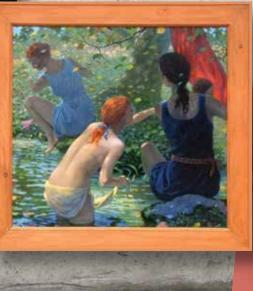




BY MIAN A. JAN, MD, FACC, FSCAI
PRESIDENT OF CHESTER COUNTY MEDICAL SOCIETY





# HEPATITIS A: A NEW OUTBREAK

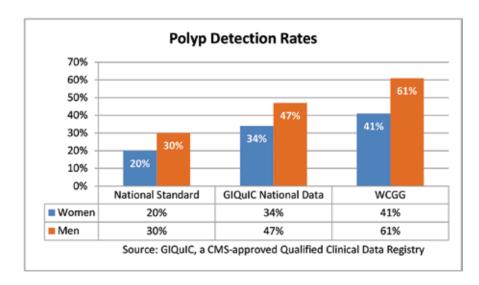
Reducing Barriers in Accessing Maternal and Child Healthcare

# What is a Quality Colonoscopy?

Not all colonoscopies are alike! Studies show a marked difference in colorectal cancer (CRC) risk reduction between facilities and physicians

What are the most important factors for a high quality colonoscopy? \*ASGE guidelines

- Cecal intubation rate with photo documentation, i.e. How often do we make it to the end?
  - o Benchmark: >90%
  - West Chester Gastrointestinal Group (WCGG): 99%
- Proper use of recommended intervals between colonoscopies performed for average-risk patients and for colon polyp surveillance.
  - WCGG has a robust, blinded, quarterly evaluation of representative pathology for each physician to ensure proper surveillance. Our CMS QualityNet Data shows compliance in excess of 98%.
- Adenoma Detection Rate or ADR, the most important measure of a quality colonoscopy (i.e. how often do we detect a pre-cancerous polyp in the colon and remove it?)
  - o Benchmark by ASGE/AGA: ADR target of 30% is recommended for men and 20% for women.

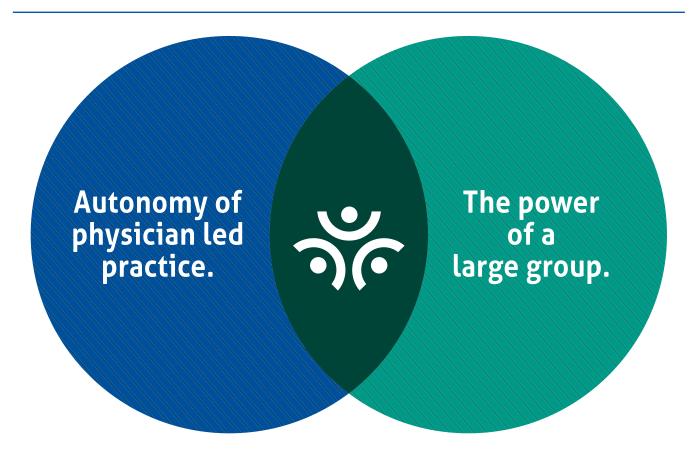


For every 1% increase in ADR, there was a 3% reduction in CRC incidence and 5% reduction in cancer mortality. Higher ADRs were associated with lower risk of cancer in both men and women.

Corley, D et al, Adenoma Detection Rate and Risk of Colorectal Cancer and Death, NEJM, 2014; 370:1298-306.



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**Letters to the Editor:** If you would like to respond to an item you read in *Chester County Medicine*, or suggest additional content, please submit a message to <a href="mailto:chescomedsoc@comcast.net">chescomedsoc@comcast.net</a> with "Letter to the Editor" as the subject. Your message will be read and considered by the editor, and may appear in a future issue of the magazine.

Cover: Artwork by Ralph Bienert, featured page 20 The Art of Chester County.



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# PRESIDENT'S MESSAGE

BY MIAN A. JAN, MD, FACC, FSCAI PRESIDENT OF CHESTER COUNTY MEDICAL SOCIETY

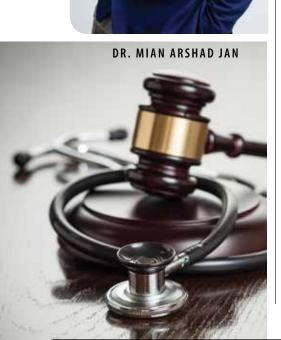
**MALPRACTICE CRISIS REDUX** 

remember 2002 like it was yesterday when the biggest crisis facing physicians was getting and affording malpractice insurance. The rising cost of malpractice in high risk specialties made it so that many doctors could not get insurance and were leaving the state to go to more reasonable parts of the country. Even Lloyds of London was reluctant to insure Pennsylvania's physicians.

In response to that crisis, which was affecting the Healthcare in Pennsylvania, ACT 13 was passed by the Pennsylvania legislature. ACT 13 lead to several reforms, most notably being the creation of the MCARE Fund. This spread the cost of high-risk coverage among a pool of physicians. Other parts of ACT 13 included strengthening the Certificate of Merit required for lawyers seeking to file malpractice suits against physicians, as well as penalties for attorneys who were found to be filing in frivolous cases. Lastly, the bill mandated the creation of patient safety protocols and for an increase in event reporting.

In addition, ACT 127, initially passed in 2002, limited the filing of the venue against a physician to be in the jurisdiction where the action occurred. This was subsequently invalidated by the Pennsylvania Supreme Court. The court issued a procedural rule imposing restrictions on "venue shopping" which remains in place today. By dealing with the situation in this manner the Supreme Court kept the venue issue under the realm of "process law" as opposed to "substantive law" which would require legislation to change.

Currently, the Standing Rules Committee, which advises the state Supreme Court, is now proposing a reversion of the venue regulation to their previous iteration on the grounds that there is no longer a malpractice crisis in Pennsylvania. True, the number of lawsuits and verdicts has become more rational and reasonable, however, Pennsylvania is still one of the highest as far as malpractice cost is concerned and returning to the



days of "venue shopping" will bring those days back. The change in ruling is being made under the pretense that ACT 127 is unconstitutional.

This committee is comprised of twenty lawyers who will make recommendations to the Supreme Court. The court can then choose to enact or ignore said recommendations. Karla M. Shultz is the counsel for the civil Procedural Rules Committee of the Supreme Court of Pennsylvania. She is an honorable person, but needs physicians' input to understand the disaster this reversion to the previous status will result in. All the correspondence sent will also reviewed by the honorable judges of the Pennsylvania Supreme Court.

Our hope is after a deep assessment of the rule the committee will be convinced that a return to those dark days in which a patient could not find a doctor because of the malpractice crisis would be against the wishes of the citizens of Pennsylvania. In the case that a change is made, the hope is that the honorable

members of the Supreme Court will reject that change. We as physicians must be engaged in this process and convey our concerns, not only to the committee members, but also to the Honorable counsel woman Schultz and the members of the Supreme Court.

For more information on this important matter all Pennsylvania physicians are strongly encouraged to take immediate action! The PAMED has developed an on-line method for you to document your concerns. Please go to www.pamedsoc.org and click on "Protect PA Healthcare Now."

Call our Chester County Medical Society staff for more details at (610) 892-7750. ■

Mian A. Jan, M.D., is a practicing Cardiologist and President of Chester County Medical Society. Contact Dr. Jan at 610-827-1543.





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# CURRENT ADVANCES IN CARDIOVASCULAR CARE 2019

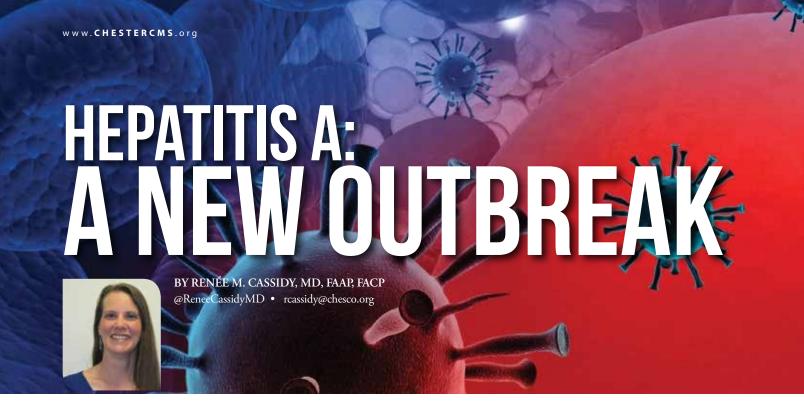
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ou are likely familiar with several prominent hepatitis A outbreaks which made the news in years past: an outbreak affiliated with green onions at a restaurant, or the ones linked to pomegranate seeds or strawberries imported from abroad. Transmission of hepatitis A by contaminated food or water remains a risk, but in recent years we have seen an increase in hepatitis A among people experiencing homelessness, men who have sex with men, and people who use drugs. Since March 2017, the Centers for Disease Control and Prevention (CDC) has assisted health departments in several states with person-to-person outbreaks of hepatitis A. Nearby states including Ohio, Kentucky, and West Virginia have seen a dramatic increase in cases, with a majority of cases in the vulnerable populations mentioned above. Ohio reported 1,370 cases in the current outbreak (as of 1/7/19), Kentucky reported 3,265 (as of 12/15/18) and West Virginia reported 2,214 (as of 1/11/19). Given the similarity of these states to Pennsylvania (especially with respect to opioid use), the Commonwealth has issued a health alert for help in identifying and preventing infections. While Pennsylvania has thus far reported only 102 cases (as of 1/11/19), this is nearly double the average annual number of cases from 2012-2016, and is expected to rise.

