in order to diagnose, treat and prescribe to patients in Pennsylvania. PAMED is strongly opposed to the legislation.

Former PAMED President Karen Rizzo, MD, testified at the public hearing on behalf of PAMED. Also testifying in opposition to HB 765 were physician leaders representing the Pennsylvania Academy of Family Physicians, the Pennsylvania Chapter of the American Academy of Pediatrics, and the Pennsylvania Osteopathic Medical Association, as well as a PAMED member who was a licensed CRNP before becoming a family physician. Additional testimony was provided by Ann Peton, MPH, Director of the National Center for the Analysis of Healthcare Data, who spoke about workforce migration trends nationwide. The information Ms. Peton presented countered claims that nurse practitioners are more likely to practice in rural areas after gaining independent practice authority.

Nearly two dozen PAMED members attended the public hearing on HB 765, which was held at the State Capitol in Harrisburg. The House Professional Licensure Committee also heard testimony from a panel of individuals in support of HB 765 and the independent practice of nurse practitioners. Committee members then had an opportunity to ask questions of those who testified.

At this time, HB 765 has not yet been scheduled for a vote by the House Professional Licensure Committee. We are also closely monitoring both HB 765 and the Senate version of the legislation – SB 717, sponsored by Sen. Pat Vance (R-Cumberland County).

Medical Marijuana

Senate Bill 3, which would legalize marijuana for medicinal use in Pennsylvania, passed the Senate overwhelmingly in May of last year, but has not yet reached a final vote in the House. With over 200 amendments to the bill having been filed and

the General Assembly still struggling to complete the 2015-16 state budget, it is unclear when the issue of medical marijuana will be taken up again. Gov. Wolf has indicated, however, that passage of medical marijuana legislation is one of his top three priorities for 2016.

Of the 200-plus amendments filed to SB 3, one particular amendment reflects recommendations issued by a House workgroup this past summer. The workgroup, which was comprised of legislators with varying opinions on medical marijuana legalization, was charged by House Republican leadership to come up with a compromise proposal that would garner enough support to pass the lower chamber.

PAMED remains opposed to broad-based legalization of marijuana for medical use. PAMED's 2015 House of Delegates reaffirmed this policy, noting marijuana's ongoing status as a federal Schedule I controlled substance and the need for adequate and well-controlled studies of marijuana's effects. Given that public opinion is overwhelmingly supportive of marijuana legalization; however, it is expected that the legislature will vote on the measure some time in 2016.

Streamlining the Physician Credentialing Process

Rep. Matt Baker (R-Tioga County) introduced legislation late in 2015 that aims to improve the physician credentialing process in Pennsylvania, making it timelier and more uniform across insurers. The legislation is strongly supported by PAMED.

House Bill 1663 specifically addresses the problem of unwarranted delays by health insurers in credentialing applicants for inclusion in their networks. Hospitals and physician practices routinely face the situation where a newly hired health care professional who is fully licensed and qualified to provide care is not reimbursed by insurers for months while the insurers work their way through an unnecessarily and cumbersome credentialing process. This costs hospitals and physicians money, drives up the cost of health care, and limits access to care by keeping fully licensed and qualified providers on the sidelines until they are credentialed by insurers.

HB 1663 will establish a standardized process and timeline for insurer action on credentialing applications. The legislation introduced would require all insurers in Pennsylvania to accept the Council for Affordable Quality Healthcare (CAQH) credentialing application and provide for provisional credentialing of a provider when a determination is not made within 30 days of a submitted application. HB 1663 is currently awaiting consideration by the House Health Committee.

PAMED is also working closely with the Department of Human Services (DHS) to ensure timelier credentialing of physicians within the state's Medicaid program. After discussions led by PAMED, DHS announced that beginning in 2016, Physical Health Managed Care Organizations (PH-MCOs) will be required to begin the credentialing process upon receipt of a provider's application and must complete the credentialing process within 60 days.

