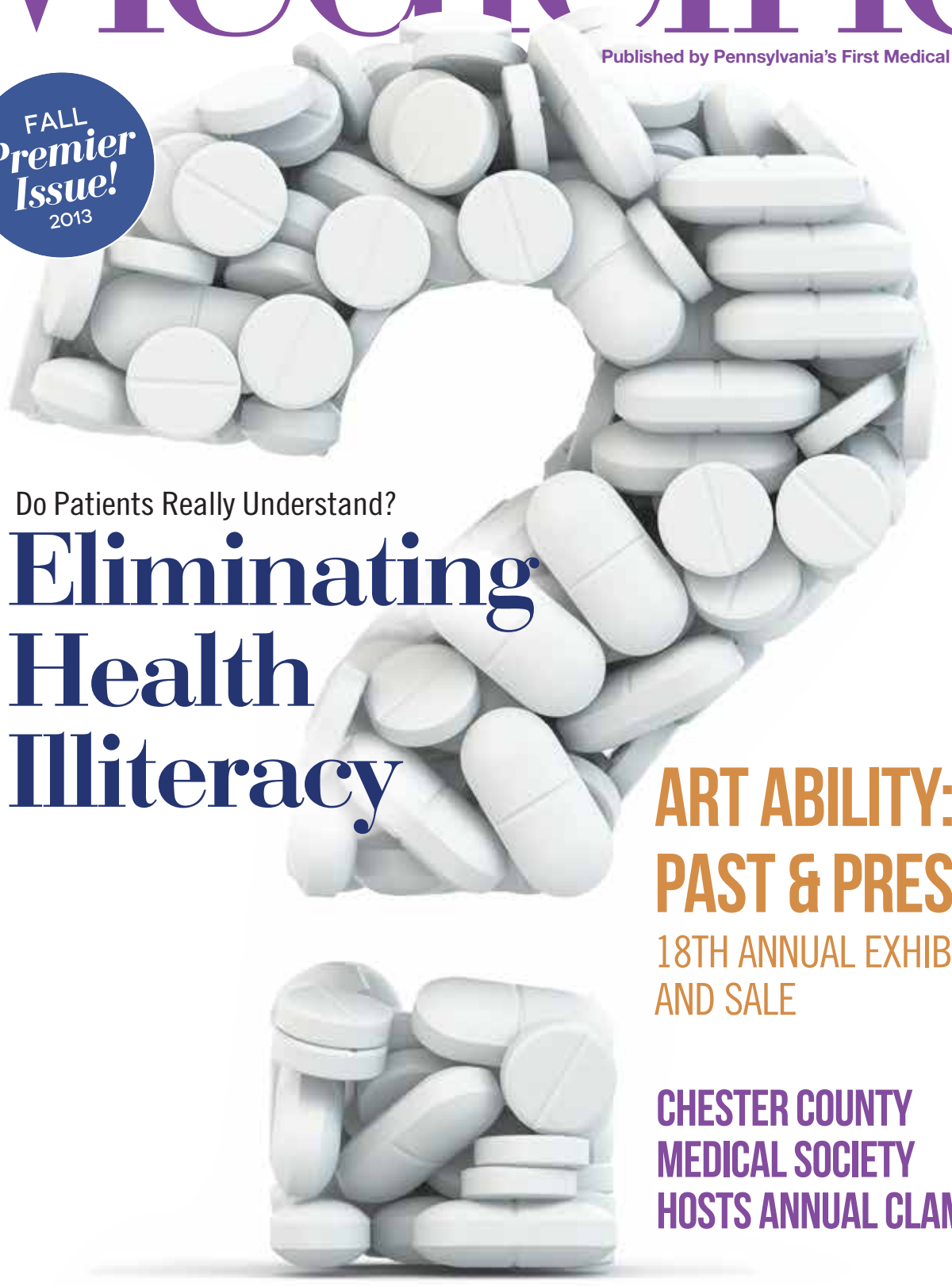
CHESTER COUNTY
Medicine
Fall 2013
Published by Pennsylvania's First Medical Society

FALL *Premier Issue!* 2013



Do Patients Really Understand?