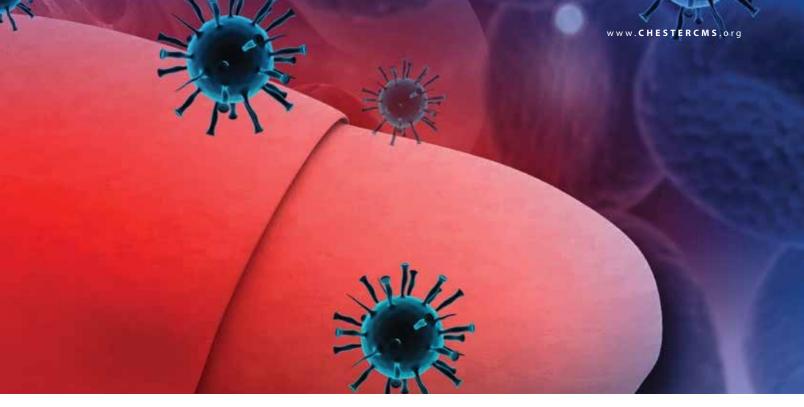
# **Hepatitis A Basics**

Hepatitis A is caused by the hepatitis A virus (HAV), a single-stranded RNA virus in the picornavirus family. Usually, HAV causes a self-limited infection that provides lifelong immunity. Rarely, fulminant liver failure may occur, but no chronic form exists. Humans are the only known reservoir, and people are affected around the world. The disease may be sporadic or epidemic, with incidence declining since the development of a vaccine in 1992. HAV is spread through the fecal-oral route, thus good sanitation and hygiene practices aid in the prevention of

HAV. Worldwide, there are an estimated 1.4 million infections per year. In the US, the vaccine was recommended by the Advisory Committee on Immunization Practices (ACIP) for those at increased risk in 1996, for children in high incidence states in 1999, and for all children in 2006. Thus, we have seen a dramatic decline in incidence. Prior to the introduction of the vaccine there were 12 cases per 100,000 population in the US (1995); by 2015, there were 0.4 cases/100,000. HAV is spread from person to person through ingesting contaminated food or water, or close personal contact with an infected person. Transmission through sexual contact, in hospitals, through blood, and by any drug use - not just injection - has been reported, but maternal-fetal transmission has not been documented. Because the virus can be shed in stool starting about 1 week before symptom onset, and because the incubation period is 15 to 50 days, in many outbreaks HAV has spread before the index case is even identified.

### **Clinical Considerations**

Signs and symptoms depend largely on age. In children younger than 6 years, up to 70% may have asymptomatic or unrecognized infection. Symptoms may be nonspecific, such as fever, malaise, poor appetite, abdominal pain, nausea, vomiting, and diarrhea. In the small number of young children with jaundice (yellowing of the skin and eyes due to bilirubin), laboratory abnormalities like conjugated hyperbilirubinemia and elevated transaminases generally begin around 1 week after symptom onset and resolve in 2-3 months, and jaundice itself is usually present for 2 weeks or less. In contrast, 70% of older children and adults develop signs and symptoms, including fever, nausea, vomiting, bilirubinuria (dark urine), acholic stools (pale stools), jaundice (40 to 70%), and liver enlargement (80%). Less commonly, adults and older children may develop rashes, joint pain, hematologic abnormalities, vasculitis, and other extrahepatic findings. The vast



majority (85%) recover completely in 2-3 months, with resolution in nearly all the rest by 6 months. Only a small number of people (less than 1%) develop fulminant liver failure, usually in those age 50 years or older or with underlying liver disease. Both here and around the world, as fewer children are getting hepatitis A infections, cases are becoming more severe. Up to 10 per cent of people may have relapse (or relapses) within 6-12 months, but once again, the vast majority have a complete recovery and no one develops a chronic infection. HAV infection can be diagnosed with serum IgM anti-HAV antibodies. Treatment is supportive, as infection is usually self-limited.

## **Prevention**

Basic sanitation prevents HAV transmission in the US, and avoidance of tap water and raw foods where sanitation is inadequate helps prevent HAV while traveling. Handwashing, particularly after toileting/changing diapers and before food handling, is also effective. Certain disinfecting solutions (for hands or surfaces) may kill HAV but not all; check product information for specifics. The best prevention is vaccination. A 2-dose series is now recommended for all children starting at age 12 months, with the second dose 6 months after the first. Catch-up vaccination is recommended for anyone who has not completed a 2-dose series. Priority populations with a recommendation for vaccination are:

- people experiencing homelessness,
- people who use drugs (injection OR non-injection),
- men who have sex with men, and
- close contacts of those with hepatitis A.

In addition, all individuals at risk for hepatitis A are recommended to get vaccinated including:

• Persons traveling to, or working in, countries with high or

intermediate rates of hepatitis A. The CDC Travelers' Health website provides specific guidance on these areas,

- Persons who have occupational risk for infection,
- Persons who have chronic liver disease,
- Persons who have clotting-factor disorders,
- Household members and other close personal contacts of adopted children newly arriving from countries with high or intermediate rates of hepatitis A, and
- Persons with direct contact with persons who have hepatitis A.

Although the 2-dose series provides optimal protection, studies have shown high proportions of people become seropositive at only 2 weeks following the initial dose, and protection may last as long as 10 years. Therefore, providing one dose of the vaccine is worthwhile, even in individuals who may not return for a second dose. Post-exposure prophylaxis (PEP) is effective because of the long incubation period of hepatitis A. Eligible individuals who have not completed the 2-dose vaccination series should receive PEP within 2 weeks of exposure to hepatitis A. These include household and sexual contacts of someone with laboratoryconfirmed hepatitis A; those who have shared injection drugs; and caretakers not using personal protective equipment. PEP depends on age and health status. For healthy individuals ages 1 year to 40 years, a dose of hepatitis A vaccine should be given as soon as possible, within 2 weeks of exposure. For those over age 40 years, vaccine should be given and immune globulin should be considered, since they are at higher risk for serious disease. Similarly, those age 1 year and older with immunosuppression and those with chronic liver disease should receive both the vaccine and the immune globulin. Finally, infants under 12 months and those who cannot receive vaccine should receive immune globulin alone. Anyone receiving a single dose of vaccine as part of PEP should receive a second dose 6 months after the first for long term protection, but 2 doses is not essential to PEP.

continued on next page >



# What now?

Anyone in health care should be alert for possible hepatitis A infection among at-risk individuals with characteristic signs and symptoms, and perform laboratory testing to confirm the diagnosis. If possible, consider holding serum for further studies (such as confirmation of antibody test, HAV RNA test, genotyping, and sequencing) which might aid public health officials in identifying and controlling an outbreak. Make sure cases are reported to Chester County Health Department (CCHD) or your local health department. CCHD will be partnering with groups in Chester County to offer vaccination to priority groups, but be sure to seek out at-risk patients in your practice and encourage vaccination. For more information, call CCHD at 610-344-6225 or visit https://www.chesco.org/224/Health.

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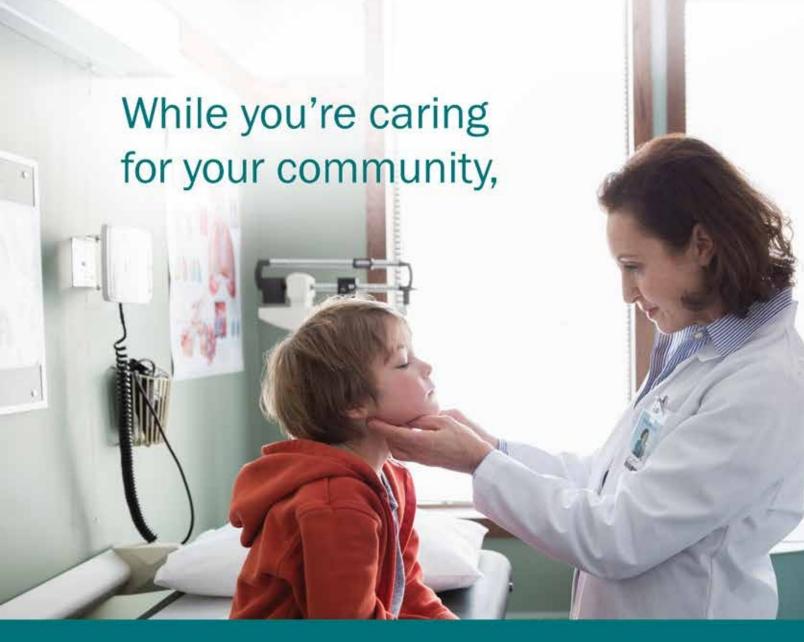
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# Put the Brakes on the CVS and Aetna Merger to Sustain Competition and Choice

BY DRS KEN FISHER AND MARION MASS



ne person stands between the American public and further increases in health-care costs and further decline of care: U.S. District Judge Richard Leon. He is single-handedly questioning the government-approved \$70 billion merger between CVS and the health insurer Aetna over public interest concerns. A court hearing is scheduled for today, where Judge Leon may demand the companies halt integration while he reviews the antitrust issues. CVS and Aetna have argued that the vertical integration of their businesses would lead to better and more efficient care for consumers.