Improving Prior Authorization Processes

Rep. Marguerite Quinn (R-Bucks County) will soon be introducing legislation to streamline and standardize the prior authorization process in Pennsylvania. The legislation is strongly supported by PAMED.

Many health plans require physicians to obtain prior authorization for certain procedures or treatments before they can be administered. While the process is intended to minimize overuse of health care services, it often becomes an extremely burdensome process for physicians and their patients. Lack of transparency and standardization in prior authorization requirements not only makes the process difficult and time consuming, but can also result in delays in needed care for Pennsylvania residents.

Rep. Quinn's legislation would increase transparency and consistency in prior authorization criteria; establish standards and reduce the overuse of prior authorization; lessen manual processes and enhance the electronic exchange of information; develop a standard prior authorization form; and improve response times for prior authorization determinations. These steps will go a long way toward addressing administrative waste in our health care delivery system, resulting in both cost savings and improved access to care.

Reauthorization of CHIP

Legislation reauthorizing Pennsylvania's Children's Health Insurance Program (CHIP), which was set to expire at the end of 2015, was signed into law a week before the New Year. House Bill 857, sponsored by Rep. Tina Pickett (R-Bradford County), extended the life of CHIP until the end of 2017. Now Act 84 of 2015, the new law also moved administration of the CHIP program from the Pennsylvania Insurance Department to the Department of Human Services.

CHIP provides health insurance to children in Pennsylvania under age 19 who don't qualify for Medical Assistance. In August of last year, Gov. Wolf announced a number of changes to CHIP would take effect on Dec. 1, 2015, to ensure that the program meets minimum essential coverage requirements of the Affordable Care Act. The changes included the following:

- All CHIP plans will cover certain preventive care services—such as oral hygiene education and dietary instruction—without cost sharing in the form of copayments, coinsurance, or deductibles.
- Annual and lifetime limits will be eliminated on the cost of some specific services and equipment like durable medical equipment, hearing aids, pediatric vision and dental service, including orthodontic services.
- Health plans must provide parity between mental health/substance abuse benefits and medical/surgical benefits.

In April 2015, federal funding of CHIP was extended for two years under H.R. 2, the Medicare Access and CHIP Reauthorization Act of 2015. ■

New Year, New Health Insurance, Old Headaches

Surprises That May Upset You When It Comes To Continuity of Care

You've made it through 2015, and as you enter the New Year, a new health insurance year is starting as well.

What does that mean for you?

For many people, likely there's not much to worry about. But for some, there may be a few surprises along the health care highway, whether your company contracts for group coverage or you shop independently for your own insurance.

According to Scott Shapiro, MD, president of the Pennsylvania Medical Society (PAMED) and a practicing cardiologist with Abington Medical Specialists in Abington, with so many health insurance options available, inevitably someone's going to hit a pothole. Those who are switching insurance products or insurers are more likely to do so, he said.

"What's covered in one plan one year may be a little different in another plan the next year," said Dr. Shapiro, a director on the Montgomery County Medical Society (MCMS) Board. "On occasion, we'll see this when it comes to physician networks and medicines. There may even be a financial surprise for care that overlaps from one insurance year into the next."

For example, says Dr. Shapiro, a physician may be included in a network under one plan, but maybe not in another.

"Even within the same health insurance company, a physician may be part of one insurance product, but not the next, particularly as more plans build narrow networks," he said. "Patients who have been seeing a specific physician for years, and are happy with their physician, may find this discouraging, but those who are undergoing treatment shouldn't have to worry."

Dennis Olmstead, senior advisor, health economics and policy at PAMED, explains that Pennsylvania Act 68 of 1998 and its accompanying regulations guide continuity of care for health plans in Pennsylvania. Among other things, it ensures that a plan enrollee may continue an ongoing course of treatment for up to 60 days from the date the enrollee is notified by the plan of the termination of a participating health care provider.

"Fortunately, there are safety mechanisms in place that requires insurers to allow patients undergoing treatments to remain with their physician, if they choose," he said. "But, a patient who is not undergoing treatment might find that their physician is not included in their new insurance plan."