Eliminating Health Illiteracy

ART ABILITY: PAST & PRESENT

18TH ANNUAL EXHIBITION AND SALE

CHESTER COUNTY MEDICAL SOCIETY HOSTS ANNUAL CLAM BAKE

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

Chester County Medicine is published by
Hoffmann Publishing Group, Inc.,
Reading PA 19608
HoffmannPublishing.com
For advertising information,
contact Karen Zach
610.685.0914
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In Every Issue

Winslow W. Murdoch, MD

I hope to continue our expanded role as an advocate for doctors and patients in our community and spearhead two new initiatives.

President's Message

New to the leadership role of the Chester County Medical Society (CCMS), I thought it appropriate to review the accomplishments accrued over the last few years under the oversight of our board and Dr. Mian Jan, Immediate Past President. CCMS has:

Winslow W. Murdoch, MD

- Developed committed relationships with Chester County legislators.
- Added DocBookMD, a HIPAA-compliant text and image smart phone messaging system for all the members of the Medical Society and their staff.
- Kept CCMS dues rates firm with a reduction pending for 2014.
- Retained membership numbers for 2013 (a huge accomplishment considering the bleed other county and state societies are experiencing).
- Transitioned to a color quarterly magazine and supporting a robust website for our county medical society.
- Tripled Clam Bake attendance since the days at Brandywine Hospital.
- Reinstated the CCMS Scholarship Program in 2010 that had been dormant for many years.
- Worked with local legislators, the Pennsylvania Medical Society, and indirectly with the AMA on larger issues. We are supported by our very own Congressman Joe Pitts, Chairman of United States Subcommittee on Health, and are giving a face to the issues of Sustainable Growth Rate or, SGR Doc fix, the Corbett Medicaid alternative expansion plans, and simplifying MOC board recertification processes.
- Actively engaged the public through the Chester County Chamber of Business and Industry and the community at large by giving talks on the ACA effects on doctors. CCMS members also sit on panels at local Chamber of Commerce forums and give community seminars.
- Reached out to several groups for employed doctors to improve their voice in organizational leadership, innovation, and sustainability.
- Formed a formal association with the Chester County Department of Health by volunteering on the board and striking a cooperative relationship with the new director Jeanne Casner, MPH, PMP, and the new medical director Kimberly E. Stone, MD, who replaced Dr. John Maher who retired on October 1, 2013.
- Employed a much more effective and organized board structure that is able to leverage the expertise of a manageable group to address local and statewide issues as they arise from our constituent doctors, local businesses, and legislators as well.

Looking forward, I hope to continue our expanded role as an advocate for doctors and patients in our community and spearhead two new initiatives. One issue that repeatedly comes up in attempts to get doctors to commit to meetings and collaboration is the issue of lack of time. I am working with experts in the online education field to implement inexpensive technologies that will allow us to more efficiently collaborate amongst ourselves and our community health stakeholders. A great value to our community, magnified by our immense pool of shared intelligence, is our ability to address practice and community issues as they arise. We hope to implement periodically-scheduled online town hall meetings with engaged physicians, elected officials, business, and community stakeholders. Additional communications, postings, and questions can then be posited electronically and asynchronously so that we can correspond when it is most convenient for all involved.

My other goal, born of my 24 years of local experience as a family physician, is to increase community awareness that the doctor-patient relationship is KEY to achieving the triple aim of cost, quality, and service. To achieve this goal, we must find ways to maximize our impact with our patients and create more space for the contemplative use of new technology and collaborative care planning. However, technology, though seductive, is not the only answer. In fact, until now, implementation of newer technology into the patient exam room has had the effect of taking time away from the building of impactful relationships with patients via increased documentation requirements and regulations. Physicians are faced with volume and information overload.

