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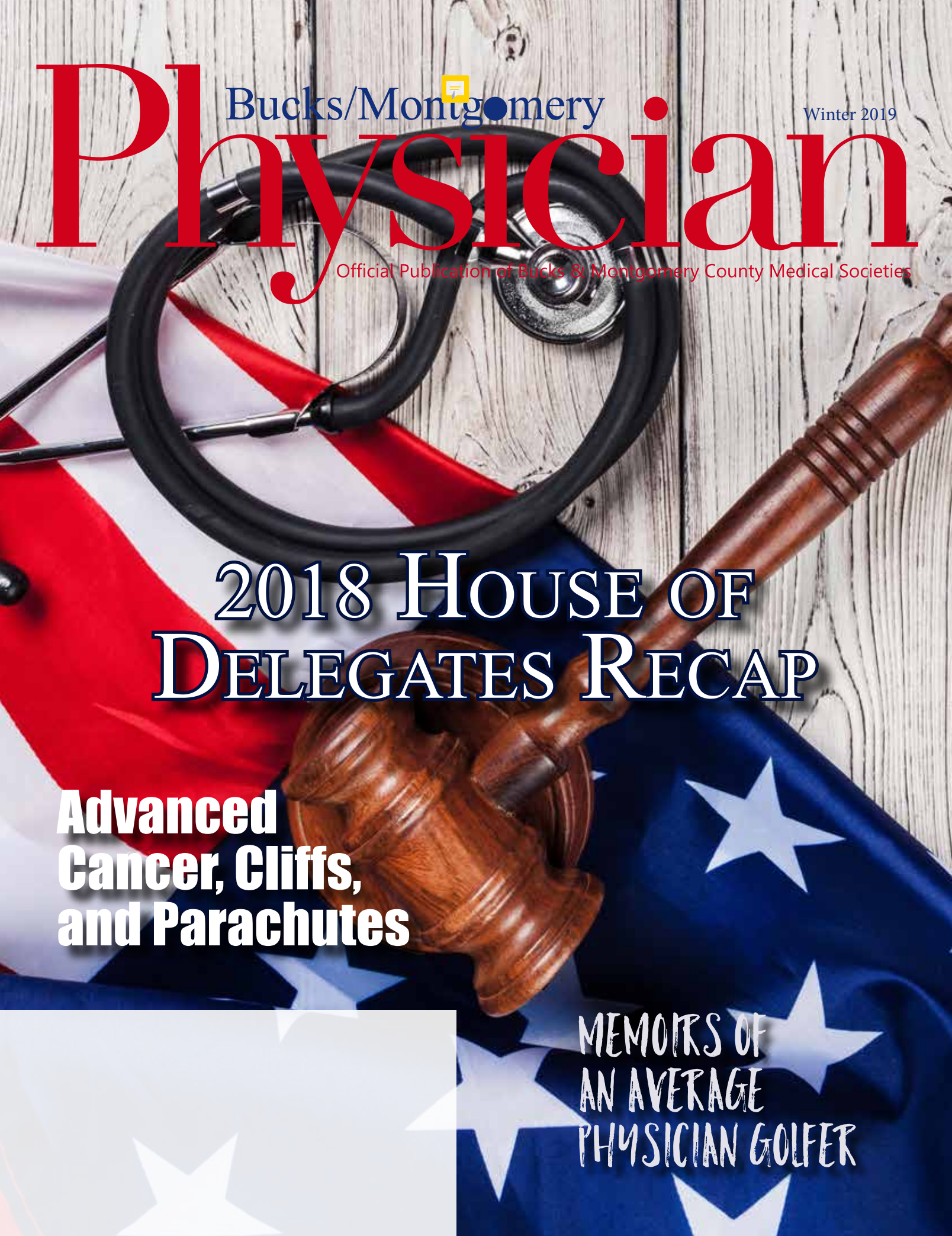

2018 House of Delegates Recap

Advanced Cancer, Cliffs, and Parachutes

Memoirs of an Average Physician Golfer

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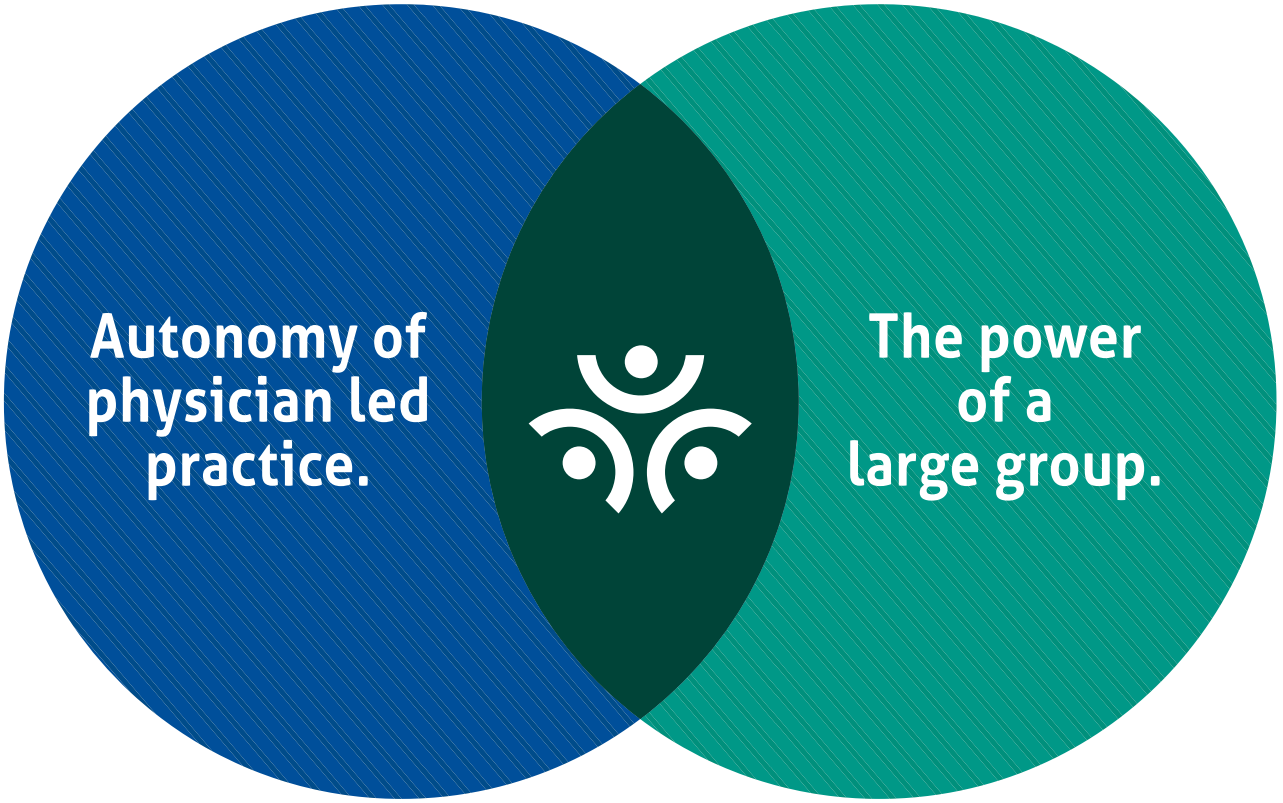

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Happy New Year!

Happy Holidays! Yes, it's that time again—crisp mornings, brilliant colors, and crunchy leaves. And by the time this issue comes to press, turkey, apple cider with cinnamon, and pumpkin pie. For some, the first flakes of snow may have already fallen, while others remain hopeful. Regardless, like the song says, "It's the most wonderful time of the year!" So, from all of us here at *Bucks/Montgomery Physician*, I'd like to wish you and yours a safe and healthy holiday season.

Now that 2018 is in the rear-view mirror, it's time to look back on what has been, and the challenges that may be coming in the year ahead. It's been a little while since I've written this column (we rotate now between our county editors and presidents, so it's only my "turn" about once a year), but I've always tried to approach the Editor's Message with a theme. In past issues, I've written about such topics as 'uncertainty' and 'change' (as nebulous as they often are), but when it comes to healthcare, if 2018 had a theme, it would undoubtedly be 'Mergers and Acquisitions'.

In October, the Department of Justice, along with the Attorney Generals of California, Florida, Hawaii, Mississippi and Washington, conditionally approved the merger of Aetna and CVS. The new entity (which is yet to be named) will truly be a healthcare colossus. And undoubtedly, it will change the way healthcare will be delivered. But is that a good thing? Is bigger always 'better'? And what about Amazon, the elephant in the room whose CEO Jeff Bezos has promised to 'shake up' healthcare delivery?

In looking at these questions, it's easy to get bogged down in the vernacular. "Encounters", "revenue", "streamlining", "vertical integration" have become the buzzwords of change in the healthcare market. But in looking at what may be to come, I find myself asking "What will happen to the 'human factor'?"

For centuries (indeed, millennia), the cornerstone of medical care has been the sacred relationship between the patient and physician. Through much of America's lifespan, 'the doctor' often was a central figure in the community—not only a healer, but a resource when times were tough, a shoulder to lean on in grief, and a mentor for whose those wanted to heal the sick. Then came the middle of the 20th century, and with it, a time of almost explosive economic growth, innovation and change. By the turn of the millennium, the 'country doctor' of decades past was nearly extinct, and independent practice under siege.