Mr. Olmstead says those patients who shop for health insurance in the marketplace and switch between the "metal plans" such as going from a bronze plan to a gold plan could find themselves in this situation.

Formularies – or a list of medications an insurance plan covers – may also be different from one plan to the next.

Since most generics for common health issues seem to be included in the majority of formularies today, many patients likely do not need to worry about a change in plans or transitioning from one insurance year to the next. But, sometimes a drug is removed from one year to the next, or moved to a different tier in the formulary, and newer drugs may not have made it onto a formulary yet.

Nicole Davis, MD, president of the Pennsylvania Academy of Family Physicians and a practicing physician in Wyncote, recommends that patients find out if the drugs they use are included in a health plan and the tier level before they change health plans.

"The patient may have to make a few phone calls or visit a website to learn if certain drugs they use are on the new plan's formulary," said Dr. Davis, who is also a MCMS member. "Periodically, we'll hear from patients that they were surprised that they had to suddenly pay more for a medication that previously was a lower out-of-pocket expense."

Another insurance scenario that sometimes catches patients by surprise involves large deductibles and occurs as one year ends and another begins.

"Patients sometimes are surprised when they meet a large deductible in December, and then have care roll into the new year that they will need to pay the same large deductible in January," said Mr. Olmstead. "It's very possible to have two large deductibles due in back-to-back months in this scenario."

Mr. Olmstead says that it isn't always possible to plan when care is needed particularly when emergencies occur, but there are some treatments that can be.

Joanna Fisher, MD, president of the Pennsylvania Academy of Ophthalmology and a practicing ophthalmologist in Huntington Valley, agrees with Mr. Olmstead and points to a common procedure her specialty performs. "For example, if you know you have cataracts in both eyes and are planning to have both eyes fixed, work with your physician," Dr. Fisher said. "You can likely schedule those in the same insurance year to avoid paying a large deductible in consecutive years." ■

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LET'S GET PHYSICAL IN 2016

PRESCRIPTION TO GOOD HEALTH: HEALTHY EATING AND REGULAR EXERCISE

BY LEONARD OLU-WILLIAMS, MPH, CHES
MONTGOMERY COUNTY HEALTH DEPARTMENT

Humans were designed for movement. For the majority of our history, physical demands were a typical and expected part of our everyday life. Up till the 19th century, we lived as gatherers, scavengers, toolmakers, hunters and farmers. Within only a few generations, the physical activity demands of work, domestic chores and leisure time have decreased so dramatically as to be nearly non-existent in industrialized countries like the United States.

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Behavioral Risk Factor Surveillance System (BRFSS), 2005

About 52 percent of U.S adults do not meet the recommended levels of physical activity; and studies have shown that many of the chronic diseases we face today are associated with our sedentary lifestyle. According to the Center for Disease Control (CDC), regular physical activity is one of the most important things you can do for your health—as it can reduce your risk for type II diabetes, cardiovascular diseases and some cancers; control your weight, strengthen your bones and muscles, reduce high blood pressure and reduce symptoms of depression and anxiety. The Physical Activity Guidelines recommend at least 150 minutes each week of moderate aerobic activity for adults—and at least an hour each day of active time for kids.

The key to achieving and maintaining a healthy weight includes healthy eating, regular physical activity, and balancing the number of calories you consume with the number of calories your body burns.

Montgomery County has an amazing parks and trail system with more than 6,000 acres of public open space that includes nine parks, five historic sites, and over sixty miles of regional trails.

Graphics on this page are grainy.

Physical activity/ weight loss has always been one of the most common New Year's resolutions. Below are some suggestions you can incorporate into your home, work and recreational life to help you become more active this year. Staying in control of your weight contributes to good health now and as you age.

When at home

- Go out for a short walk before or after a meal. Start with 5-10 minutes and work up to 30 minutes. When walking, pick up the pace from leisurely to brisk.
- Spend a few minutes pedaling on your stationary bicycle while watching television.
- Play with the kids — build a snowman or dance to favorite music.
- Exercise to a workout video.