While Americans have radically different views on how to bring down skyrocketing health-care costs, there seems to be a bipartisan consensus that increased consolidation among remaining health care behemoths is not the answer.

Both the Trump administration's Health and Human Services and the left-leaning Center for American Progress have recently issued reports making the case for choice and competition rather than consolidation in the health care space. For good reason. Oligopolies reduce competition and raise prices. Studies have found that vertical integration is associated with higher prices. In California, for instance, hospital-owned physician practices have higher per-patient spending than physician-owned ones.

How would an Aetna-CVS merger increase costs? Both CVS and Aetna have been forthright in stating that their intended purpose is to expand on CVS Minute Clinics as their model for improving access to care. The 22 million Aetna enrollees could be financially led to use these clinics for their primary care needs.

This approach is penny-wise and pound foolish. This new captive audience will likely be required to use CVS pharmacies for their prescription and non-prescription needs, giving one of the biggest retailers in the country significant pricing power. Patients will lose the ability to shop around for a lower price.

In addition to more pricing power, Minute Clinics, staffed by mid-level professionals, not doctors, tend to over-prescribe and over-refer to specialists, driving up system costs. According to a Centers for Disease Control study released this year, nearly half of people who visit walk-in clinics with cold or flu symptoms walk out with an antibiotic, despite clear guidelines that antibiotics are useless for treating such viruses.

Minute Clinics are cheaper for a reason, namely they eschew committed doctors for roving health professionals. They disrupt the doctor-patient relationship that has long been proven to improve health outcomes, especially in cases of chronic illness which account for 86 percent of health-care costs in the U.S. A meta-analysis published this year in BMJ found a marked link between continuity of care and lower death rates. The trust, caring competence associated with this relationship leads to better health outcomes.

One other merger consequence patients would likely face is fewer prescription drug options. That's because CVS, through its Caremark subsidiary, is a pharmacy benefit manager, which control the formulary of prescription drugs while receiving legalized kickbacks from drug manufacturers. Its leverage over manufacturers and drug choices will increase significantly with its massive new insurance customer base. As a result, CVS Caremark will be incentivized to provide those drugs that make a profit for its insured patients. Previously, Caremark had to respond (at least partially) to the market demands of the third party health insurers it was serving.

The corporate conflict of interests and increased control generated among pharmacy, insurer, benefit manager and, pharmaceutical manufacturers will leave patients with a bigger bill and erosion of trust in care.

What's a primary care alternative that overcomes these conflicts of interest and maintains trust? There's a growing competing health-care model known as Direct Primary Care, which allows patients to see their personal doctor and have all their primary needs covered without insurance for a fixed monthly rate of around \$100, providing rapid access, while receiving prescriptions at cheaper, wholesale prices. Paired with an inexpensive catastrophic insurance plan, this is a better health-care model to lower costs and improve patient outcomes.

In contrast, the CVS-Aetna merger would consolidate the insurance, pharmacy benefit manager, pharmacy, Minute Clinic brick and mortar CVS stores, threatening to destroy an already eroding primary care system and fraying doctor-patient relationships.

At the moment, Judge Leon is the only one standing in the way of this future that threatens the public interest. But if the public can be educated on the merger consequences while he does, there's still time to block it.

Dr. Ken Fisher is a nephrologist and author of "Understanding Healthcare: A Historical Perspective." He is an advisory board member of Practicing Physicians of America. Dr. Marion Mass is a pediatrician. She is the co-founder and vice president of Practicing Physicians of America. The views expressed by contributors are their own and not the medical society's.

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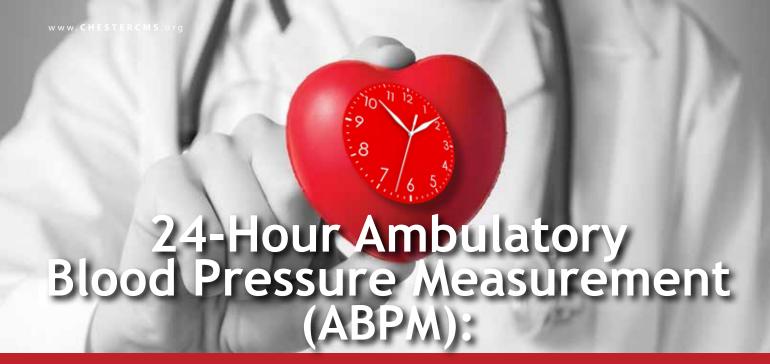
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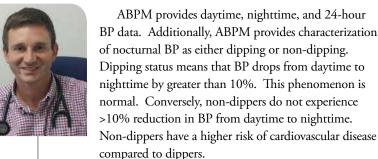
# A Transformative Approach to Blood Pressure Diagnosis and Treatment

BY MICHAEL LATTANZIO, DO

24-hour Ambulatory Blood Pressure Monitoring or ABPM is a valuable tool for the management of the patient with hypertension (HTN). For the ABPM test, the patient is fitted with a specialized, blood pressure measuring device that records the blood pressure over a full 24-hour period. The BP measuring intervals are every 20 minutes during the daytime and every 40 minutes during the night. The BP data is recorded and plotted against time. The data is analyzed by a trained specialist and interpretations can be used to guide BP treatment strategies.

ABPM is the gold standard for detecting hypertension and/or confirming hypertension. Since blood pressure is a highly variable target, physicians are often forced to make decisions to initiate anti-hypertensive therapies based on incomplete and sometimes, contradictory BP data. ABPM allows physicians to confidently confirm, or, alternatively, exclude the diagnosis of hypertension. It also provides useful data on the efficacy of anti-hypertensive treatments for the individuals with existing HTN.

ABPM is the gold standard for excluding white coat HTN (elevated BP in the office, but normal BP out-of-the office). ABPM is also excellent at detecting masked HTN (normal office BP, but elevated out-of-the office BP). Masked HTN (essentially the inverse of white coat HTN) carries a significant risk of CV disease and should be considered in individuals with signs of end organ damage (LVH, proteinuria, CKD) who DO NOT have elevated BP in the office.



Due to ABPM, new categories of hypertension came into existence that were previously not identifiable. For instance, isolated nocturnal HTN occurs when individuals have normal daytime BP, but have elevation of BP at night. Isolated nocturnal HTN carries a similar risk of CV disease to sustained HTN. ABPM has led to the concept of chronotherapy, which is adjusting the timing of BP medication dosing based on an individual's circadian pattern of blood pressure.

The US Preventative Services Task Force (USPSTF) now considers ABPM as the reference standard for confirming the diagnosis of HTN. Unfortunately, ABPM remains an underutilized tool in the management of HTN. Establishing the blood pressure phenotype through ABPM aids in determining long-term CV risk, treatment success, and response to therapy. Blood pressure management through analysis of diurnal blood pressure patterns is a transformative approach. If you are interested in scheduling or referring patients for ABPM, please contact my office at (610) 524-3703.

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# **Funding Options for Long-Term Care**

**Self-pay** | Self-pay may be the most obvious choice, but it's not cheap and may not be affordable for longer-term needs. With prices ranging from \$21 per hour for homemaker services and home health aides, to day rates of \$123 in assisted living facilities, to more than \$7000 per month for semi-private nursing home care, self-pay may not be the most appealing option.

**Government benefits** | Despite what many think, Medicare will pay for long-term care. While Medicare covers some home and nursing home care, it is truly for rehabilitation purposes and, therefore, not categorized as long-term coverage.

**Traditional long-term care insurance** | Traditional long-term care (LTC) insurance has been in existence for decades. It is not as cost-effective as originally thought due to its many limitations. It's typically written to cover specific, and potential, long-term care needs, however, unless it's broadly written, it may not provide any benefits should you ever need long-term care.

Combined life insurance with long-term care benefits | A strategic approach being utilized with larger frequency is a combined life insurance policy with long-term care benefits. These may have similar features to an LTC (e.g., inflation protection, varying elimination periods, and more), but would provide a tax-free death benefit to beneficiaries should the policy holder pass away prematurely.

## Combined annuity with long-term care benefits

Similar to option 4, a combined annuity/long-term care policy might provide a higher dollar amount or greater flexibility surrounding the tax-free death benefit.

Life settlement | Regardless of whether you own a term or permanent life insurance policy, you may be able to convert it into a long-term care benefit. The value of your current life insurance policy could be used as leverage to secure long-term care by assigning beneficiary rights depending upon your individual situation. It is suggested that you contact a competent financial adviser well-versed in long-term care to help you navigate through the many choices to funding long-term care.