I am optimistic that this trend is changing. Emerging medical record programming has largely focused on complying with a huge litany of insurance and government mandates.

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Just now, it is starting to focus on workflow and improved patient outcomes. Our patients and doctors are getting better at using multiple modes of communication, and ever more information is "in the box." Until now, little has been able to be shared and none of these information repositories have been proven to improve outcomes. They have introduced errors and failed to replace our unique role in providing comfort and reducing our patients' fears.

It is critical, however, that the stakeholders in government, the insurance industry, and our business and community partners be made aware of the value of spending time with our patients.

Time with our patients is:

- **Time to listen**
- **Time to ask**
- **Time to observe**
- **Time to show and feel compassion**
- **Time to contemplate**
- **Time to reconsider our hypotheses for the individual patient in all their complexity**
- **Time to uncover hurdles that stand in the way to our shared goals**
- **Time to research or call a colleague**
- **Time to collect and review information collected outside of our office**
- **Time to share our insights with others in the healthcare team**
- **Time to chart a course, and as needed, re-chart a new shared action plan with our patient, and finally,**
- **Time to accurately document information to be shared, presented in a medical decision-making, user friendly format**

We need to allow, encourage, and actively support doctors so that they can lead, facilitate innovation, and test strategies that strengthen our relationship with patients. This may come in the form of private contracting, collaborative arrangements, and other integrated models that provide relevant solutions across specialties, practice settings and geographies. Only by doing this important work can we take ownership and make our profession more attractive to the next generation and our children.

Winslow W. Murdoch, MD
Family Medicine
West Chester, PA
President of the Chester County Medical Society

Spotlight

Pennsylvania Medical Society Inaugurates 164th President

Bruce MacLeod, MD, FACEP, an emergency physician in Pittsburgh, was installed as the 164th president of the Pennsylvania Medical Society (PAMED) on October 26, 2013, during PAMED's annual House of Delegates meeting in Hershey.

Bruce MacLeod, MD, FACEP

Dr. MacLeod has been a PAMED member for more than 14 years. Prior to his election as president of the state society, he served two terms on PAMED's Board of Trustees representing hospital-based specialty physicians. He served as chair of the board from 2003 to 2009. Dr. MacLeod's inaugural address is included in its entirety below:

It is an honor to become the 164th President of the Pennsylvania Medical Society. Thank you for allowing me to share my reflections and ideas for this very exciting upcoming year.

We are in the middle of a major shift in health care which began even before the Affordable Care Act. Issues such as change in employment status, EMRs, meaningful use, transitioning from RVU to value based compensation, liability reform, scope of practice, and physician-led teams all crowd our consciousness. But this change is not like a tsunami which implies that processes, institutions, and organizations would be washed away. Rather, it is an earthquake where the ground is moving, a shift in the foundations which will have many of the same structures and institutions but many will be doing different things.

So how do we survive and thrive in this new world? Mahatma Ghandi said, "The future depends on what you do today." And what we can do is advocacy. I have adopted this as one of the major focuses of my year leading you as president.

Democracy is not a spectator sport. And this American society is a democracy and as such needs and even demands your participation. While there are a lot of things that the Medical Society does effectively, one of its irreplaceable functions is advocacy. And while we do it well, thanks in no small part to a talented staff, we are nowhere close to the level of influence that we could have. At the basic level, advocacy is simply about relationships between people such as you and your state representative or mayor or member of Congress. We, as physicians, are still highly respected by our patients and society in general and alone we can give the physician's perspective on the issue at hand.

Imagine a membership who all know their state representative and senator and are engaged with the political process. It matters not whether the advocacy is even for an issue germane or salient to the Medical Society. What matters is the engagement and the investment in building and nurturing relationships which shall yield the fruits of success. As members of "Team PAMED," why should we sharpen this tool? Because some day or every day we will need it to promulgate our message and our initiatives.