Many of us have sedentary jobs, and work takes up a significant part of our day. You can still try to be active while at the job.

When at work

- Take the stairs instead of the elevator. Or get off a few floors early and take the stairs the rest of the way.
- Join a gym near your job. Work out before or after work to avoid rush-hour traffic, or drop by for a noon workout.
- Get off the bus a few blocks early and walk the rest of the way to work or home.
- Walk around your building for a break during the work day or during lunch.

During recreation

- Plan family outings and vacations that include physical activity (hiking, backpacking, swimming, etc.). Also, when you visit new cities, go sightseeing by walking, jogging or bicycling.
- Do activities you like—if you look forward to a particular physical activity, e.g. Zumba or kickboxing, you will be more inclined to do it.
- Formulate achievable goals and milestones. For example, if you want to lose 20 pounds, think of it as a goal of losing five pounds a month for 4 months.
- Share your goals with the people in your life. Share what you are doing with the people around you. Having the support of others can both inspire you and hold you accountable.

If you have a chronic health condition such as arthritis, diabetes, or heart disease, talk with your physician to find out if your condition inhibits your ability to be active. If your condition limits you from meeting the minimum guidelines, try to do as much as you can. What's important is that you avoid being inactive. Moderate-intensity aerobic activity, like brisk walking, is generally safe for most people. Montgomery County has an amazing parks and trail system with more than 6,000 acres of public open space that includes nine parks, five historic sites, and over sixty miles of regional trails. All of which can be utilized year round to provide recreational opportunities in a natural environment. For additional information on park and trail maps, visit **www.montcopa.org.** ■

Member Resource Legal Triage Program

Legal triage is a local program that assists members of the Montgomery County Medical Society in assessing their need for legal services in areas related to the business of medical practice (i.e., excludes medical malpractice related matters). The service consists of an initial telephone consultation for members without charge by Attorney Karen E. Davidson, an experienced health care lawyer who will assist MCMS members in assessing their legal needs.

Attorney Davidson has been providing legal guidance in health law for more than 20 years. She has represented healthcare providers including physicians/groups p foundations, hospital/health systems, bi others that do business in the healthcare

see comment above

Ms. Davidson is offering members a free initial telephone consultation. Types of matters that may need legal consultation by members include

- Sale of your medical practice to a hospital/health system, and/or negotiation of a related employment agreement
- Internal practice arrangements related to ownership and/or compensation
- Renewal of hospital/health system employment agreements and concerns related to revised compensation formulas
- Billing, coding or other reimbursement matters related to third party payers including contract negotiation, repayments, etc.
- Review and analysis of accountable care organization documents
- Separation and/or medical practice retirement/departure
- Start-up of medical practice, or
- HIPAA breach issues and/or compliance issues/concerns

Within the last year, several of these issues have come before Ms. Davidson by healthcare providers. Once the legal triage consultatio CMS members can seek outside co of Ms. Davidson. If additional s. Davidson, MCMS members will receive a discount on her then applicable hourly rate. You can reach Ms. Davidson at her Conshohocken office, (610) 940-4014 or by e-mail, karend@kdavidsonlaw.com .

see comment above

In addition to offering this service to MCMS members, Ms. Davidson will also share information about legal matters related to the business of health care through this publication, *MCMS Physician*. If there is a healthcare related topic you would like addres MCMS Executive Director Toyca W verizon.net or call (610) 878-9530. ■

see comment above

2016 Medicare Fee Schedule Released – *Here's What You Need to Know*

**BY JENNIFER SWINNICH, ASSOCIATE DIRECTOR
PRACTICE SUPPORT OF PENNSYLVANIA MEDICAL SOCIETY**

The MPFS Proposed Rule which aims to enhance support for the final rule detailing how Medicare will reimburse physicians in 2016 was issued by the Centers for Medicare and Medicaid Services (CMS) on Oct. 30. With your practice and family responsibilities, the Pennsylvania Medical Society (PAMED) knows you don't have time to read and analyze the 1,358 pages to figure out how your reimbursement may be impacted next year. PAMED has you covered with what you need to know.