# How Much Do You Asking the important questions...

By: Joseph Leary, CFA®, MBA, CFP®, CPA, and Jeremiah Sensenig, financial advisors with MassMutual Greater Philadelphia.



The need for long-term care can happen to anyone... at any time. It could be you, your spouse or partner, a parent, or even a sibling. The need for long-term care may result from being chronically ill, from a severe cognitive impairment or something as unexpected as an accident or injury.

# What is long-term care?

Long-term care is a variety of services and supports to help meet personal care needs over an extended period of time. Long-term care commonly involves non-skilled personal care assistance, such as help performing everyday Activities of Daily Living (ADLs), which are: bathing, dressing, using the toilet, transferring (to or from bed or chair), caring for incontinence and eating. Long-term care services may help you maximize your independence and functioning at a time when you are unable to be fully independent.

# Where is long-term care provided?

Long-term care may take place at home or in assisted living facilities and it can also be provided in a community setting, in a nursing home or through hospice services. You may initially receive assistance at home or in community-based settings before moving into more intensive care settings.

# **Know About Long-Term Care?**

# Can my family take care of me?

A need for long-term care may have a substantial impact on your relationships with family or friends. Sacrifices may be made to provide for your care. Family or friends may have to give up free time, spend less time with their family, and take on the stress and physical strain of becoming your caregiver. In addition, those caregivers may need to take time off work or cut back on their work schedule, adding financial strain. In the past, children took care of their aging parents. Today, adult children may live at a distance from their families and work full-time. Whether you need care, or find yourself in the position of caregiver, long-term care impacts your whole family.

# How much do long-term care services cost?

Long-term care services may be very expensive. The national median cost for a home health aide is \$20.50 an hour. With home care, you also have ordinary home and living expenses. The national annual median cost for a private room in a nursing home is \$97,445 and can be almost double in some areas of the country.<sup>1</sup>

# **LONG-TERM CARE COSTS ON THE RISE Year National Median Nursing Home Costs**

2017 \$97,445

2040 \$240,174

2020 \$109,612 2025 \$133,360 2030 \$162,253 2035 \$197,406

# How will you pay for care?

You may begin paying for long-term care services on your own but find that your savings will only cover care for a limited amount of time. You may plan to rely on health insurance or government programs, like Medicare or Medicaid<sup>2</sup>. Long-term care typically isn't covered by traditional health insurance plans. Medicare generally provides for long-term care if it is part of a rehabilitative plan or skilled care. Medicaid only pays after you meet eligibility requirements, including significant restrictions on income and assets.



# Why should you consider whole and term life insurance, annuities and long-term care insurance to fund your long-term care needs?

Whole and term life insurance, annuities and long-term care insurance are three options to help you plan for the high cost of care. While you may also receive support from family or loved ones, one way to help ensure that you receive the type of care you want — in the setting you choose — is through individual long-term care planning. A comprehensive policy may help you by protecting your home, assets, retirement funds, and your estate from being used to pay for care. In turn, those funds may be used to maintain your spouse/ partner's standard of living, financial security, and peace of mind.

<sup>1</sup> Genworth 2017 Cost of Care Survey, conducted by CareScout®, June 2017. Based on 2017 national median annual costs for a private nursing home room with a 4% inflation rate assumption for subsequent years.

<sup>2</sup> For more information regarding benefits provided by Medicare or Medicaid, visit www.cms.hhs.gov. Medicaid guidelines vary by state. Contact your local Medicaid office for details.

Provided by Joseph Leary, CFA®, MBA, CFP®, CPA, and Jeremiah Sensenig, financial advisors with MassMutual Greater Philadelphia.

Joseph and Jeremiah are registered representatives of and offer securities, investment advisory and financial planning services through MML Investors Services, LLC. Member SIPC. Supervisory Office: 2 Bala Plaza, Ste 901, Bala Cynwyd, PA 19004. Tel: 610.766.3000

CRN202012-241043

# A Refresher on Business Associate Agreements

BY VASILIOS J. KALOGREDIS, ESQ., AND ANDREW STEIN, ESQ.



Vasilios J. Kalogredis, Esq.



Andrew Stein, Esq.

Due to their legal necessity, and resultant ubiquity, nearly all medical practitioners and practices have at least a general familiarity with the Business Associate Agreement ("BAA"). However, like with most ubiquitous things, sometimes it is worth taking a step back to remind ourselves of the what, when, and why. That is particularly true when the thing in question is a contract subject to numerous regulatory requirements. This articles aims to provide just such a refresher.

### The What.

Many may think of BAAs as nothing more than a standard form, like any other, to be quickly signed before getting on with the business of collaborating with a third party. The truth is that they represent a crucial tool defining the rights and obligations of the parties involved. They also represent an important line of defense in the protection of patients' protected health information ("PHI").

To determine more clearly what a BAA is, we turn to the regulations promulgated in connection with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). The regulations at 45 C.F.R. § 164.502(e)(1) discuss how and when a covered entity may disclose PHI to a business associate. To understand this requires the definition of both "covered entity" and "business associate." As to the former, "covered entity" is defined at 45 C.F.R. §160.103 as a health plan, a health care clearinghouse or "a health care provider who transmits any health information in electronic form in connection with a transaction covered by this subchapter." As most of you will know, a common example of a "transaction covered by this subchapter" is electronic billing for services rendered.

As to the latter, the definition of "business associate" at 45 C.F.R. § 160.103 essentially describes an individual or organization outside the workforce of the covered entity that "creates, receives, maintains, or transmits" PHI for purposes including "claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, . . . billing, benefit management, practice management, and repricing." The purposes also include the eight categories of patient safety activities listed at 42 C.F.R. § 3.20. The regulations at 45 C.F.R. § 160.103(4) describe what a business associate is not, which helps to more clearly define the limits of the definition. Note, also, that a covered entity may be a business associate of another covered entity. 45 C.F.R. § 160.103(2).

With the parties to a BAA defined, it is time to address the definition and requirements of the BAA itself. In the simplest sense, the BAA is a contract between a covered entity and a business associate (or between a business associate and its subcontractor) aimed at documenting assurances related to the business associate's handling of PHI. The

HIPAA regulations at 45 C.F.R. § 314 set forth the various requirements of a BAA. Included among them are requirements related to reporting security incidents, complying with the HIPAA regulations applicable to covered entities, and implementing administrative, physical, and technical safeguards.

While these requirements may seem overwhelming upon first glance at the regulations, covered entities and business associates need not start from scratch when preparing a BAA. The U.S. Department of Health & Human Services ("HHS") very helpfully published form BAA provisions on January 25, 2013. The date is worth mentioning because it means that the proposed provisions reflect the additional BAA requirements at 45 C.F.R. § 164.504(e) arising from the 2013 HITECH HIPAA Omnibus Rule (e.g., related to complying with the HIPAA Privacy and Security Rules, reporting breaches, and ensuring that business associates' subcontractors are subject to the same conditions and restrictions as are the business associates themselves). These form provisions are available on HHS's website. Simply type "Sample Business Associate Agreement Provisions" into the search box on www. HHS.gov and the link to the form provisions will be among the first three links listed.

## The When.

A BAA is required when a covered entity wishes to "permit a business associate to create, receive, maintain, or transmit" electronic PHI. Under applicable law, covered entities are held to a higher standard than business associates with regard to PHI protection (e.g., the Privacy Rule under HIPAA applies to covered entities). But the different standards do not change the fact that covered entities do not and cannot work alone. Covered entities often require the assistance of business associates and such assistance often involves the creation, receipt, maintenance, and/or transmission of PHI.

Recognizing this, 45 C.F.R. §164.308(b)(1) allows a covered entity to grant permission to a non-covered entity (i.e., a business associate) to "create, receive, maintain, or transmit" PHI on the covered entity's behalf. The next subsection, 45 C.F.R. §164.308(b)(2), grants that same right to business associates working with subcontracted business associates. Short of unreasonably and unnecessarily expanding the definition of covered entities to ensure all who handle PHI are held to the same standard, the BAA is a document that pulls the non-covered entity up nearer to the standard that the covered entity must meet. As discussed in the previous section, the BAA formalizes the administrative safeguards that address concerns about PHI. So, before engaging a business associate in connection with any work that involves creating, receiving, maintaining, or transmitting PHI, the covered entity and its business associate must sign a BAA.

# The Why.

Apart from the fact, mentioned above, that a BAA represents a useful way to define the rights and obligations of the covered entity and its business associate with regard to protecting patients' PHI, there are also the financial implications to consider. By way of a recent example, in December of 2018 a group in Florida called Advanced Care Hospitalists ("ACH") agreed to pay the Office of Civil Rights ("OCR") \$500,000 and to adopt a corrective action plan to settle potential claims that it violated HIPAA's Privacy and Security Rules by releasing PHI without a BAA in place.

ACH's business was contracting internal medicine physicians to hospitals and nursing homes in western central Florida. From November 2011 to June 2012, ACH utilized the services of an individual who held himself out to be a representative of a Florida company called Doctor's First Choice Billings, Inc. ("First Choice"). Though that individual provided ACH with medical billing services ostensibly through First Choice and its website, the individual allegedly did so without either the knowledge or the permission of First Choice's owner. On February 11, 2014 a local hospital informed ACH that PHI (including names, dates of birth, and social security numbers) were viewable on First Choice's website. After ACH was able to identify at least 400 affected individuals, it asked First Choice to remove the information from First Choice's website.