When I was growing up, my late grandfather, who was a flight surgeon in the Burma theater during WWII, used to tell me stories about the diseases he saw. This sparked my initial interest in medicine, which my late father, a cardiologist, cultivated in later years by taking me on rounds to the hospital and his two-person practice with my grandfather in North Philadelphia. Those experiences were transformative, and they cemented the importance of the patient-physician relationship. They also taught me something about its uniqueness, about a bond that is not easily replaced or dismissed.

Nowadays, many physicians are employed by large health systems, and are learning to deal with a whole new reality. MACRA, MIPS, readmissions, bundles, CDI—it's easy to wonder where the patient has gone. So what to do? The answer, in my opinion, lies in education and advocacy. Patients are no less overwhelmed by the changes than physicians, and it is our duty to inform them of what those changes mean. We must also inform them of what the impact of circumstances like the Aetna/CVS merger will have on access to care, and that patients understand the differences in training between a physician and an advanced-practice practitioner. This is not to denigrate any member of the healthcare team, but rather to provide knowledge, so that our patients can make the most informed choice about whom they wish to deliver their care.

In regards to said teams, it is, in my opinion, important that they remain physician-led. There has been intense lobbying by some who promote the idea that physicians are 'overtrained', or only provide 'sick care', or don't treat 'the whole patient', and that providers who take shorter paths grounded in allied fields can replace doctors on the front lines of care. While perhaps politically expedient (especially in light of the shortage in primary care), policy that is built on a foundation of misinformation is doomed to fail in the long run. While a doctor may not need to be 'in the room' for well-checks or uncomplicated follow-ups, the depth of knowledge acquired during the rigorous training it takes to become a physician cannot be replaced or circumvented—especially online. Again, this is not meant to be derogatory towards any provider, but rather an acknowledgement that skills are complimentary, not

equivalent, and that physicians are best suited to be leaders of the healthcare team. With the proliferation of 'minute clinics' and 'urgent care'—which will only grow under the aforementioned merger—the ability of many to cultivate a long-standing relationship with a physician who knows them inside-and-out may one day be substantially curtailed.

I have to admit that at first, such thoughts were new to me, even a little strange, like an old shirt that no longer fits. But there's also something right about it, the idea that in some ways, perhaps our lives have gotten a little too complicated, that maybe our grandparents were on to something. I think back to my childhood, and how different growing up in the '80s was compared to now, some 30 years later. I watch my children with their Kindles and iPads and wonder not only what kind of future they might have, but who will care for them when the time comes. Will there still be women and men who follow that sacred calling to become physicians, willing to sacrifice years of their lives and enormous sums of money for the privilege to enter this noble profession? Will patients be 'allowed' to choose a physician, or will that choice be made for them by insurers with an eye on the bottom line? Will medical school and residency still hold value, or will the way forward be paved with an army of 'providers', an alphabet soup of degrees in which everyone practices to the 'top of their license', but lacks the depth to know the entire patient? I don't have all the answers, but the trend is concerning.

As we look towards what will surely be an eventful year, perhaps it's time to pause and catch our breath. Change has come so fast, and is often so dynamic, that we haven't had much opportunity to digest what it means. Reflection, contemplation, awareness—these things require stillness, the absence of movement. And healthcare has been anything but. With the New Year upon us, maybe we should resolve to find that stillness, pause amidst the flurry of tectonic shifts, and ask "Is this change for the better, or are we in motion solely for its own sake?" One can improve, even save lives, while the other is often just wasted energy. This is a journey with an unclear destination. It's long past time to stop driving aimlessly around, pull the car over, and take a look at the map. Physicians are considered leaders, and sometimes, leadership requires that we stop, pause, and reassess. Let's do so, and do it soon.

In the long run, our patients will thank us.

~ Jay Rothkopf, MD

Outrageous is Falling

By Jay Rothkopf, MD

Outrageous is smiling. She's eight years old, but short for her age. Her eyes are a pair of onyx-colored almonds, her hair as curly as the cord of old phone that's been sitting in an attic since the ancient Reagan years. Her skin, the soft brown sheen of a melted Hershey's bar, is smooth as a baby's who has just been washed. Her mouth, its corners pointed towards the overcast sky, is home to a mouth of brilliant white teeth.

The building, their destination, is up ahead. Shiny and new, its walls are white with dark tinted windows. It looks almost like snow made solid, but inside it will be warm. Mommy said so.

Mommy looks down at her. "Are you ready, sweetheart?"

"Yes." Her voice sounds far away, small. She's cold, from the wind or the unknown she isn't sure, but mommy's holding her hand, and that makes it okay. "Can we go in now?"

"Of course." Mommy gives her a squeeze, bringing life to her numb fingers. The gloves were wool, but well-worn, and they sometimes had trouble keeping out winter's bite. They start to walk. Slowly at first, then faster and faster, until they're almost at a trot, passing the throngs of people heading in the same direction. Right before the glass doors, Outrageous looks up, and points to a glowing symbol affixed to the wall. "What's that?"

Mommy smiles. "That means you're going to get well."

"Really?" Outrageous looks at the red cross as they pass through the entrance, "Then I think I like it." They stop at the desk for passes, then head off down the hall, past another red cross hanging next to a sign. It had a word next to a pointy arrow, telling them where to go. Outrageous was a good reader, but this particular collection of letters was too peculiar for her to reason out. "What does it say, mommy?"

"Hush, girl," Mommy said, pulling her gently towards the elevator. "We don't want to be late."

Outrageous hushed. Mommy was wise, and she wanted to be a good girl for her. As the door slid closed, she squinted at the sign a final time, and tried to sound out the word in her head.

On-col-ogy.

* * *

Outrageous is shouting.

"No!" she says. Her voice is tiny yet full, the forceful tones of an adult mixed perfectly with the petulance of a child. She stands, hands on her hips, lower lip pushed out in a sour pout, and stares at the object of her ire. She is short but looks like a missile ready for take-off. Her shoulders, round and straight, hold not a hint of uncertainty or slouch. Her mother, blocking the door with her shapely frame, glances down and bites back a smile. Outrageous is angry, and Mommy wants to know why.

"What's wrong, sweetheart?" Mommy asks. She's using the voice, like Ms. Baxter's at school, the one coated with honey and a layer of hugs.

Outrageous points to the person standing behind her. "I don't want him to use that needle!"

Mommy leans down and gives her a hug. "I know you're scared, sweetie," she says, "but it'll only take a minute."

"No!" Outrageous is shaking, her skin covered in goosebumps. The only thing worse than seeing the blood stuff was needles. "You promised they'd make me well! Needles are OUCHIE!"

The tears are falling now. Mommy drops down to one knee and wraps her arms the heaving chest. Outrageous's heart is jackhammering – could it burst through her chest and make her die? She didn't want to find out. Inches away, the man with the needle is staring at her. His eyes are blue, like the funny pajamas he's wearing, and his face is plain, like vanilla ice cream without jimmies.

Mommy strokes her cheek with one finger, wiping away the tears. "I need you to be brave, sweetheart. Can you do that for Mommy? For God?"

"God is watching over me, right?" Outrageous heard that often in church. The pastor talked about it every week. Last Sunday, he even asked the entire congregation to pray for her, right before the choir sang. "Everyone in church asked Him to help me get well."

"Yes sweetheart, God is watching," Mommy said. She cocked her head to one side. "Do you think you can be brave for Him? Just one little pinch, and then it will be done."

Outrageous swallowed. She didn't want to disappoint God. The Bible said that was bad. "Yes mommy." Her voice sounded quiet, so she made it more firm. "I can be brave for God."

"Good." Mommy stood up. "Then come back to the table and hold out your arm."

Outrageous obeyed. The man in the blue pajamas leaned down and smiled. A name tag hung from the pocket on his chest, followed by the letters 'RN'. "What's a rrnn?" she asked.

He laughed. "It means 'registered nurse.'" A length of rubber tube was wrapped around her arm, then the rrnn rubbed her arm with something wet and cold. "That tickles," she said, as a giggle escaped her lips. "And it's already dry. Wow!"

"Yep." He leaned forward with the needle. "Close your eyes." Outrageous froze. Her heart was speeding up again. She glanced at Mommy, who gave a small nod. God was watching. Time to be brave.

Her lids slid down. She felt a tiny pinch. Her lids rolled up.

"All done," the rrnn said.

"That's it?" Outrageous wasn't sure she believed him. "That's it."

"Cool!" Outrageous was speechless. She watched as the blood stuff shot down a thin plastic tube and into a cylinder of glass with a round pink top. "What's that?"

"It's for your test," he said. She watched as it quickly got full. He slid it off and popped another one on. It too began to fill. "One more to go."

"And then I'll be done?"

"You got it." The third cylinder was locked into place. Before she could count to ten, it was filled to the brim. He popped it off, then reached for a white thing. It landed on her arm, soft, but harder than cotton. Another pinch, and the needle was out.

"All done," he said, and slapped a band-aid over the white thing. It had Snoopy on it. She liked Snoopy. He turned to Mommy. "We'll run these right away. They should be back by the time the doctor sees you."

"Thank you," Mommy said. She placed a hand on Outrageous's shoulder. "You were very brave."

"Is God happy with me?" Outrageous asked. The thought made her smile.

Mommy nodded. "I'm sure He is."

"Yay!" Outrageous pointed to the door, which the rrnn had just walked through with the tubes of her blood stuff. "That way?"

"Yes." Mommy said, and held out her hand. Outrageous took it.

"I'll go first," she said. And off they went.

To be continued....