PAMED's experts are continuing to analyze the final rule, but, at first glance, here are some of the items that may be of particular interest to physicians:

• **Advance Care Planning** – The rule finalizes a proposal for separate payment for two advance care planning services provided to Medicare beneficiaries by physicians and other practitioners. The Medicare statute currently provides coverage for advance care planning under the "Welcome to Medicare" visit available to all Medicare beneficiaries, but they may not need these services when they first enroll. Establishing separate payment offers providers and beneficiaries greater flexibility in using these services.

• **Incident To** – In an effort to clarify "incident to" requirements, CMS reiterates that the supervising physician is the physician who bills for "incident to" services. In a conversation with CMS' subject matter expert, PAMED was told the rule "is intended to clarify that the ordering physician or other practitioner and the supervising physician or other practitioner DO NOT need to be one in the same. Rather, the proposal is intended to clarify that the physician or other practitioner who bills for the "incident to" services must always be the supervising physician or other practitioner."

• **Modifications to Physician Quality Reporting System (PQRS)** - If an individual eligible professional (EP) or group practice does not satisfactorily report or satisfactorily participate in PQRS for 2016, a two percent negative payment adjustment will apply to covered professional services furnished by that individual EP or group practice during 2018.

There will be 281 measures in the PQRS measure set and 18 measures in the GPRO Web Interface for 2016. Also, as recently authorized under the Medicare Access and Children's Health Insurance Program Reauthorization Act of 2015 (MACRA), CMS is adding a reporting option that will allow group practices to report quality measure data using a Qualified Clinical Data Registry (QCDR). The 2018 PQRS payment adjustment is the last adjustment that will be issued under the PQRS. Starting in 2019, adjustments to payment for quality reporting and other factors will be made under the Merit-Based Incentive Payment System (MIPS), as required by MACRA.

• **Physician Value-Based Payment Modifier** - In the final rule, CMS finalized the following provisions related to the value-modifier:

- To apply the value modifier to non-physician EPs who are physician assistants (PAs), nurse practitioners (NPs), clinical nurse specialists (CNSs), and certified nurse anesthetists (CRNAs).
- To use CY 2016 as the performance period for the CY 2018 value modifier and continue to apply the CY 2018 value modifier based on participation in the PQRS by groups and solo practitioners.
- For groups of 10 or more EPs - Continue with maximum upward adjustment of +4.0 to be multiplied by an adjustment factor (to be determined at conclusion of the performance period) and a maximum downward adjustment of -4.0 in CY 2018.
- For groups of two to nine EPs and solo practitioners – Upward adjustment of +2.0 multiplied by an adjustment factor and a maximum downward adjustment of -2.0 in CY 2018.

• **Physician Compare** - The final rule continues the phased approach to public reporting on Physician Compare. CMS will continue to make all 2016 individual EP and group practice PQRS measures available for public reporting. All Consumer Assessment of Healthcare Providers and Systems (CAHPS) for PQRS measures for groups of two or more EPs who meet the specified sample size requirements and collect data via a CMS-specified certified CAHPS vendor are available for public reporting. In addition, all Accountable Care Organization (ACO) measures, including CAHPS for ACOs, are available for public reporting. CMS is also finalizing the following proposals:

- To include Certifying Board, and specifically add American Board of Optometry (ABO) Board Certification and American Osteopathic Association (AOA) Board Certification.
- To include an indicator on profile pages for individual EPs who satisfactorily report the new PQRS Cardiovascular Prevention measures group in support of the Million Hearts initiative.
- To continue making individual-level QCDR measures available for public reporting, and, new to 2016, to publicly report group-level QCDR measures.
- To publicly report an item (or measure) - Level benchmark derived using the Achievable Benchmark of Care (ABC™) methodology.
- To include in the downloadable database the value modifier tiers for cost and quality, noting if the group practice or EP is high, low, or neutral on cost and quality; a notation of the payment adjustment received based on the cost and quality tiers; and an indication if the individual EP or group practice was eligible to but did not report quality measures to CMS.
- To publicly report in the downloadable database utilization data for individual EPs.