Two months after learning of the issue, ACH filed a breach notification report with the OCR indicating that at least 400 individuals were affected. ACH raised that number by 8,855 in a supplemental breach report. OCR Director Roger Severino said of the incident, "[t]his case is especially troubling because the practice allowed the names and social security numbers of thousands of its patients to be exposed on the internet after it failed to follow basic security requirements under HIPAA." While one may quibble with how basic the requirements are, the consequences of such a failure can be devastating to both patient privacy and practice solvency. It is for these reasons that we prepared this refresher. We hope that it proves useful to you.

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Lamb McErlane PC, a full service regional law firm based in West Chester, PA, has built a reputation on delivering the highest caliber of legal service in an environment focused on personal attention and results that clients deserve. www.lambmcerlane.com.

# The Art of Chester County A CHESTER COUNTY GEM RALPH BIENERT

BY MIAN A. JAN, MD, FACC, FSCAI

# Dr. Jan's Story

I first met Ralph Bienert in 2002 and I have been seeing him as a patient all these years. As often happens with me and my patients we develop a relationship and friendship that transcends patient/ doctor relationship, a trust and a sacred bond that only a patient and his doctor can fathom and feel.

One day I saw him sketching in my waiting room and I asked him if I can see the sketches for I at that time did not even know that Ralph made his living teaching art. Sketches reminded me of French post-impressionist Paul Gauguin's work especially toward the end of his life when he lived in French Polynesia.

I asked to look at his other work, what was astounding was how skillful he was not just at painting but many other artistic mediums including drawings, coins and medallic work and sculpting.

Chester County has produced some world renowned artists but what about lesser known gems like Ralph, what are we doing to help them and give them recognition they so richly deserve?

It's so sad as age and ravishes of time take away an artist's beautiful skills, they are forgotten and their great works are not appreciated.

I hope and pray we can put some system in place where not only are they recognized but their work is seen, enjoyed and appreciated by generations to come.

We at the Medical Society try to profile such artists in our journal as "Art of Chester County" and if someone is interested in being profiled, they can contact me (610) 344-7652.

# **Ralph Bienert**

My interest in the visual arts began when I was a child. I always remember the smell of my mother's watercolors when she opened a tube and put some paint on her white metal palette. Young though I was, I found myself transfixed by the timeless beauty of Edward McCartan's bronze female figure standing in the goldfish pond/fountain and Dupre's painting, "La Balloon," depicting French peasants gazing at a hot air balloon in the distant sky. I saw both of these during a family outing to the Reading Art Museum. I still return to the museum to admire them whenever I have a chance.

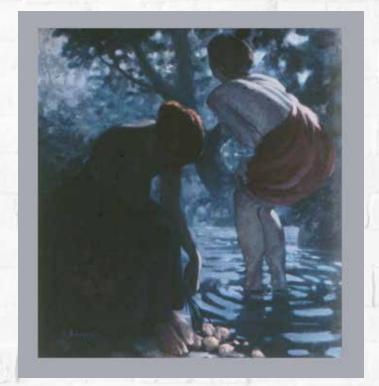
After graduating from high school, I went to Kutztown University and later to the Art Center College of Design, now in Pasadena, California. There, I studied painting and drawing with Lorser Feitleson and Harry Carmean. Around the time I graduated from Kutztown, I met a fellow art student, Bonnie Draper, in a studio. We were married a few months after our first date, a visit to the Russian Hermitage exhibit at the National Gallery in Washington, DC. Bonnie has had a profound influence on my life and art ever since. For six years, we both taught painting and drawing at numerous private schools. I also taught art history at Northampton Area Community College. Following that, I worked as a medallic sculptor for the Franklin Mint for 17 years. Then, I did freelance sculpting for many companies, including the Franklin Mint, the Danbury Mint, the Bradford Exchange, and the Tonner Doll Company. This resulted in some perks, including several Doll of the Year awards (Doty), presidential inaugural coins, and meeting an ambassador of the Egyptian government.



Mother and Infants Bathing in a Stream Composition #1 oil on canvas







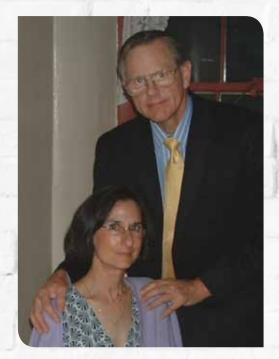
Composition silver oil on canvas



Cindy

continued on next page >

# The Art of Chester County: Ralph Bienert continued from page 21



Bonnie and Ralph Bienert



Cleopatra Copper test for Egypt

My wife and I always wanted to devote more time to painting, but freelance sculpting provided a dependable income as Bonnie and I raised our family. Things did not change for years until I became a patient of Dr. Jan. From time to time, he saw me working on sketches for paintings when I was in the waiting room. He told me that if I ever finished any painting, he would like to see them. At the time, I was unaware of his deep appreciation of art. Not only that, the aforementioned medallic work was remunerative and had to be my primary focus with familial obligations. But, his interest in my work encouraged me to try to complete some paintings. I finally managed two oil compositions. He liked both works, and that inspired me to c,ontinue. Since then, I have been devoting more of my time to my first love. I hope I will spend the rest of my life painting and composing figures.

The composition of figures is, in my opinion, the most fascinating aspect of creating an artistic work. When I was studying with Carmean and Feitelson at the Art Center, they introduced me to the titans of painting; among them, Corot, Millet Michelangelo, Degas, and Vermeer. It was their aesthetics, composition, color, and drawing that I fell in love with. My own artistic process usually begins with a sketch like the ones Dr. Jan first saw. When I believe a composition will work, I transfer it to my canvas. Because inspiration and time are fickle masters, I often work on several paintings at once and may take many months to complete one. I have always believed that it is easy to make something that is ugly, but it is quite another matter to create something that is beautiful enough to be timeless.



Dr. Mian Jan is a cardiologist practicing in Chester County and is President of the Chester County Medical Society. He and his wife Ambereen Jan are avid amateur collectors of Chester County Art.

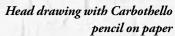
# Cortney paper mache acrylic paint

# Girl washing hair bronze figure











Mother and Child oil on canvas

# Reducing Barriers in Accessing Maternal and Child Healthcare Improving Perinatal Birth Outcomes for Vulnerable Women and Children

BY CATHERINE BINZ AND EMMA GARNER

n Chester County, heart disease is reported as the number one major cause of death, while diabetes is the sixth leading cause of death (Chester County Health Profile, 2016). Not only does Pennsylvania have the 25th highest adult obesity rate in the nation, but its adult obesity rate has made a steady incline in the past two decades, raising to 30.3% from 20.3% in 2000 and from 13.7% in 1990 (*The State of Obesity: Better Policies for a Healthier America, 2017*).

While cardiovascular disease, diabetes, and obesity have obvious physical health impacts, they also greatly affected Chester County citizens financially. For example, those living with diabetes have average medical expenses that are approximately 2.3 times higher than those who are not affected by the disease. In Pennsylvania, medical expenses for diagnosed and undiagnosed diabetes, pre-diabetes, and gestational diabetes were estimated at a sum of \$10.2 billion in 2012 (*The Burden of Diabetes in Pennsylvania, ADA* 2015).

These numbers create an even larger burden on those who are already financially vulnerable and affected by chronic disease. By preventing heart disease and diabetes, there could be a reduction in health care costs, contributions to a healthier economy, and an overall improvement to the quality of life in Chester County. Because obesity is a multi-factorial condition, if addressed early and properly it could lead to reduced risk of developing unhealthy lifestyles that contribute to heart disease and other chronic conditions.

At Maternal and Child Health Consortium (MCHC), a nonprofit organization in Chester County that aims to reduce barriers in accessing maternal and child healthcare and improve perinatal birth outcomes for vulnerable women and children, chronic disease prevention, including diabetes and heart disease prevention education, is provided to pregnant and parenting women and their partners, children and their family members, and to community members to improve their long-term health outcomes. MCHC's recent strategic planning helped them to understand the link between social determinants of health and diabetes can lead to the identification of nontraditional strategies by using nontraditional partners and identifying opportunities for



improving or preventing negative health outcomes in communities affected by the inequitable conditions that create them.

In early 2017, MCHC developed their bilingual Diabetes and Heart Disease Prevention education program integrated into their home-visiting Healthy Start and Family Center programs, leveraging the current structure and Community Health Worker (CHW) approach. The program is delivered by MCHC's trained, culturally competent and bilingual CHWs during home visits in a one-on-one setting with participant mothers and their partners and children. Group workshops are also offered to participants' extended family members, friends, and community partners and providers as well as members of the community. The goal of the program is to increase low income mothers' and their children and families' awareness on self-management of diabetes and heart disease risk factors. For one MCHC participant, a stay at home Latino mother, her daily routine of cooking meals for her family, getting her daughters, aged 4 and 7, ready for school, cleaning the house, and caring for her newborn made healthy meal preparation a challenge, in addition to not always having the means to afford healthy food options. She often chose prepared foods for convenience to help her manage her busy days. She had been enrolled in MCHC's Healthy Start home visiting program while she was pregnant with her third child. During her health assessment, she shared that her husband had been diagnosed with high cholesterol a few years ago, but they really did not understand what having a high cholesterol level meant or what chronic diseases it could cause and were guilty of poor diet and lack of





exercise. Her CHW noticed during home visits that often there were unhealthy snacks, such as cookies and chips, which the family would snack on in a jar on the kitchen counter.