Establishment of the Women Physicians Section

By Sherry L. Blumenthal, MD, FACOG

At the PA Medical Society (PAMED) House of Delegates (HOD) Oct. 28, 2018, a resolution was passed officially changing the Society Bylaws to establish a Women Physicians Section. Until then, the Women Physicians Caucus, established in February 2017, had no independent authority, no representation on the Board of Trustees (BOT), and no ability to submit resolutions to the HOD.

While it is late in coming, this Section will provide a guaranteed voice for the unique issues confronting women in medicine. It guarantees a seat on the BOT that is occupied by a woman. Currently 2 seats on the BOT that were occupied by women are now occupied by men. While this was not deliberate sexism, we do need to be concerned about the gross under-representation of women in PAMED leadership and participation.

One of our first tasks, as voted in a resolution that passed the HOD this year, will be to draft a recommendation for reasonable and equitable maternity leave for women physicians. As an OB/GYN, I advised my patients to take a minimum of 6 weeks leave and encouraged breast-feeding. Now, The American College of Obstetricians and Gynecologists (ACOG) recommends 12 weeks, which is evidence-based. It also allows more time to establish breast-feeding. This is difficult in a busy workday and there are still facilities where there is no clean space to pump. These recommendations are also consistent with The American Academy of Pediatrics and the American Academy of Family Medicine.

While some new mothers may wish to return to work sooner, many feel guilt and have issues with post-partum depression. We should have the same medical advice and privilege as our patients. There is also the issue of financial hardship and punitive policies for women physicians who take maternity leave. This cannot be tolerated. It is important to remind everyone that, without women having babies, our species would become extinct, and no man would have the option of becoming a father. In addition, most of us do not have more than 2 or 3 pregnancies, therefore maternity leave issues are self-limiting. The other important principle is that childbirth is neither a medical illness nor a vacation! Yet we are expected to use sick-leave and vacation time to avoid financial penalty. We hope to submit our recommendations as a formal resolution at the 2019 HOD.

We are beginning our pilot mentoring program, helmed by Candace Good, MD, to match woman mentors with younger women physicians who wish to have contact with an experienced woman as a guide to leadership, work-life balance issues, and career goals. We are also encouraging networking events, to bring women physicians in closer contact with each other. Ideally, these should be local. There have already been events in Lancaster, Montgomery, Delaware and Chester counties, and Philadelphia.

As soon as we have completed our organizational structuring, we will need to work on wage equality and leadership equality. As women physicians become more numerous and eventually equal in number to males in our field, we need to strive to share the power structure and feel empowered to rise to leadership!

Please register on the PAMED website to become part of our Facebook group. Welcome to the Women Physicians Section of PAMED.

WINTER IS HERE:

Are Your Patients Prepared?

By Thomas Gillon, MD

We may have to wait another four months for winter to return to HBO's Game of Thrones; however, winter is currently knocking on (and soon to be barreling through) our front door.

We have learned from our great first president, General Washington, and his soldiers to be prepared for a harsh winter in suburban Philadelphia. As Jack Frost blows in from the north, Pennsylvania physicians can expect to see many patients with weather-related injuries and ailments. From slips of the knife to slips on the ice, we at the Philadelphia Hand to Shoulder Center see a dramatic increase in volume of patients with hand, wrist, arm, elbow and shoulder injuries during this time of the year.

Accidents will happen, but there are certain precautions we can all share with our patients to help prevent some injuries.

KNIFE SAFETY

Every year thousands of Americans cut their fingers with kitchen knives. Whether you are carving a brisket, turkey or ham, here are some safety tips to consider.

- Keep your knives sharp. A dull knife is more likely to slip, requires more force to cut, and yet is still sharp enough to cut a human finger. An electric oscillating knife is a safer choice when carving meat.
- Never place your hand under the object being cut, i.e. a roll or bagel.
- Never try to catch the carved meat with the other hand. Always slice away from your free stabilizing hand.
- Keep the food prep area dry to prevent slippage. If the object to be cut is slippery, try stabilizing it with a dishcloth with your free hand.
- Try to be free of any known possible distractions when wielding a knife. Don't watch TV while chopping vegetables, etc.

If you cut your finger or hand, wash the wound with soapy water and then apply direct pressure with a clean cloth. Most hand and finger wounds will stop bleeding with direct pressure.

Seek immediate medical assistance if:

- The cut doesn't stop bleeding after 15 minutes of direct pressure.
- You are unsure if your tetanus shot is up to date.
- You are unable to thoroughly clean the wound with soap and water.

Schedule to see a board-certified hand surgeon within a few days if:

- You are unable to feel distal to the cut.
- You are unable to bend or straighten the finger(s).

SNOW & ICE

While snow-laden fields may be picturesque, more often than not we are subject to an icy, wintery mix here in the greater Philadelphia area. If you must venture out on an icy path, then you should be extra cautious. Ideally pretreatment of paths and steps with salt may lead to fewer accidents. Always use a handrail when going up or down steps, especially when they may be icy.

Probably one of the most devastating injuries to a hand is a snow blower injury. Each winter the hand surgeons at the Philadelphia Hand to Shoulder Center are referred patients from all over the tri-state area with snow blower injuries. We often spend many countless hours in the operating room replanting amputated fingers and repairing these mangled hands. Unfortunately, theses injuries can have such severe soft tissue and bone injuries that replantation is not possible – sometimes leading to multiple finger amputations.

Fortunately, these injuries are completely preventable!

- Understand how your snow blower works! Most snow blower injuries occur because the blades get clogged with wet heavy snow and the operator didn't know that their snow blower had two sets of blades—a two-stage snow blower. The second set of blades at the bottom of the chute propels the snow up and out of the chute. When the unsuspecting plower places his hand in the chute to clear stuck snow, he or she could be off to the ER.
- Another mechanism of injury is via the potential energy in the stuck blades. Once cleared the blades can still rotate just enough to cut whatever is in their path.
- Never operate your snow blower after drinking alcohol or using sedatives/narcotics.
- Never operate when others are near that could slip or slide into the blades.

If your snow blower is clogged:

- Always make sure the engine is OFF
- Disengage the clutch
- Wait for all blades to stop moving
- Never declog the blades with your hands or your feet! Most blowers come equipped with a declogging utensil or alternatively you could use a stick

Tips on how to keep your snow blower from clogging:

- Spray the blades and chute with cooking oil
- Plow multiple times if accumulation is expected to be deep or the snow is expected to be heavy.

Thanks for sharing these tips to help keep your patients' hands, wrists, arms, elbows and shoulders safe from injuries in 2019!

A member of the renowned Philadelphia Hand to Shoulder Center physician team, Thomas J. Gillon, MD is a Board Certified Orthopaedic Surgeon, fellowship trained in Hand and Upper Extremity Surgery. He is on staff at Temple-Jeanes Hospital, Holy Redeemer Hospital and Thomas Jefferson University Hospital. A native of the Philadelphia area, Dr. Gillon welcomes new patients at his office in Rockledge. To schedule an appointment with Dr. Gillon call 1-800-385-PHSC. For more information about Philadelphia Hand to Shoulder Center visit Hand2Shoulder.com.

Advanced Cancer, Cliffs, and Parachutes

By Jeffrey Cohn, MD, MHCM

People have described the clinical trajectory of a patient with advanced cancer's life as "falling off a cliff." This means that the person can seem to be doing relatively well, and then, once the disease exceeds a certain threshold, the person deteriorates progressively, in a relatively short period of time (weeks to months), until death. For most patients with advanced cancer, this metaphor of "falling off a cliff" still applies. So, what's different now? There is a new class of drugs, collectively referred to as "immunotherapy" or "targeted therapy," that, for some people with advanced cancer, can cause the disease to be arrested, even seem to disappear for a few. And this control can occasionally last for a long time – even years. A few oncologists are even using the word "cure." Continuing with the metaphor, I feel like the individuals for whom these new therapies are working have been given a parachute that opens as they are "falling off the cliff" and allows them to land safely at the bottom, unharmed.

The problem is, we can't really tell yet which candidates for these new therapies will benefit and who won't. And these therapies all have potential toxicities, some severe, some even life-threatening or lethal. So, if you're a person with advanced cancer being offered one of these new therapies, staying with the metaphor, it's as though you're given a sack with a parachute in it – but, until you pull your ripcord, you don't know if it's a working parachute or one with holes in it. Even worse, these "faulty parachutes" may catch onto ledges or brush along the cliff and cause additional injuries on the way down, making the fall to the bottom even more difficult and painful than if you never had a parachute in the first place.

Before we had these drugs – before we could offer a possibly working parachute- people "knew" what was coming and could prepare. There was some uncertainty regarding when and how, but not what, was going to happen. This is where our current model of hospice care was developed, and it works pretty well. Knowing you are falling off a cliff without a parachute, caregivers focus on whatever interventions can be provided to have you feel as safe and comfortable as possible. None of this changes what's going to happen once you reach the bottom, but it makes the fall as easy as it can be. And for your loved ones who will be the survivors, they have as easy a time dealing with their loss as is possible.

Now, with most current regulations, if you receive the parachute and pull the ripcord, hospice care is not an option–at least not until it's clear that this parachute doesn't function–and that can be perilously close to the bottom of the fall (i.e., days before end of life). During the time where it's unknown if, and how well, this treatment is going to work, you and your family may be (understandably) focusing on hoping for the working parachute, even as you get closer and closer to the bottom. Uncertainty may dominate the experience for much of the time you have. And most of us don't deal with uncertainty very well.

So, what can be done? Palliative care can be a critical support during the fall. This can do much of what hospice care can do, but while still waiting to see if you have a parachute that is going to work, at least for a while. Palliative care can provide medications to treat symptoms causing suffering, spiritual support, care coordination, and care planning for whatever the future might bring. Unfortunately, many communities have little to no access (yet) to community-based palliative care (care outside of the hospital), though that is changing.