CMS is not finalizing the proposal to include a visual indicator on profile pages for group practices and individual EPs who receive an upward adjustment for the value modifier. CMS is, however, finalizing its proposal to publicly report an item-level benchmark for group practice and individual EP PQRS measures using the ABC methodology. The benchmark will be stratified by reporting mechanism to ensure comparability and reduce the interpretation burden for consumers. The benchmark will be displayed as a five-star rating on Physician Compare. CMS will conduct analysis and stakeholder outreach around the star attribution methodology prior to public reporting in 2017.

PAMED will monitor any developments, and will continue to review the final rule and provide information on any changes that could impact your reimbursement. ■

Feature

MCMS Happenings

MCMS Welcomes Two New Board Members – MCMS is grateful to add two new faces to its governing board – Joseph Grisafi MD and Jennifer Lorine DO. Dr. Grisafi is a vascular surgeon who is in private practice in East Norriton. Dr. Lorine specializes in neuromusculoskeletal medicine and family medicine. Her private practice, located in Blue Bell, focuses primarily on osteopathic manipulative medicine & integrative (non-narcotic) pain management. In addition to practicing, she enjoys teaching at Philadelphia College of Osteopathic Medicine. Both are eager to work on your behalf in addressing the challenges you face daily in this changing health care environment.

Don't Let Your Membership Lapse – Don't forget to remit your 2016 membership dues. We don't want to lose one member this year. Each member is valued and MCMS strives daily to provide a valuable service to our members. Your MCMS and your PAMED continue to work together to be your advocate locally and in Harrisburg. To learn more about what resources are available for your profession, your patients and your life, visit www.montmedsoc.com and www.pamedsoc.org. You can renew online at either site or by phone, 855-PAMED4U (855-726-3348).

Save the Date: Installation Dinner Set for June 7 – Join your colleagues for good food and fellowship at the 2016 MCMS Annual Membership Dinner and Installation Tuesday, June 7, William Penn Inn, Route 202 and Sumneytown Pike, Gwynedd. Jay A. Rothkopf MD will be installed as the new president, and MCMS will honor 10 physicians who have practiced medicine for 50 years. Husband and wife physicians, Dr. John Eck and Dr. Alieta Eck, will share how their political advocacy may change the face of medicine for physicians and their patients. Frustrated by the inadequacy of New Jersey's health insurance system, Drs. Eck founded the Zarephath Free Clinic. The center gives physicians an opportunity to revert back to the old model of donating time each month to care for the poor and uninsured.

Save the Date – Annual Medical Practice Management Conference -- The 11th Annual Tools for Success Medical Practice Management Conference is set for April 27-28, Villanova Conference Center, 601 County Line Road, Radnor. There will be an evening program on April 27 and a full day conference April 28. If you want a particular topic covered, please send suggestions to MCMS Executive Director Toyca Williams, montmedsoc@verizon.net. More details to come.

MCMS Members Welcome To Attend Board of Directors Meeting – The next board of directors meeting is Tuesday, March 1, 6 p.m., MCMS office, 491 Allendale Road, Ste. 323, King of Prussia. If you are interested in attending a board meeting, contact Toyca Williams, MCMS executive director, montmedsoc@verizon.net or call (610) 878-9530. The MCMS Board of Directors represents you. For a list of board members, visit the MCMS web site, www.montmedsoc.com.

What Keeps You Up at Night? – MCMS wants to help you navigate the evolving health care environment. If there is a particular issue you are interested in knowing more about, let your county medical society staff know. Send suggested topics to Toyca Williams, MCMS executive director, montmedsoc@verizon.net. MCMS would like to continue to host live

or virtual meetings to address challenges that negatively affect your practice's health.