Unaware of the harm that food high in calories, cholesterol, sugar, and fat has on the body, especially in those already suffering from high cholesterol levels, she was not looking at nutritional labels before purchasing food. "They really did not understand what high cholesterol and diabetes were and how to go about starting to make changes, especially with limited resources like many of the families we serve," said Cecilia Arce, MCHC's Director Programs who oversees the Diabetes and Heart Disease Prevention education program. "During home visits our CHWs are able to get a more concrete grasp of participants' levels of diabetes and chronic disease knowledge through our comprehensive health assessments and by conducting the CDC Diabetes Prevention pre-test completed when participants enroll in our home visiting programs. This helps our CHWs to better understand our participants' levels of knowledge and pinpoint specific areas for education and awareness opportunities during the sessions provided at home visits," added Arce. Focused on prevention, the modules delivered at home visits and in the workshops include talking points for persons who are overweight, heart health tips, fat and calorie education, and guidance for reading Nutrition Facts labels. With a hands-on curriculum adapted from the National Heart and Lung and Blood Institute and the CDC Diabetes Prevention Program, educational materials also include the USDA's My Plate and The American Heart Association's "Life's Simple 7" in order to provide simple, straightforward, and helpful guidelines to follow. CHWs educate participants on diabetes and heart disease risk factors and track grams of fat and calories, physical activity, body weight, healthy dietary patterns, normal values for blood pressure, cholesterol, blood sugar, and BMI, and specific nutritional needs of children.

Interactive education workshops, another strategy for MCHC to reach more at-risk individuals in the communities they serve, provides a series of sessions for participant's extended family members and participants of MCHC's other programs

and services. This past year MCHC's community workshops reached nearly 200 additional individuals, with workshop series held in West Chester, Coatesville and Kennett Square. All participants, both home visiting and group workshop, complete a pre and post test to measure changes in knowledge, exercise and activity, and BMI and weight changes. Participants also receive pedometers, review their food intake logs, participate in cooking demonstrations, review sample menus and recipes, and share experiences and provide feedback on their monthly nutrition and exercise goals.

Participants also learn the importance of lowering intakes of food rich in saturated fats, trans-fats, added sugars, and sodium, and began to gain a higher understanding of preventing and managing different types of chronic diseases, choosing healthier foods to add to their family's diet, and increasing weekly levels of exercise. CHWs teach participants how to read Nutrition Facts labels, stressing the importance of buying more fresh produce and less processed snack foods. "We actually see the food our participants have in their refrigerators and cupboards. We can see the changes as our families become more aware, such as bowls of fruit on their tables instead of a package of cookies," said Arce when speaking about the changes they see in the nutrition habits of their participants.

This particular Latino mother and her family's story is just one example of the hundreds struggling to access the healthcare and culturally and linguistically appropriate health education needed to take charge of their health and the health and well-being of their children and families. While she was able to lose six pounds through changes she made, her husband is still working to make changes to manage his diabetes. She now feels she is in a better position with an increased understanding and activities to help support her husband's condition and encourage him to work towards a healthier lifestyle. She has also been able to impress upon her young daughters the benefits of healthy eating and exercise, telling her CHW how her children are choosing healthy vegetables and increasing their daily activities.

Many low-income, vulnerable minority populations struggle with understanding their health risks and conditions and do not have the opportunity to engage in health education programs such as this one offered by MCHC in Chester County. More prone to chronic conditions, research shows that minority populations, specifically, Latino and African Americans, are at greater risk for obesity, cardiovascular disease, and Diabetes Type 2, due to social, environmental, and behavioral factors. Nationally, there is a higher prevalence of obesity in Latinos and African Americans, 21.9% and 19.5% respectively compared to 14.7% for non-Hispanic whites. MCHC's Diabetes and Heart Disease Prevention education program specifically targets these minority mothers and families who are at a greater risk of later developing diabetes and cardiovascular disease.

Although it has been proven that physical activity and diet can reduce the risk of developing chronic diseases such as coronary artery disease, hypertension, diabetes, and the metabolic syndrome,

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# Reducing Barriers in Accessing Maternal and Child Healthcare

continued from page 25

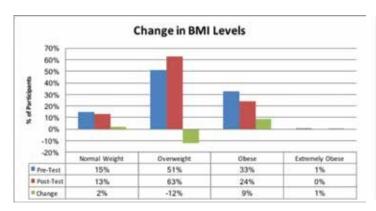
many low-income individuals do not, or often cannot make the necessary lifestyle changes and incorporate them into their lives. Poverty, low education attainment levels, language barriers, lack of health insurance and access to healthcare cause forks in the road and healthy lifestyle changes are difficult to maintain.

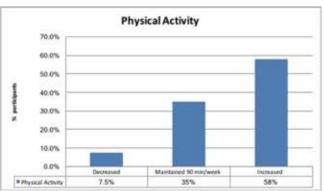
In a world full of so many unhealthy temptations, it is difficult to lead a healthy lifestyle if one does not have a strategic plan in action or the knowledge accessible to them. MCHC's program instills the idea that good physical activity and a healthy diet are key factors in reducing the risk of developing many chronic diseases and furthers the main goal of the program—prevention. MCHC's approach to educating their target participant, the mother (and their partners) during home visits, makes it much easier for other members of the family, especially children, to join in healthier eating and exercising, due to a 'halo effect.' The first year full year program results collected by MCHC's CHWs speak volumes. This past year, 120 mothers along with an additional 257 family members received education sessions during home visits. A majority of participants initially did not score the minimum 70% score on the knowledge pretest. However, at the end of the program 91% of participants scored at least 70% or higher. Of individuals participating, the levels of BMI at intake indicated 15% of participants had normal weight, 51% were overweight and 33% were obese and 1% extremely obese. At the end of the first year, during the post-test, the levels of BMI changed to 13% (decrease of 2%) with normal weight, 63% (increase of 12%) overweight, 24% (decrease of 9%) obese, and there were not any extremely obese participants (decrease of 1%). Physical activity decreased weekly for 7.5% of participants, 35% maintained at least 90 minutes per week, and 58% of the participants increased their weekly time of exercising. Once participants gained a better understanding of how to prevent and manage diabetes and heart disease, changes in BMI levels and increased activities resulted in measurable changes, including weight loss and changes in eating and exercise habits, charting them on a path for healthier living.

The mission of MCHC is to empower families to build a healthier, brighter future for their children by overcoming the social and environmental barriers that lead to poor health conditions in our communities. Founded in 1991, MCHC



provides its core programs, Healthy Start, Family Benefits and Family Center programs and supporting services that reduce barriers to accessing health insurance coverage and food stability programs and ensures access to healthcare, reduces health disparities to ensure healthy pregnancies and births, and provides parenting skills and early childhood learning and development to prepare children for school and build strong, healthy families who may thrive and grow. In 2017, over 5,000 mothers, children, their family members and members of the community across Chester County and in Pottstown, Montgomery County participated in MCHC's programs and services. MCHC's Diabetes and Heart Disease Education Program was integrated initially into MCHC's home-visiting programs in 2017 with funding from The Edna G. Kynett Memorial Foundation, which help to start the program to serve all five of MCHC's Healthy Start locations. Other generous funders now include the Longwood Foundation, Janssen Biotech, Inc., and most recently Jack and Jill of America Foundation funding the education program specifically in the Coatesville community, and funding provided by the Pennsylvania Department of Human Services' Health Program Assistance and Services Appropriation Grant for Chester County families. For more information on MCHC's program and services please visit our website at www.ccmchc.org.





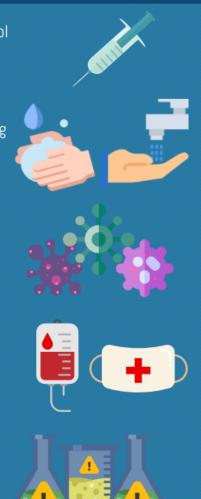
<sup>&</sup>lt;sup>1</sup> Increased weight and decreased minutes in activity per week are attributed to pregnant women participating in the program for who these goals are not targeted.



# 10 Common OSHA Violations in the Healthcare Setting



- Failure to implement and maintain an exposure control program under BPP Standard
- 2 Failure to train under BPP Standard
- Failure to engineer out hazards / ensure hand washing under BBP Standard
- Poor housekeeping under BBP Standard
- Failure to implement and maintain a written Hazard Communication Program
- Failure to make the Hepatitis B vaccination available under BBP Standard
- 7 Failure to prepare exposure determinations under BBP Standard
- Failure to use personal protective equipment under BBP Standard
- Pailure to provide post exposure Hepatitis B vaccination under BBP Standard
- Failure to train employees under Hazard Communications Standard



To avoid potential areas of noncompliance regularly audit your practice for safety and health hazards. Employee training and periodic refresher training is essential, especially regarding Bloodborne Pathogen and Hazard Communication education.