I think the most important thing to be done is to talk. In a recent *Wall Street Journal*, "How to Talk With Your Dying Loved One," the author described six categories of the kind of things one can talk about with someone who's on the way down from the top of the cliff. These are: conversations about love, "identity messages" (conversations that frame who you are), religious/spiritual talks, everyday talk, difficult relationship talk (attempting to repair hurt of some kind), and "instrumental death talk" (about funerals, end-of-life care, burial, etc.). To these I would add a few more. I think talking about uncertainty can be supportive. "I imagine it must be hard living with so much uncertainty–about whether this treatment is going to work, about what new symptoms are going to appear, about whether you'll feel better tomorrow..." or something like that can show empathy and caring about a topic we don't talk openly about very much. I also think sharing and discussing fears and hopes (the focus of the first two questions from the game Hello) can provide comfort and meaning for the person with the disease, as well as opportunities to help (if asked).

One final use of the metaphor. Maybe conversations are a different kind of parachute, one that opens regardless of how well the first one is functioning. This parachute slows down the fall so that you have time to appreciate various things along the way–the blue sky, the warm air, the cool breeze, everything that makes life worth living. This parachute doesn't slow you down enough to prevent you from hitting the bottom, but it allows you and everyone you've been in conversation with to have found some pleasure and meaning together. Instead of the hard canyon floor being at the bottom of the fall, there is a big, soft pillow. The fall into it is still fatal, but it's an end that is embracing and comforting, and leaves the survivors capable of getting up from the fall and moving on with their lives with the memories of their loved ones' words and deeds to guide and comfort them going forward.

Jeffrey Cohn, MD, MHCM, is a former medical oncologist/hematologist from Ambler, PA. He is currently the Medical Director for Common Practice and a personal/leadership coach for physicians.

Same Day Surgery Total Joint Replacement

By Thomas H. Vikoren, MD

As 2018 comes to a close and 2019 is about to commence, the field of total joint replacement (TJR) surgery is also about to dawn a new era – the era of the routine outpatient TJR surgery. According to data by the Centers for Disease Control, the average length of stay of a total hip replacement in 1992 was 10 days. By 2000 it was 6.2 days and by 2010 it averaged approximately 3 days. Not only was the hospital stay protracted, but a significant number of patients also discharged to a post-acute facility such as a skilled nursing facility or acute rehab center before finally heading home. The idea of a truly same day surgery (SDS) procedure would not have even been considered feasible.

Advances in the surgical methods of TJR surgery, as well as the perioperative care and postoperative rehab, have improved dramatically to allow for SDS TJR. One of the biggest intangible contributions was made possible by the shift in orthopedics from low quality

observational or retrospective studies to a greater appreciation for the value of prospective clinical studies as is more common across other medical disciplines. I will highlight just two of the most significant impacts below.

A hemostatic agent with the on-label use for menorrhagia, tranexamic acid (TXA), has had a landmark impact in reducing bleeding in TJR surgery. Although described in European literature earlier, in 2010 one of the first prospective randomized studies in the US showed the benefit of TXA on minimizing blood loss following TJR surgery. These findings, including evidence of safety of this intervention, were replicated across numerous subsequent trials. Widespread adoption of TXA has spread across TJR surgery nationwide. Transfusion rates, which previously averaged 20% or more, now are in the range of 1% at our facility. For patients with normal starting hemoglobin, postoperative blood draws are no longer even considered a necessity.

Another example of the power of prospective studies in TJR surgery was the demonstration in 2013 that dexamethasone administered intraoperatively has a profound effect on reduction of postoperative nausea and pain. Hospital length of stay was also reduced significantly as patients were able to reduce opiate consumption and start physical therapy sooner. Because these studies were prospective and well designed, TJR surgeons were able to know with confidence that complications such as infection would not increase due to this therapy.

My first foray into short stay TJR surgery started in 2013 through serendipity. Due to an unusually high hospital census it became clear that a healthy 65-year-old man who had just undergone total hip replacement surgery would be without a ward bed for a protracted period of time. He indicated that he felt so good, perhaps he could start his physical therapy right in the postoperative recovery room. Taking him at his word I called the physical therapists to do just that. By that evening he was walking the hallways, clearly functionally independent and ready for discharge by the following morning, a first at our institution. Emboldened by that patient's success, a rapid recovery pathway we termed DASH (Doylestown Accelerated Surgical Healing) was developed through a multidisciplinary approach.

DASH served as a model that eventually transitioned to nearly all patients at our hospital. Fast forward 4 years to 2017, and the average length of stay for patients of all ages, including the elderly, was averaging only 1.3 days. Amazingly these advancements occurred with a concomitant reduction in post-acute facility utilization. In 2017 it became clear it was time to jump to truly SDS TJR, and a new protocol was developed to ensure a seamless interdisciplinary approach that emphasized patient safety and comfort. Now as we turn the page to 2019, it has become a routine event for our physically capable and motivated patients of all ages to return home the same day following surgery.

Ideal SDS TJR candidates have a support network of family or friends but need not have first floor living accommodations. They are well prepared through preoperative teaching classes and physical therapy "prehab." The surgery itself in our program is performed under a short acting spinal anesthetic lasting less than 1 hour in duration. Patients start physical therapy in the postoperative recovery room and are discharged after they meet criteria of walking unassisted for 100 feet, urinating and ascending stairs. Amazingly, even though the 30 days TJR readmission rate nationwide for all comers is approximately 5%, our program has not had one readmission or even an ER visit following an SDS TJR procedure in the 18 months since it began. This is in line with a recent prospective, randomized study that found lower complications in SDS total hip among patients with predefined inclusion criteria.

Patient satisfaction with SDS TJR has been excellent, and, for many patients, has resulted in significantly reduced expense for the surgery. Since TJR surgery as a procedure is expected to increase substantially over the next decade, reducing the economic impact to our health system as a whole will be paramount. The next step in this evolution will be the movement of SDS TJR from the hospital setting to that of free-standing ambulatory surgery centers. Nationwide this trend is already occurring and estimated to grow by 500% over the next 10 years, driving expenses down even further while increasing convenience for patients, a win for the entire health system.

MEMOIRS OF AN AVERAGE PHYSICIAN GOLFER

By Jerome Burke, MD

Golf is a complicated game and very difficult, if not impossible, for most people to master. Witness Charles Barkley, one of the NBA's old-time greats and one of the best athletes of our generation. He is a terrible golfer and has trouble hitting the ball off the tee.

So, what is so hard about hitting a little white ball siting on the ground waiting to be struck by a player with a 3-foot stick? This seems simple enough but, suffice it to say, that many things can go wrong from the time the player stands over the ball, goes into the back swing and finally makes contact with the ball. Trust me on this, I speak from personal experience. So, what makes us pedestrian golfers keep coming back for more punishment? That my friend is the million-dollar question. My guess is that in any given round, even bad golfers find a way to make a couple of shots on their round of golf that resemble shots made by players on the PGA tour.

My foray into golf began at a relatively late stage of life, my early 50s, for a variety of reasons. I grew up on Staten Island, New York in the 1960s and early 1970s and this was the most "blue collar" of the 5 boroughs of New York City. It supplied a high percentage of the City's cops, firemen, sanitation men, and secretaries. Kids from "The Island" (not to be confused with its bigger cousin "Long Island"), for the most part, knew about or played one or more of the three major sports – Baseball, Football and Basketball. My dad, James Aloysius Burke, son of an immigrant family, became an all-star basketball and baseball player and was elected to his high

school's Hall of Fame. My oldest brother, Jimmy, was also a stand out in basketball and baseball, and his high school baseball team won New York City public school championship and made it to the semifinals in basketball. My brother, Jack, played football and basketball, and his son, Tim, is an Olympic athlete for Team USA in the Biathlon. I guess that you could say that playing sports is in our family's "DNA."

As an elementary school and junior high school student, I played all of the "big three" sports. In March, with the ground still frozen, I would get out my glove and get ready for baseball tryouts. Once baseball season was over, my dad would sign me up for Pop Warner football and we would begin practice in August and play well into November. In December, I would turn in my football gear and start playing for my school's CYO (Catholic Youth Organization) basketball team. Soccer was a sport that they played in Europe and South America, and Lacrosse was a game that the Iroquois Indians played in Upstate New York before they were driven out by the Colonists. The girls pretty much played tennis and some basketball, if they played sports at all. I would usually walk to practices or take the city bus if it was a distance away from home. There were no such things as travel teams, and kids did not go to camps or specialize in one sport. Parents were not involved unless they coached. They might come to your game if it was on a weekend. Outside of league sports, my neighborhood friends Rondo, Tony, Johnny, Sal, Tim, and Bobby would meet at the city park, choose up sides and play whatever sport was in season. We had TV then, but no computers, cell phones or video games like "Call of Duty" or "Fortnite." None of my friends played golf and we questioned if it was even a "real sport." It was a game that the kids who belonged to the country club played with their dads. Sometimes I would flip through the channels on a weekend day and catch a glimpse of NBC's "Wonderful World of Golf" and was puzzled by why all those people were following Arnold Palmer around the course. Fast forward 50 years, every year I ask my office manager not to put me on call Father's Day weekend, so I don't miss any of the US Open golf tournament. My younger brother, Pat, was more forward thinking than the rest of us and took advantage of free clinics for kids at the local public golf course. He became a member of his high school team, and, to this day, can pick up his clubs and shoot in the mid 80s even if he hasn't played in two years.