Latest Medical Mystery – No two days are alike in any medical practice. Each day brings new patient challenges, some fairly simple to resolve and others not so. The *Philadelphia Inquirer* readers want to know more about the medical mysteries that physicians encounter. If you have a medical mystery to share, contact Charlotte Sutton, Inquirer Health and Science Editor, csutton@philly.com.

Share Your Passion Outside Medicine – The readers have missed hearing about your passions outside of medicine. We all have them, so open up and provide insight into your favorite pastime. You've read about our physician pilot who enjoys flying with his grandchildren, our ER doc who releases stress by coaching his dragon boat team in competitions all over the world or the determined young resident who scaled Mt. Everest and practiced medicine along the way. We want to hear more. *MCMS Physician* Editor Jay Rothkopf MD also encourages physicians to submit articles for the publication. For more information or to send articles or ideas, contact MCMS Executive Director Toyca Williams, at montmedsoc@verizon.net.

Don't Delay: Medicaid Revalidation Deadline March 24 -- Pennsylvania physicians who enrolled in Medicaid on or before March 25, 2011 must revalidate by March 24. As required by the Affordable Care Act, the Department of Human Services (DHS) must re-validate (re-enroll) all providers at least every five years. Pennsylvania's DHS sent a message to its stakeholders on Jan. 7, strongly encouraging providers to submit their revalidation applications as soon as possible. DHS says that 67 percent of service locations have been revalidated as of Jan 7. While progress is being made, there are still many service locations that have yet to revalidate.

Like Us on Facebook – If social media is a favored hang out, then like MCMS on Facebook. Haven't been on MCMS Facebook page lately, you're missing out:

- Top nine issues affecting physicians in 2016.
- Nominations being accepted for PAMED Awards
- Real-time updates on the naxolone standing order.
- Decisions made on medical marijuana.
- Updates on the CRNP Independent Practice Debate.
- Varying opinions on maintenance of certification (MOC). ■

Welcome New Members

MCMS is pleased to welcome the following individuals who joined the Society in 2015:

November 2015

Elizabeth Dale, MD

Brandon Eck, DO

December 2015

Robert Fleyshman, MD

Anna Karasik, MD

Sarika Madari, Medical Student

Thai Quoc Vu, MD

To publish photos of new MCMS member physicians, please submit digital copies to montmedsoc@verizon.net

Necrology Report

MCMS regrets the loss of these society members since June 2015.

William C. Cochran MD
B. Mary Haythornwaite MD
H. Tom Tamaki MD

Physicians *Play a Key Role* in Fighting Opioid Abuse

PAMED Tools and Resources

- **Child Abuse Reporting Laws—**Suite of resources to help you understand and comply with the state's child abuse reporting laws.
  www.pamedsoc.org/childabuselaws
- **ICD-10 and coding resources—**Access specialty-specific crosswalks that map commonly-used ICD-9 codes to ICD-10, get physician documentation training, and find other coding resources.
  www.pamedsoc.org/icd10
- **CME *Consult*—**Get the latest PAMED patient safety and risk management activities in this CME compendium available both online and in print. CME credits available.
  Free for members; $249 for nonmembers
  www.pamedsoc.org/cme
- **Volume to Value Online Courses—**Get the skills to succeed in value-based delivery with six online, on-demand courses.
  www.pamedsoc.org/valuebasedcare

PAMED's Opioid Education and CME

"Addressing Pennsylvania's Opioid Crisis: What Health Care Teams Need to Know"—Multimedia education with video interviews, statistics, prescribing guidelines, scenario-based learning, and more

- CME credits available
- Free for PAMED members

Long-acting and extended-release opioids online courses—Learn about prescribing, monitoring, assessment, and documentation

- CME credits available
- Free for all prescribers in Pennsylvania

Opioid Prescription Checklist

Use this checklist to start the conversation about pain management with your patients. Includes a list of things to consider when taking pain medication and is printed in the form of a prescription notepad.

$4.95 for members; $19.95 for nonmembers

Visit PAMED's opioids resource center for the latest news, education, and tools.

www.pamedsoc.org/opioidresources