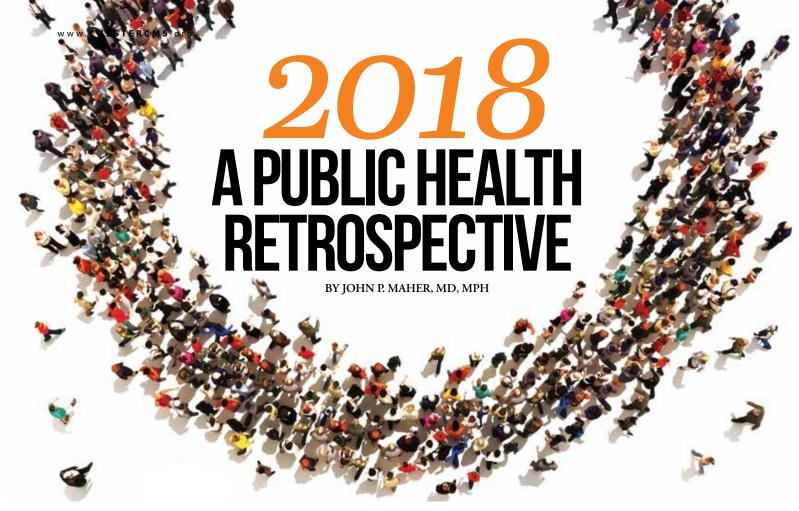
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Every year, around mid-December, and as the holiday season starts winding down, it is customary for the news media (TV, radio, newspapers and news magazines) to start the recap of what they consider the "Top Stories" of the previous 12 months. These Top-10 or Top-20 stories generally cover a wide gamut of those stories, issues and events which caught the public's (and especially the media's) attention as judged by the amount of headlines and editorial space taken up that year. They are mostly stories about political events and personages, spots, economics, entertainment, crime and punishment, and finally, the "passing" (no one just dies anymore) of famous and important people.

However, unless a particular story covering a health or medical issue lends itself to a certain kind of notoriety ("if it bleeds, it leads") or political "spin" (e.g., its effects on free trade, the impact on international trade or our allies) or can be tied to the issues of illegal immigration, the mass media do not always give those topics the same level of coverage which many health care professionals might think they deserve.

From that standpoint, at least the US Centers for Disease Control and Prevention (the CDC) did put out a news release in December highlighting those health issues and topics which had occupied much of their time and attention during 2018, and with much thanks on our part, we have used their documentation as our starting point for this article.

And so, we have decided to put together this article on the top medical and public health-related topics of 2018. Clearly, of course, no one article could cover every single health/medical story of 2018 in just a few pages. Thus we were forced to pick and choose from among all of those we felt might have far-reaching public health impact for the general public as well as for our professional colleagues despite what seemed to us to be less than adequate coverage by the mass media.

To start with, since we cannot cover everything here, we have a few words about **global or international health issues** which could affect the USA. The CDC is actively involved with African nations and the WHO in helping the response to the second largest Ebola outbreak in history in the Democratic Republic of Congo. Staff and resources are supplied and emphasis is on rapid response, proper preventive care, and experimental vaccine usage.

Most Americans are aware (or ought to be) that a large percentage of our food products, both meat and produce, as well as such things as cut flowers and manufactured goods, are imported from third world countries. So, the potential exists for accidental or deliberate contamination of such goods. Similarly, some of our contaminated food-borne outbreaks continue to be traced or linked to large produce farms not just in Central America but also in our own country, particularly in the southwest and western coastal areas.



Also, in that same context of trade and imports, (See Table I) we periodically hear of the importation of infectious diseases, such as malaria, Zika, MDR-TB, leprosy and Chagas Disease to name but a few, as well as vectors such as the Asian Tiger mosquito. We pass over in silence the major economic pests such as the Asian pine borer, the Asian and Formosan subterranean termites, and the Spotted Lantern fly.

# TABLE I: Exotic Diseases Periodically Imported into the USA

MDR-TB

Zika virus

Leprosy

Chagas Disease

Ebola (usually an exposed health care worker)

Monkey Pox (2003 outbreak)

Dengue

On a different tack, we have to mention the CDC's concern about some of what we might call our **nation's vital statistics.** A list of our leading causes of death is shown in Table 2. The CDC notes that **Chronic Diseases** remain one of their top priorities. Heart attacks, strokes, heart failure and other chronic diseases — all of them largely preventable — caused 2.2 million hospitalizations, 415,000 deaths, and over \$30 billion in health care costs.

For the first time, our national **Life Expectancy at Birth** showed a drop of 0.1% (final 2016 data), reflecting worrisome increases in mortality due to unintentional injuries, homicide, Alzheimer's Disease, suicide, opioid overdose deaths, and Parkinson's Disease.

**Suicide** rates have been increasing in every state and increased nationally by 25.4% between 1999-2016. It is now the 10th leading cause of death here, with over 45,000 cases aged 10 years and older. Three methods (firearms, 55%; suffocation, 27%; and poisoning, 10%) account for 92% of all suicides.

Another important factor affecting these data is the extent of our **national Epidemic of Opioid Overdose Deaths.** Drug overdose deaths in the US numbered over 700,000 between 1999-2017, and 70,000 in 2017 alone (or an average of 190/day) for all types of opioids, including heroin and illicit opioids which accounted for over 2/3 of all OD deaths. Consequently, Congress appropriated \$476 million in FY 2018 to provide increased funding to all 50 states and 4 US territories for increased prevention and response activities. PA had the 6th highest drug OD death rate in the country. Here in Chester County, it should be noted that the County's Dept. of Drug and Alcohol Services posts an Opioid Epidemic Community Tool Kit on its website.

# TABLE 2: Leading Causes of Death, USA

1. Heart Disease	6.Alzheimer's Disease
2. Cancer	7. Diabetes mellitus
3. Accidents	8. Influenza/pneumonia
4. Chronic lung disease	9. Kidney disease
5. Strokes	10. Suicide

Despite the importance and preventability of many of the foregoing issues, it is generally the area of Infectious Diseases which grabs most peoples'attention, and the area which gets the most media attention deals with "outbreaks," especially **food-borne outbreaks** and related "product recalls." CDC lists 24 food-borne outbreaks in 2018. Two of the most important of these are those

continued on next page >

related to Salmonella and to pathogenic E. coli (particularly type O157-H7). Perhaps the largest **Salmonella** outbreak in 2018 (which actually began back in 2016 and continued through September, 2018) involved Salmonella contamination of beef products shipped nationwide to over 100 retailers, affecting 34 different states, and the recall of 12.1 million pounds of beef. PA was not involved in this one, but the national scale of this drawn out problem underscores just how easily such diseases can spread.

It should not be too surprising how often Salmonella species are involved in such incidents. Older reference books taught that there were between 1100 and 1500 Salmonella species, but there are now at least 2463 serotypes (serovars) known to lab science (see the J. Clin. Microbiol., July, 2000).

Examples of other Salmonella outbreaks during the last year or so are shown in Table 3.

### TABLE 3: Other 2018 Salmonella Outbreaks (Partial List)

S. agberi (white cake mix)

S.sandiego (pasta salad)

S. concord (tahini products)
S. montevideo (raw sprouts)

S. mbandaka

(Honey Smacks dry cereal)

S. enteritidis (shell eggs, kosher chicken)

S. reading (raw turkey)

S. infanti (raw chicken products)

S. newport (ground beef)

S. adelaide (pre-cut melons, mail order poultry)

Similarly, in 2018, much attention was given to widespread cases of **Shiga-toxin producing E. coli (STEC)** O157-H7 linked to contaminated romaine lettuce from the central coastal growing area of northern central California. This outbreak wound up involving the US, several states, and Canada. Consumers were advised not to eat, and retailers not to serve or sell any romaine lettuce from the suspect three counties in California. Health professionals were also advised not to use antibiotics to treat suspected STEC cases since there was no evidence of benefit for that and an apparent increased risk of HUS.

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The Chester County Medical Society works collaboratively with the Pennsylvania Medical Society, but our focus is on our local community. The Society's role in Chester County is to support, protect, and advocate for our physicians and our patients. We look forward to growing an important healthcare service for our community that will benefit us all, and we look forward to hearing from you.

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Another infectious disease category causing growing concern among health care providers is that of **Sexually Transmitted Diseases (STDs)**, which have shown steep and sustained increases in recent years. About 2.3 million cases of Chlamydia, Gonorrhea, and infectious syphilis were reported in 2017, the fourth consecutive year of sharp increases. Infectious syphilis rose 76% and GC rose 67%, raising another specter – that of increasingly antibiotic resistant gonorrhea.