I continued playing football, ran track, and played CYO basketball in High School. I ran track one season in college, and played two seasons of lacrosse, even though I never played it prior going to college. I considered myself to be at least a decent athlete. The first time I went golfing was with my best friend from high school, Bill, who was taking lessons at the time. I was in my early 30s and actually played well–hitting in the high 40s for 9 holes. I felt no pressure and didn't think about what I was doing. I didn't pick up a club for another 20 years, when encouraged by my dear friend, Pete, to join him and a group of friends from our church for a golf outing. The group, which gets together multiple times a year, goes by the name "The O Boys," as the founders of the group met at our Orthodox Church. Pete frequently tried to impress upon me that I was "working too hard" and needed to spend time with the guys. I credit Pete, or discredit him, for getting me started with golf. That outing did not go well for me. I hit the side of houses, sliced numerous balls into the woods, and even missed the ball completely on a couple of swings. I needed a calculator to tally up my score. The harder I tried, which usually worked out well for me in other sports, the worse I played. Out of the group of 15, I finished dead last and was awarded a trophy of a horse's ass for my performance. My ego took a huge hit that day. How could this happen to Jerry Burke from Staten, Island NY? I swallowed my pride and played with the group a couple more times with similar results.

At that point, I decided that I was either going to abandon golf entirely, or do something to improve my game, and thus repair my self-esteem. Enter Greg V. into my life – the pro golf instructor at the local driving range.

Greg V. is a wonderful teacher who has certainly seen the good, the bad and the ugly in golf over many years. I call him the "Golf Whisperer," as he is so patient and effective. I think he may have ice water running though his veins, an advanced degree in psychology, or both. I've seen him barely blink when his students hit the ball a couple of feet or into the wall of the adjoining lesson bay. After a few lessons with Greg, I was able to make decent drives, hit my irons reasonably straight, and play a respectable round of golf. I moved closer to the middle of the pack of the group in a relatively short time and, when the planets were all in alignment, I have been among the leaders. Golf became a lot more fun for me. I have improved since that first year of lessons but have not made that much progress shooting, the same scores as I did ten years ago. I have not achieved my goal of scoring under 90 for a round. Every time I come close, I get nervous toward the end round and my game goes off the rails. Golfers sometimes call this "the Yips". I read somewhere that golf is a game played on the course and over twelve inches – the distance between your two ears.

There are several thoughts that golfers will often express, particularly if they, or their partners, are having a rough time on the course, that I have heard with some frequency. In an effort to console oneself, or a struggling partner, they will say, "a bad day on the golf course is better than a good day at work." Another one is, "it is just great to be out walking around in such beautiful surroundings playing golf" even in the midst of a dreadful round. I take issue with these statements. First of all, I'd rather have a good day at work, as I would be productive, than playing miserably and getting poison ivy from looking for my ball in the woods. If I wanted to appreciate nature, I would skip the fifty-dollar greens fees and take a hike on the Perkiomen trail or around Lake Galena.

There are many social aspects of golf, and I have learned much about people and myself by playing. When I go out and play alone on a day off during the week, I've been randomly paired with many different people. Everyone I've met, with few exceptions, has been very pleasant to be around. One time I was paired up with an older gentleman who kept looking at me during the round and saying, "I know you from somewhere – but I don't know where." At about the 15th hole – the light bulb went off in his head and he said "I got it – you are the guy who did my colonoscopy." He laughed and indicated that I didn't recognize him because I was more familiar with the opposite side of his body. Keeping score in golf is much like filling out a tax return. Some people do not cheat, some people cheat a little, and some people cheat a lot. Every so often, a player will hit the ball into the woods, flub another shot, three putt and post a lower score on his card than you! I guess it must be magic. One nice thing about golf is that you play mostly against yourself and try to improve. My friends encourage each other and are rooting for their partners to have a good round, unlike in some other competitions. I continue to play with my friends from Church – Pete, Steve, the two Mikes, Dave, Ron, and Ernesto. Pete graciously invites us all to come down to his home at the Jersey Shore for a long weekend in early June every year. We play golf, make good food, drink a few beers and, if we don't fall asleep too early as we age, play poker. Several of our sons have joined us in recent years. We have lost two dear friends, Jimmy and Leon, to illness since we started doing this 15 years ago. Some of our fondest memories of these friends were created during these weekends.

My advice to anyone starting out in golf is that it is a great game and one you can play well into old age and with your spouse and children. Do yourself a favor and take lessons early so that you don't reinforce bad habits and let frustration develop. But – buyer beware, golf can be a time suck and is not cheap. As for you experienced golfers, have fun and do keep things in perspective. The vast majority of participants are never going to be that great, so view golf for what it is – a recreational activity. Try to remember though, even in the middle of an awful round, the "perfect shot" may be just around the corner on the next hole!

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SETTING SAIL ON OUR OWN BLUE OCEAN

By Jaan Sidorov, MD, MHSA, CEO & President, Care Centered Collaborative at the Pennsylvania Medical Society

In what promises to be classic "blue ocean[1]" strategy, JPMorgan Chase, Amazon.com and Berkshire Hathaway recently announced a new business venture. Led by Dr. Atul Gawande, it is aimed at lowering healthcare costs and increasing quality for their 1.2 million employees. While the details remain fuzzy, it's a good bet that the initiative will likely use blockchain[2] to substitute for traditional centralized insurance claims processing, leverage artificial intelligence (Alexa) to tailor the insurance benefit plans and enable app-based smart contract payments to substitute for unwieldy payment authorizations.

As this high-stakes experiment in innovative disruption unfolds, the lesson for the rest of us in healthcare is that there are opportunities to not only anticipate where our market is going, but to shape it. While we await the outcome of Dr. Gawande's Excellent Journey, the question for the physician community is whether we can find our own blue ocean.

One safer blue ocean bet lies in concept of "value." Classically defined as the ratio of "quality" and "cost," it's obvious that current health insurance arrangements are not meeting our patients' value expectations.

Health insurer administrators, leaders of self-insured businesses, regulators, policy-makers and politicians are well aware of this. The staff of the Care Centered Collaborative has met with dozens of key industry leaders, and their response to their constituents' dissatisfaction can be summed up as "value-based care." Defined as a delivery model in which healthcare provider are paid based on patient health outcomes, hundreds of millions in healthcare dollars in Pennsylvania are being regulated and contracted away from traditional fee schedules and toward payment models based on quality reporting architectures that include HEDIS, the Stars Program, and NQF.

In our current "red ocean," these standard approaches to value-based care are arguably making things worse. In an effort to trim fee schedules, payment terms are not keeping up with inflation, and they're being further undercut by denials, prior authorizations, opaque coding rules and narrow networks. As these cuts are being used to fund value-based care, physicians are confronting quality reports that are late, inaccurate, not risk-adjusted, statistically dubious and disconnected from what they and their patients really count as "value."

Many of my physician colleagues are understandably fed up. Some have suggested that the only answer is to banish government and insurers from the economics of the doctor-patient relationship. Others believe that only a single payer system can cut through the noise by imposing

a democratic and centrally planned physician payment system. While we "can agree to disagree" on the merits of each of those extremes, the blue ocean lies in the middle, where approximately 90% of healthcare delivery is still based on pooling risk in commercial and government insurance programs. The majority of Americans don't want traditional health insurance to go away, they want it to work better.

Blockchain, consumerism and smart contracts were not invented by JPMorgan, Amazon or Berkshire Hathaway, and us physicians don't need to re-invent value-based care. The real lesson here for the physicians is that we can make it work uniquely better.

In response, The Pennsylvania Medical Society's Care Centered Collaborative is scaling a value-based care strategy that uniquely leverages five key overlapping characteristics on a network level:

1. Physician leadership that understands the strengths as well as the weaknesses of quality reporting architectures and reconciles them with real-world and patient-based preferences.

2. A quality-reporting warehouse that is compatible with any electronic health record, insurer claims processing system and patient data reporting format.
3. Actionable reporting with patient-centered benchmarks that are timely, accurate, evidence-based and comprehensive at the individual patient level as well as at the level of attributed covered lives, regions and populations.

4. All-payer care management programs that emphasize physician-led team-based care and extend the impact of the physician from the bedside and clinic to the home and community.

5. Accountability through the prudent assumption of limited risk arrangements for populations that make sense for physicians, but most importantly, serve patients.

Building, coordinating and scaling these five capabilities in a regional (and eventually statewide) clinically integrated network is daunting, but Pennsylvania's physicians are lucky to have a Medical Society that is prepared to co-invest with them in the personnel, informatics and administrative support necessary to make it happen. In the five months since the Collaborative has begun to recruit physicians into this enterprise, we have already signed up dozens of physicians in the Central PA/ Capitol Region market. We are on track to manage enough covered lives to engage insurers and employers away from their "off-the-shelf" quality contracts and toward tailored agreements based on physician insights, community-based resources, meaningful outcomes and real accountability. This will help insurance in Pennsylvania to work better. Other areas of Pennsylvania will soon follow.

JPMorgan, Amazon and Berkshire Hathaway are fortunate to have access to vast amounts of capital, the recent hire of a visionary CEO and expertise in novel financial and insurance arrangements. We wish their employees and shareholders good luck. The Medical Society has a safer bet that is based on Pennsylvania's physicians, latest generation informatics, team-based care and smart accountability. Our odds of success are much better.

REFERENCES

[1.] Blue ocean strategy refers to the creation by an enterprise of a new, uncontested market space that makes competitors irrelevant and that creates new value propositions. It was described by Kim and Mauborgne in a best-selling book of the same name.

[2.] A blockchain is a growing list of electronically maintained and distributed records over a network, which are linked using cryptography.

Women's Health Education Program:

A Highlight of My Medical School Career

By Sitara Soundararajan

Since the school was founded, Drexel University College of Medicine has represented values of committed mentorship, academic excellence, and innovative spirit in areas of education, service, and advocacy. The medical school is the successor to two separate historic medical schools, Hahnemann Medical College and Woman's Medical College of Pennsylvania – the latter was the first medical school in the world that afforded continuous access to training for women. This institution revolutionized women's education by providing invaluable opportunities in academic training, innovative research, and effective leadership.

Upholding its original values, Drexel University College of Medicine implemented the Women's Health Education Program (WHEP), titled as one of the three original National Centers of Excellence in Women's Health by the U.S. Department of Health and Human Services Office on Women's Health. The program has become a popular path for students who are interested in enriching their educational experience at Drexel, as it exposes students to a variety of women's health issues through seminars, research, and community outreach experiences throughout the four years of medical school.

As a current second-year student, my experience in the program has been immensely rewarding so far. With a keen desire to advocate for the female population during my medical school career and beyond, I find WHEP to be the perfect platform for further exploring relevant women's health issues. Students pursuing the program's Scholar's Track are expected to fulfill a number of requirements that aim to not only educate them on sex/gender disparities, girl's/women's health, and effective care for the female patient population, but also to drive them to share that knowledge with their communities. For example, the track requires its students to create an educational resource for the public (e.g. a brochure, blog, newsletter, etc.), write an academic paper on an extensively-researched women's health topic, and demonstrate leadership in community outreach/education. Students are also encouraged to attend seminars in women's health throughout the year to explore more specialized topics. During the four years of medical school, students work under the guidance of the Director and Associate Director of the Women's Health Education Program, Dr. Ana Nuñez and Dr. Judith Wolf, respectively.

WHEP has encouraged me to identify opportunities in my community that push me to further develop my skills in advocacy and service. As a part of my community outreach project, I became very involved in the Freedom English Academy India (FEA India) organization, an established program that is dedicated to providing a free education to students from low-income backgrounds. This program makes use of potential mentors all around the world who can expose their students to professional careers, inspire them to pursue their personally-chosen path, and provide them with useful advice to help them succeed. My role as a mentor started with regular Skype calls to a classroom of 15 to 20 students, with the hope of guiding these young individuals into a professional career trajectory.

My Skype sessions with the entire group typically last one to two hours in duration. I often continued discussions with my students over email or WhatsApp calls and text messages outside of our formal group calls – particularly

in the case of female students who tend to be fewer in number and less talkative in group settings. During the one-one interactions, we aim to have honest and open conversations about students' individual concerns, barriers to pursuing particular careers, and personal motives in pursuing certain educational paths. Though our backgrounds and experiences may be wildly different, we are able to work together to identify practical courses of action based on available resources and locate additional sources of support and guidance. This aspect of my FEA India involvement has been perhaps the most challenging, yet the most fulfilling. I feel extremely honored to be a part of such an organization and I am grateful that WHEP encouraged me to seek out such opportunities.

WHEP also exposed me to a wide array of pertinent issues in women's health through its unique seminar series electives. Over the course of my first year, I had the pleasure of attending seminars exploring topics such as intimate partner violence, heart disease among women, breast surgery, pelvic floor dysfunction, and even LGBTQ patient care. During a span of 90 minutes, students are provided with an overview of relevant issues that are unfortunately rarely discussed in the majority of school and clinical settings. Perhaps the most valuable aspect of these lessons is the interactive, engaging nature of the discussions that follow – students are encouraged to ask questions, network with speakers, and vocalize their thoughts.

In short, the Women's Health Education Program that Drexel University College of Medicine offers has been one of the highlights of my medical school education as it has provided me extraordinary opportunities and role models. As I enter my third year of medical school and start clerkships, I feel more confident to apply the invaluable knowledge I have gained through WHEP to improve my skills in providing care for women.

I would like to thank the Drexel University College of Medicine's Women's Health Education Program faculty, Dr. Ana Nuñez, Dr. Judith Wolf, and Lorie Cannon, for their mentorship and continued support.

2018 House of Delegates Recap

This article is being reprinted with permission from the Pennsylvania Medical Society.

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

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

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

Health Care Legislation & Regulations

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

- **Defending the Physician-Patient Relationship** – PAMED will continue to recognize, support, and lobby for the need for physician oversight, whether by direct supervision or a written collaborative agreement, of all non-physician practitioners who deliver care as part of a physician-led care team.
- **Maintenance of Certification (MOC)** – PAMED will strongly encourage organizations such as hospitals, network employers, and insurance companies to recognize multiple qualified board organizations when credentialing physicians. Further, at the HOD's direction, PAMED will share more information from a September 2018 Department of Justice letter containing MOC guidance.
- **Clarifying State Legislation on Ambulatory Surgery Centers (ASCs)** – The Pa. Dept. of Health has ruled that a 2017 state law intended to increase the allowable time of care in ASCs to 23 hours, 59 minutes did not specifically address Pennsylvania code which prohibits overnight stays. As a result, current Pa. code prevents care in an ASC to last up to 24 hours except in "extreme circumstances." The delegates voted to work with stakeholders to ensure that the intent of the law is executed and, if necessary, seek a legislative remedy.
- **Maternity Leave Equity** – The delegates directed PAMED to support the elimination of punitive salary policies on the career opportunities of women physicians who become mothers, and, with guidance from the Women Physicians Caucus, develop best practice guidelines for physician employers.
- **School Resource Officer (SRO) Training** – In light of the multiple incidents of school violence, PAMED will advocate for legislative initiatives to implement minimum standards of training for SROs to include topics like conflict resolution and cultural competency.
- **PAMED Support of Local Legislative Efforts** – PAMED's Board will study ways to increase the grassroots involvement of physicians

statewide. They will explore whether to create a council or committee that would coordinate advocacy initiatives at the state and county level.

Public Health & Education

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

- **Improving Health Care in Correctional Institutions** – The delegates directed PAMED to address a range of public health issues in the U.S. prison system. They approved resolutions on issues affecting individuals in the prison system including: improving treatment of depression in older adults, support of medication-assisted treatment (MAT), health education programming, and prevention of hygiene-associated and sexually-transmitted infections. The PAMED Board was directed to study the issue of funding for disease prevention programs, including vaccinations, in the prison system.
- **Immunization** – PAMED will promote American Academy of Family Physicians and/or Pennsylvania Academy of Family Physicians outreach campaigns to educate health care providers about immunization platform visits at 16 years of age that can enhance the well-being of older adolescents.
- **Firearms Safety Education for Physicians** – The delegates directed PAMED to explore partnerships with other stakeholders to provide physicians with comprehensive educational resources on firearms safety.
- Promote Substance Abuse and Mental Health Services Administration (SAMHSA) Treatment Referral Helpline – PAMED will continue to promote awareness of the SAMHSA national helpline, 1-800-662-HELP (4357).
- **Social Determinants of Health (SDOH)** – PAMED will support addressing SDOH to provide comprehensive care to patients. We will also encourage primary care providers to recognize the correlation between adverse childhood experiences and chronic disease to appropriately tailor care to the patient.

Practice Issues & Reimbursement

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

- **Out of Network Balance Billing** – PAMED will support state legislation to get patients out of the middle of billing disputes between insurers and providers that result from "surprise" insurance gaps, out of network emergency services, or other situations where patients do not have the ability to select their provider. We will also oppose initiatives that base the benchmark or default payment rate for non-contracted physician services on Medicare rates.
- **Support for Repeal of Merit-based Incentive Payment System (MIPS)** – PAMED will support the repeal of MIPS and petition the American Medical Association (AMA) to support the repeal and to oppose any federal efforts to implement pay-for-performance programs unless they do not add significant regulatory or paperwork burdens to the practice of medicine and have been shown by evidence-based research to improve quality of care.
- **Corporate Practice of Medicine** – PAMED will commission a study to determine the current extent of corporate ownership of physician practices in the state, which will include physician and patient feedback
- **Health Insurance Parity** – The delegates directed PAMED to advocate for essential health benefits, seek legislation to ensure Pa. consumers are protected, and ask the Pa. Insurance Department to provide resources to consumers seeking comprehensive health insurance.
- **Physician Credentialing** – PAMED will advocate that physician credentialing by insurance companies be based on professional training and licensure rather than solely on employment status or hospital affiliation. We will also advocate to payers that, once credentialed, physicians be listed as equal-tiered providers to those employed by the hospital or health insurer.
- **Drug Shortages and Drug Prices** – Delegates voted to directed PAMED to support evidence-based policy to address drug shortages and drug prices, advocate for increases to supply chain transparency and pharmacy choice, and advocate for effective implementation of pharmacist gag clause legislation. Additionally, PAMED will provide member education on the safe harbor exemption to the anti-kickback statute.