Acute Flaccid Myelitis (AFM) is a serious but, so far, rare but frightening condition which causes weakness in one or more limbs, mimicking poliomyelitis. The CDC has identified Coxsackie A16, EV A71, and EV 68 in these patients, but no sign of polio viruses. Cases have occurred in 46 states, some 90% in children, and most having onset with a respiratory illness between August and October. In November the CDC formed an AFM Task Force to help define the cause of, and improve treatment outcomes for, patients with AFM.

For want of unlimited space, we will close with a few comments about the **Viral hepatitides.** Serious **Hepatitis A** (**HAV**) outbreaks occurred (and continue) in several states, particularly in large urban populations of drug users and homeless people. Over 7000 cases were reported in 12 states. Between January, 2017, and April, 2018, the CDC received over 2500 HAV case reports from multiple states, 2/3 of which were in patients reporting drug abuse, homelessness, or both. Over 1500 were in four states (CA, KY, MI, UT), and 71% required hospitalization and 3 % died.

And, finally, the highest incidence of **Hepatitis C (HCV)** in the US is now among persons aged 20-29. HCV infections have more than tripled in recent years, and what the CDC calls "an HCV epidemic," as a consequence of the opioid epidemic, is emerging among PWIDs (persons who inject drugs), especially in rural and suburban settings.

Physicians and other healthcare providers are encouraged to monitor these events and activities closely via the websites for the CDC, WHO, Pro-MED and other health related sources.

Dr. Maher is a retired Public Health physician, former County Health Director, and a long-time member of the CCMS Board.



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# Local Pilot Ophthalmologist Brings Aviation To The Classroom

BY STEVEN SIEPSER, MD



was invited to be a guest author at Charles Patton Middle School Writers' Day in Unionville, PA. My focus was to be how to start a writing project. My goal was to inspire creative thinking through the fantasy of flight as well as inculcate within the students the fun, excitement and utility of flying. The "back story" is being a physician is fun and there are so many things a doctor can do and writing stories is just one of them.

We began by creating a compelling event to be fleshed out with consequences and outcomes. Generating a story like this gets the action going, without the tedium and effort to "start at the beginning." The approach incited active class participation.

I asked students to invent an adventure. One of the students, who had been a passenger in my airplane, eagerly suggested his own experience of having the airplane's cabin door pop open. I told them that the pilot must have forgotten to use his checklist!

Students were incredulous, asking "How could a pilot forget that?"

In my airplane, I explained, "Before takeoff, I usually recite a mnemonic verbal checklist: doors, cap, cap, flaps, flaps, pulse, pulse, ice, lights, trim." That day, the pilot (me) overlooked a critical component, and the very first: the door. The door refers to having the pilot manually push on the door, cap, cap refers to checking the gas caps. Flaps, flaps means the cowl flaps are open and the wing flaps are in take off position. Pulse, Pulse refers to having the pulsing strobe lights on and the pulsing of the transponder that identifies the airplane for the controllers. Ice, refers to putting on the de-icing equipment in bad weather, lights: proper lights for takeoff and navigation. Trim, refers to

the placement of the leveling assistance for takeoff. Whew that's a lot! It is always quite easy to miss something if rushed or not disciplined in doing a check list every time. In fact I use the same processes in the operating room to assure safety through check lists and redundancy.

To understand an airplane's safety mechanisms, I presented an analogy with which they would be familiar:

"In your family minivan, the beep-beep and warning lights indicate a door is open. Your Mom or Dad asks you to close the offending door and off you go. Believe it or not, in little airplanes, there are no lights; no warning that a door is open. This is due to complex airplane safety regulations."

I explained that pilots are not involved in making changes to regulations. For example, if pilots want to have a light added to an airplane to warn the pilot a door is open, we have to apply to the government for that change. The warning light must not create malfunctions in other plane operations. The light must work from -30 degrees to 120 degrees F and be stressed to destruction. All this involves expensive testing environments, equipment and time. Eventually making a \$1 sensor cost \$5 for an airplane and possibly taking a year to get approved. No airplane company wants to make those types of small changes as even at \$5, there are not enough sensors sold a year to be economically feasible. It would cost approximately \$20,000 to do all the tests, write them up and file a myriad of forms. 4,000 switches need to be sold just to recoup the costs of certification. For example there are only 13,000 flying models of the particular airplane that I fly and many need that important sensor they will never get. Forgetting to firmly



close and verify the door latching mechanism is only a matter of time.

Returning to the collaborative group write, I ask, "What do you think would happen to a door that's open if you're flying 200 mph? In a small airplane, the vessel isn't pressurized."

Details unfold. The audience learns that the door has opened even further as the airplane reached cruising speed. Bernoulli's principle is applied as the aircraft's speed increased. I demonstrated the principle by using a dollar bill: "Blow across the top of a bill held by your fingers at one end and the other will mysteriously rise." The door was essentially pulled into a neutral position to balance the force of the wind and the negative pressure just behind the trailing edge of the door.

I explained how flying gives my family and me the means to do an array of things that wouldn't otherwise be possible. For example, this summer there was the solar eclipse. I wanted to see it in totality. I located a place with white cement, not a grassy landing strip, so we could see the flickering lights. During totality, this is an important, exciting phenomenon. When the eclipse occurs, the ripple effects of the light passing through the edge of the atmosphere are visible on the ground. These scintillations on the ground all around you are similar to the irregular lighting patterns one sees on the bottom of a wavy pool on a sunny day.

Up in the air, the edge of the atmosphere is a wavy surface, likes waves in a pool. This causes the intense light of an eclipse to be disturbed in an unusual sparkling pattern projected on the earth's surface, in this case the cement taxiway.

Having my pilot's license and being a part owner of a small airplane allows me to catch up with my family and support them in their passion for horseback riding competitions. I can quickly travel wherever there's a meet without having to spend the entire weekend driving to and from these disparate venues. The airplane is a magic carpet. You can fly to the Bahamas, South Carolina, etc. We flew to Angel Falls in Venezuela for our honeymoon. It was a "wow" trip. We also gave a presentation to the Pennsylvania Aero



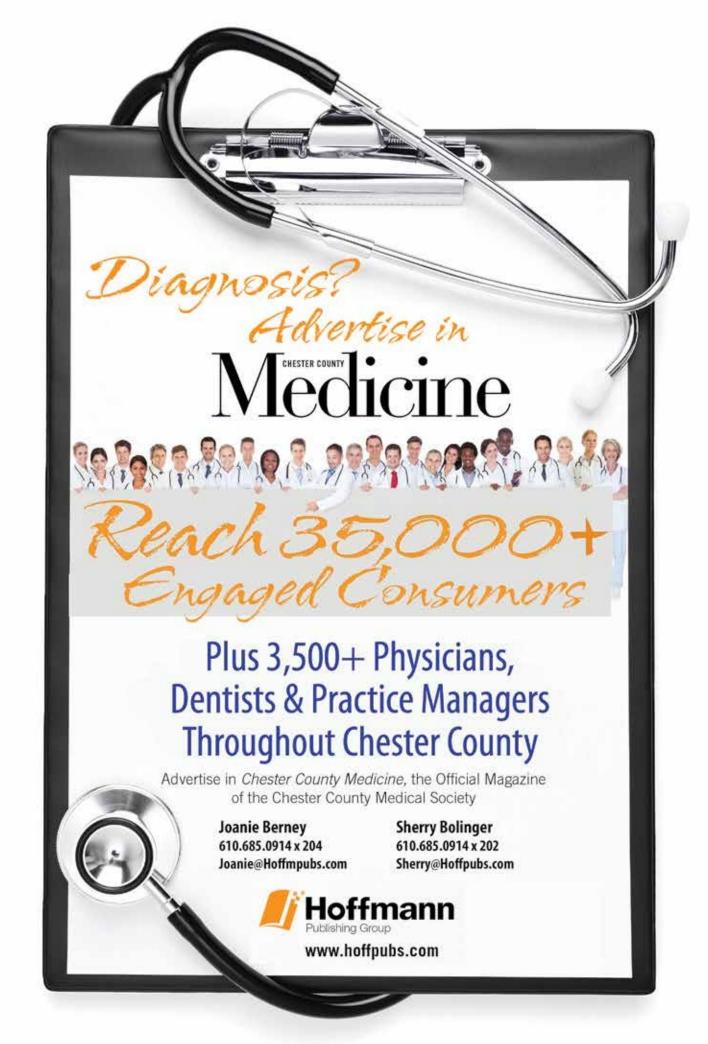
Recently I flew two of my staff members and myself to the annual meeting of the American Academy of Ophthalmology in Chicago. We could land in East Lansing 3 minutes from downtown and no traffic or big airport. For departure no security lines or parking problems, pull up to the hanger, load the airplane and you are off! I have used the airplane for countless visits to colleagues to observe their surgical and office procedures. This has helped my practice be at the leading edge with the constant input of the many colleagues I have "flown in" for a visit. We have also volunteered our services and our airplane for service in Haiti and Grand Turk Island, flying in an airplane full of needed supplies and instruments.

The class was told to "Remember, build a story that your reader can visualize."

I explained not only do I write about travel, but as an eye doctor, this form of communication is essential to my career.

At the end of the exercise, I asked the students, "What did you learn today?"

The students responded: "Writing can be fun" and "planes are cool!" Being a doctor can lead to all kinds of adventures. ■





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