PAMED Membership

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

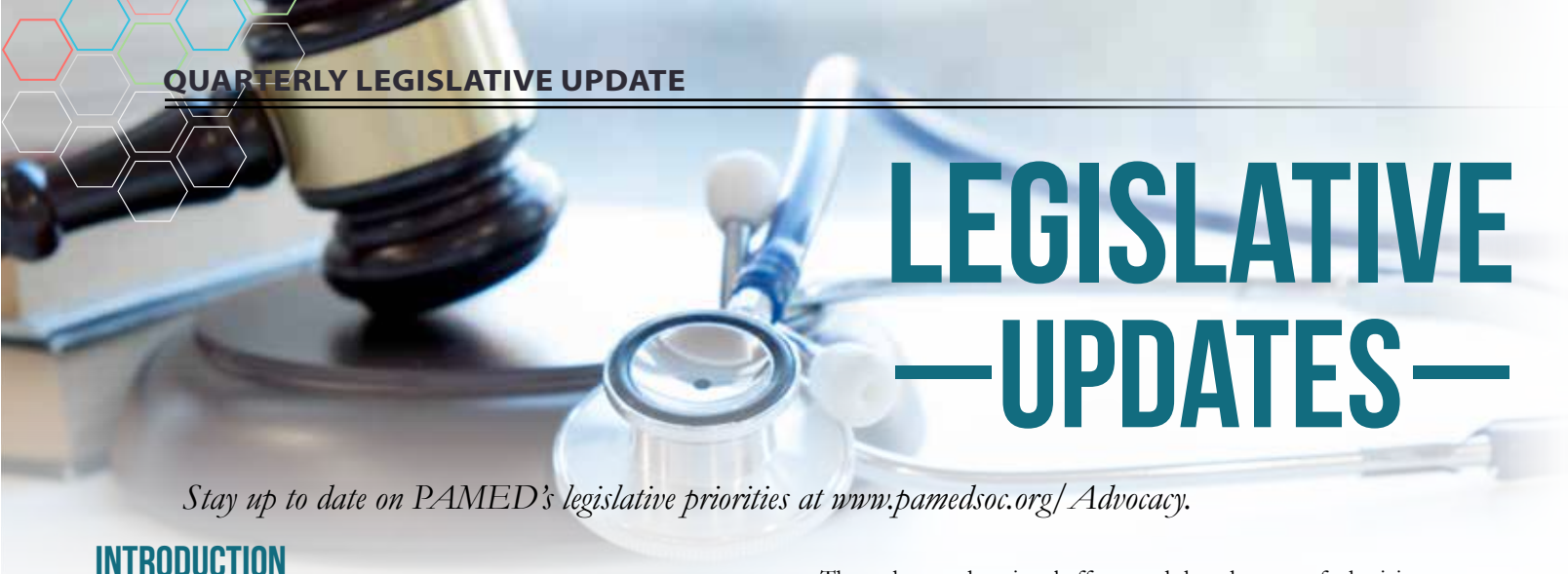
- **Find Methods to Increase Communication and Transparency** – The HOD recommended a variety of strategies to effectively communicate with members. One such strategy recommended by delegates is an "Ask the Board Chair" website providing members an opportunity to submit questions for physician leadership. This new feature will be available soon.

Note that PAMED members can currently access Board of Trustee and Executive Committee meeting minutes at https://www.pamedsoc.org/community/Board-of-Trustees-aspx.

- **Role of County Medical Societies** – The HOD reaffirmed that county medical societies are integral components of the state medical society.
- **Update to PAMED's Bylaws** – The HOD adopted several bylaws amendments that will (1) clarify dues for medical staff coordinators, (2) give county medical societies increased flexibility in setting their own dues, (3) streamline PAMED's membership categories; (4) update provisions regarding the Early Career Physicians and Medical Student Sections; and (5) create a new Women Physicians Section and Board of Trustees seat.
- **Regionalization of County Medical Societies** – PAMED will form a task force to create a grant process through which county medical societies who wish to participate in the process of regionalization can apply for assistance.
- **PAMED's Care Centered Collaborative** – The Collaborative, PAMED's for-profit subsidiary, will continue to share information about its activities to PAMED members on a regular basis. You can find the Collaborative's quarterly reports at www.pamedsoc.org/CCC.
- **Explore Options for Making the HOD Virtual** – A task force will be created to explore the incremental virtualization of the HOD as a means to increase member participation and engagement.

Thank You to This Year's HOD Delegates and Attendees! PAMED thanks the physician and medical student leaders who attended this year's House of Delegates.

We will soon share final versions of the 2018 resolutions adopted or recommended for study online, and we will provide monthly updates on progress concerning each resolution. We will also continue to share updates via the website at www.pamedsoc.org, the Doseweekly email newsletter, social media, and other communications channels.



LEGISLATIVE —UPDATES—

Stay up to date on PAMED's legislative priorities at www.pamedsoc.org/Advocacy.

INTRODUCTION

The Pennsylvania General Assembly concluded its regular session, passing more than 80 pieces of legislation in the final days of the two-year session. In total, 3,953 bills were introduced and considered by the legislature in 2017 and 2018. Only 246 bills — approximately 6 percent — were passed and signed into law.

At last count, the Pennsylvania Medical Society (PAMED) staff actively tracked 259 bills that were introduced during the 2017-2018 session that affect physicians, from proposals that would directly impact the practice of medicine to those that more generally relate to the provision of health care in our state. Below is a review of what PAMED accomplished this session, what we hope to build on in the coming year, and a summary of some of the significant initiatives advanced this session.

LEGISLATION

PRACTICE ADVOCACY ISSUES – SCOPE OF PRACTICE

PAMED dedicated a substantial amount of time and resources this session to the successful defeat of legislation that would allow Certified Registered Nurse Practitioners (CRNPs) to practice independently of physicians in Pennsylvania without the safety net of a collaborative agreement. Legislation was introduced in both chambers — House Bill (HB) 100 in the House of Representatives and Senate Bill (SB) 25 in the Senate — to eliminate the current requirement for CRNPs to collaborate with physicians in order to diagnose, treat, and prescribe drugs to patients. In the end, neither HB 100 nor SB 25 were brought up for consideration in the House of Representatives this session.

Two bills — SB 895 and SB 896 — were introduced in the Senate that would have changed the patient record review process, the composition of the State Board of Medicine and State Board of Osteopathic Medicine, and the supervisory/written agreement between physician assistants and physicians. PAMED went on record to oppose both bills by relaying our position both verbally and in written form to key senators. Neither of the bills were brought up for a committee vote and did not see any action beyond introduction of the bills. PAMED also supported the Pennsylvania Association of Ophthalmology (PAO) in opposition of SB 668, which would have allowed optometrists to perform ocular surgery, treat systemic diseases, and order imaging tests. SB 668 saw passage in the Senate late in the legislative session but did not move in the House of Representatives.

Through our educational efforts and the advocacy of physicians who answered our call for grassroots action, all scope of practice bills were defeated. PAMED will continue to strongly oppose scope of practice expansion legislation and support the preservation of physician-led, team-based care for all patients in Pennsylvania. It is within the framework of education and clinical training that health care professionals are prepared to deliver safe, quality care. The rigorous education and supervised training physicians receive ensures that they are well-equipped to independently provide complex differential diagnosis, develop a treatment plan that addresses multiple organ systems, and order and interpret tests within the context of a patient's overall health condition.

PRACTICE ADVOCACY ISSUES

Credentialing and ASC Tax HB 125, introduced by Rep. Matt Baker and supported by PAMED, would have standardized the credentialing process for health care practitioners in the Commonwealth. All health insurers licensed to do business in the Commonwealth would be required to accept the CAQH credentialing application or other nationally recognized form designated by the Pennsylvania Insurance Department. The bill would have required health insurers to issue a credentialing determination within 45 days after receiving a complete credentialing application. While HB 125 passed the House of Representatives (190-0), it did not get out of committee in the Senate.

Originally included in the Governor's budget was a three percent tax on Ambulatory Surgery Center (ASC) Net Patient Revenue. PAMED supported several specialty societies and their efforts to oppose the assessment. The tax was not included in the final state budget.

PUBLIC HEALTH ADVOCACY ISSUES – OPIOIDS

While dozens of bills were introduced this session to address the opioid epidemic and heroin abuse facing the state, a handful of bills were identified as priorities by both the Governor and legislative leaders and ultimately received action before the end of the year. Thanks to the strong lobbying efforts of PAMED's government relations team, we were successful in adding several exceptions to HB 353, which sought an e-prescribing mandate for Schedule II-V controlled substances. Emergency situations, temporary technological malfunctions, lack of access to the Internet/EHR system, and direct administration by a physician were listed as exceptions.

Act 96 was signed by the Governor on Oct. 4, 2018. Any

physician, pharmacy, or health care facility that does not meet one of the exceptions in Act 96 but is unable to timely comply with the electronic prescribing requirements may petition the Department of Health for an exemption from the requirements based upon economic hardship, technical limitations, or exceptional circumstances. The Department is required to adopt rules establishing the form and specific information that must be included in a request for an exemption. The exemption may not exceed one year from the date of approval but may be renewed annually upon request and approval. The Department, in its discretion, may establish additional exemptions through the regulatory process.

Act 96 does not take effect until Oct. 24, 2019. As the law just was enacted on Oct. 24, 2018, the Department has not released its rules establishing the form and specific information that must be included in a request for an exemption. Once the Department does so, PAMED will provide this information to its members. Members can also access PAMED's informational Quick Consult at www.pamedsoc.org/QuickConsult. It is recommended that physicians not wait until next fall to begin preparing for this e-prescribing requirement. Physicians who may be seeking a hardship exemption are encouraged to continue to plan for the e-prescribing requirement, as that requirement must be implemented unless an exception applies, or the Department grants a hardship exemption.

Another bill, SB 655, would have created an Advisory Council within the Department of Health that could have mandated that physicians follow guidelines, such as the current voluntary guidelines, when prescribing opioids. PAMED opposes legislation that would force physicians to practice "cookie-cutter" medicine. PAMED was at the Capitol in Harrisburg on Sept. 25, 2018, visiting the offices of House Health Committee members to talk about why cookie-cutter approaches don't work well in medicine. It was a chance to deliver our message in a unique way – with sugar cookies and caduceus cookie cutters. We urged House members to oppose SB 655 and instead focus on a more immediate need in this crisis: increasing funding and access for those who need treatment for an opioid use disorder. This legislation was passed unanimously in the Senate but was never voted on in the House of Representatives. Of particular concern was HB 1987, which would have limited the use of fentanyl to surgery within a health care facility or to a hospice patient. PAMED and The Hospital and Healthsystem Association of Pennsylvania (HAP) wrote a joint opposition letter expressing concern over appropriate use of the drug in clinical settings and preventing patients from receiving appropriate care.

Through our concerted lobbying efforts, HB 1987 was successfully amended to include "chronic pain not associated with cancer" and therefore, our position moved to neutral. It is also important to note that HB 1987 was voted on favorably within the House of Representatives, but it saw no action within the Senate Health and Human Services Committee or on the Senate floor.

Thanks to strong lobbying efforts, PAMED was able to advocate for bills that do not infringe on physicians' ability to address the individual needs of their patients. PAMED worked closely with legislative leaders and staff to ensure that what ultimately was signed into law was clinically sound and in the best interest of patient care.

PUBLIC HEALTH ADVOCACY ISSUES – LYME DISEASE AND SUNSCREEN IN SCHOOLS

HB 174, introduced by Rep. Matt Baker, would have required insurance coverage for Lyme disease and related tick-borne diseases as prescribed by a patient's health care practitioner, regardless of if the treatment plan includes short-term or long-term antibiotic treatment. Similar legislation was introduced in the Senate (SB 100) by Sen. Stewart Greenleaf. Both bills never made it out of the Senate Banking and Insurance Committee.

HB 2301, introduced by Rep. Rosemary Brown, would have established that a licensing board require a licensee complete at least two hours of continuing education in the assessment, diagnosis, and treatment options for Lyme disease and other related tick-borne diseases as a portion of the total continuing education required for license renewal. The bill was introduced in April 2018 and saw no movement in the House or Senate.

The issue of Lyme disease continues to evolve in the state legislature as lawmakers try to respond to constituent concerns about treatment protocols for treating the disease and for insurance coverage. PAMED expects to see additional legislation introduced related to Lyme and other tick-borne diseases in the next session.

PAMED supported the Pennsylvania Academy of Dermatology regarding legislation (HB 1228) that allows school students to have sunscreen at school in order to apply and reapply as needed for recess, field trips, sporting events, and other extracurricular activities. The governor signed Act 105 into law on Oct. 24, 2018, and the earliest effective date is Dec. 23, 2018.

Physicians help build healthy communities in every corner of Pennsylvania. Combining legislative advocacy efforts with PAMED's "Building Healthy Communities" – a project that provides an outlet for physician members to educate the public on relevant public health topics – we believe that PAMED is a commonsense resource for lawmakers as they work to address public health issues. Learn more about "Building Healthy Communities" at www.pamedsoc.org/HealthyCommunities.

PATIENT ADVOCACY ISSUES – TELEMEDICINE, POLST, AND PATIENT TEST RESULTS

Two bills – SB 780 and HB 1648 – would have established a statutory definition for telemedicine, mandated that telemedicine services be reimbursed, and prohibited "audio only" services (video available if requested by the patient or provider). This legislation had the potential to bring health care to the most vulnerable populations such as those who reside in remote areas of the commonwealth, urban communities that lack reliable or affordable transportation, and for patients with significant mobility challenges that present a barrier to in-person consultations with physicians. PAMED strongly believed that passage of SB 780 would help improve access to care across the state. In June 2018, SB 780 was favorably voted on in the Senate and passed 49-0. Coming right off the heels of the Senate vote, retiring House Professional Licensure Committee Chairman, Rep. Mark Mustio, toured facilities over the summer to witness telemedicine technology firsthand. A public hearing was held on Sept. 12, 2018. Momentum for this critical legislation looked positive. However, 26 amendments were added to the bill in September and October and they ultimately slowed the legislation to a grinding halt.

While this bill was not signed into law, it did pass a chamber for the first time since introduction.

The Pennsylvania Senate passed legislation 47-1 that would have created a legal framework for Pennsylvania Orders for Life Sustaining Treatment (POLST) directives and ensured that a patient's wishes for end-of-life care followed the patient across health care settings. PAMED strongly supported SB 623 and is part of a multi-year, collaborative effort of nearly 30 health care and patient advocacy organizations, with the goal of easing the difficult clinical decisions patients and their family members encounter when end-of-life circumstances present themselves. While this bill did not make it through the House of Representatives, it did pass a chamber for the first time since its initial introduction more than five years ago.

HB 1884, introduced by Rep. Marguerite Quinn, requires an entity performing a diagnostic imaging service, in addition to sending the results to the ordering physician, to directly notify the patient or the patient's designee that the results of the test were sent to the ordering physician when there is a significant abnormality and that follow-up with the ordering physician is recommended. Act 112 was signed into law by the governor on Oct. 24, 2018. PAMED is reaching out to the Department of Health to seek clarification on several issues, including the requirements of Act 112, who is subject to Act 112, and how the Department will be implementing the law.

Act 112 takes effect on Dec. 23, 2018. PAMED will provide updates to its members as we obtain them from the Department. In the interim, it is recommended for physicians and facilities to start discussions on developing policies on implementing Act 112 and to speak to their in-house legal counsel, malpractice carrier, or other applicable legal counsel for further guidance. Members can also access PAMED's informational Quick Consult at www.pamedsoc.org/QuickConsult.

At PAMED, we believe that while business outcomes are important, patient outcomes are more paramount. As we look toward the 2019-2020 legislative session, we will continue to shine a light on patients and give them the tools they need to ease health care related burdens while also safeguarding against administrative red tape for physicians.

PAMPAC UPDATE

PAMPAC is the political arm and the muscle of PAMED. One of the largest bipartisan political action committees in the state, it is made up of members of PAMED and its Alliance who are interested in making a positive contribution to the medical profession through the political process. PAMPAC supports pro-medicine candidates, as well as provides interested members with advice on organizing local fundraising events for legislative candidates and advises members interested in seeking public office. If you're not a current PAMPAC member, learn more and join 500+ of your colleagues in adding your voice at www.pampac.org.

POLITICAL MEET AND GREETS

Given the sheer volume of bills introduced each legislative session, it should come as no surprise that lawmakers often find themselves unable to digest the details of each proposal. While PAMED, through its legislative staff, works to inform and educate policymakers, when a local physician reaches out to their representative or senator, the result is even more effective. Personal relationships between legislators and their physician constituents is the ideal of legislative advocacy. Political campaign meet and greets are often the first chance that physician constituents have to meet a candidate for office or an already elected lawmaker. Meet and greets offer the opportunity for physicians to establish a relationship with their local lawmakers that allows them to educate lawmakers on important health care issues. During the last few months of the election cycle, a total of four meet and greets were hosted and 100 physicians attended.

FUNDRAISERS

PAMPAC supports pro-medicine candidates running for the Pennsylvania state legislature or statewide office. During the 2017-2018 legislative session, PAMPAC hosted three fundraisers, engaging 100 physicians and raising $17,500 in order to make the physician voice stronger in the legislature.

DISTRICT VISITS

As we all know, relationships are not built by people who talk at one another. Relationships of any substance are built on a foundation of trust. The PAMED Government Relations team works diligently to build trust with lawmakers when representing Pennsylvania physicians. In the last few months of the legislative session, PAMED's Government Relations team met with 11 lawmakers and their staff in their districts to advance PAMED's legislative priorities and advocacy topics. This, of course, was in addition to the countless informal discussions in the halls and offices of the Capitol on session days.

PAMPAC FUNDS

PAMPAC uses member contributions to support the election and retention of pro-medicine candidates. PAMPAC also campaigns against vulnerable incumbent legislators who consistently vote against the interests of patients and physicians. Through PAMPAC, members have a highly visible impact on the election process and help shape the future of reforms such as medical liability, patients' rights legislation, and insurance contract reform.

A LOOK AHEAD

The 201st regular session of the General Assembly convenes on the first Tuesday in January 2019, when House and Senate members are sworn in for two- and four-year terms, respectively. Selection of committee chairs, several of which are of significant importance to PAMED, will be announced after legislators are officially sworn in in early January.

As we look ahead to the 2019-2020 session, we have a lot of work to do to protect and advance the practice of medicine in Pennsylvania. Crucial to PAMED's success, however, is sustained physician involvement. When individual physicians speak up and make their voice heard, organized medicine is strongest.

To become a PAMPAC member, visit www.pampac.org.

To learn more about PAMED's 2018 advocacy priorities, visit www.pamedsoc.org/advocacy.

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MEDICAL SCHOOL SCHOLARSHIP

Congratulations to Mary Chen and Adjoa Mante for being awarded the 2018 MCMS William W. Lander, MD, Medical Student Scholarship! They will be honored at the Annual Dinner on June 3, 2019.

IN REMEMBRANCE

The Bucks County Medical Society extends its deepest sympathies to the family and friends of Erk A. Ketels, MD, who passed away on November 6, 2018. Dr. Ketels completed medical school at the University of Heidelberg, Germany and then completed his obstetrics and gynecology residency at Temple University before settling in to Levittown, PA to practice. He was a 57-year member of the Bucks County Medical Society.

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