As my first recommendation as president-elect, I therefore propose that the Pennsylvania Medical Society develop and implement a plan where 50 percent of all Pennsylvania Medical Society members participate in an advocacy activity sometime over the course of the year with a goal of 75 percent of all members in two years.

Quality has historically been assigned to physicians, has been a part of our fabric, and is part of our mission statement. And we all participate in quality improvement activities in our practices which are often legislated external to the practice. And at the hospital level, it is the organized medical staff that is assigned the responsibility of the quality of care provided in the institution. Where does the Pennsylvania Medical Society fit into the quality equation? If you examine the Dartmouth Atlas of Health Care, there is marked variability of any number of clinical practices across this state including surgical procedures, end-of-life care, medication use, and many others. While there are potential mitigating variables, the geographic differences in practices are vast. And there are those outside the practice of medicine who may ascribe adverse motivations to these variations even so far as suggesting pecuniary gain. The Medical Society has the potential to serve a unique role, a "Switzerland-like" role or arbiter of good practice.

As members of "Team PAMED," we should seek to understand these differences and variability and then work to reduce the clinically inappropriate variations in care. There are many potential stakeholders to join us such as state specialty societies, departments of health, schools of public health, insurance companies, and others. Do we have the courage to take on this controversy in our House?

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And to those who say that this is not the purview of the Medical Society, I say, if not us, then who? If not now, when?

As my second recommendation as president-elect, I therefore propose that the Pennsylvania Medical Society develop a plan to evaluate the variability of clinical practice in Pennsylvania and working with a consortium of specialty societies, insurance companies, and other stakeholder groups to develop a process to improve quality of care by reducing inappropriate clinical practice variability in Pennsylvania.

Because of the cleverness and impeccable timing of our predecessors in the Society, we are blessed with a very large endowment which many have nurtured to a healthy financial state. The endowment belongs to the Medical Society, to all of us. It is the House of Delegates who ultimately decides what is to be done with this asset.

As the endowment grows, the contribution to the ever expanding Society operations grows proportionally. This is what has been prescribed by you the House of Delegates. After more than 10 years of existence, this is a call to examine if we are going in the right direction with use of the endowment.

Which begs the question of why a member organization needs to have so large an endowment? If the needs are being met, the members will sustain and grow the Medical Society. If that is the case, then the Society will not and should not need the crutch of the bloated endowment with its wake of money to sustain inefficiency and lack of agility and focus. There are some who might say that we need it for a big, big fight. To which I say that if there is a big fight and the Society needs money then the membership will stand and deliver. But that call to arms should be a high bar, a major moment for this Society and medicine in this Commonwealth, not just the hubris of men.

If the Society is not supported by the members then it must question its direction, focus, value, and ultimately even its need to exist. This process of introspection and reinvigoration should not be muffled by the crutch of the endowment.

Then what would be other uses of the endowment? There have long been suggestions about using the endowment to reduce dues now and going forward. This should be a consideration along with others asking what would strengthen and preserve the Medical Society legacy for generations to come.

As my third recommendation as president-elect, I therefore propose that the Pennsylvania Medical Society assemble a blue ribbon panel of internal and external experts and stakeholders to evaluate the use of the endowment fund and offer suggestions to strengthen and preserve the legacy of the Pennsylvania Medical Society and report back to the House of Delegates.

I would like to offer some simple thoughts as we address the seemingly overwhelming challenges that confront us personally as physicians and as the Medical Society. The first thought is that one definition of insanity is "to continue to do the same thing and expect a different outcome." In other words, systems or processes are designed to generate the outcome that they produce. If you want different outcomes, such as more member value, more member engagement, and more relevance in today's health care environment, then we must change the systems and processes in our Medical Society

The next thought is encouragement to maintain a patient centricity to our decision and policy-making. Often it is the patient perspective or what is best for the patient that can help to identify the ideal course of action when there are competing interests.

The final thought is..."the way that we got here will not be the way that we get there." You, the House of Delegates, will have the opportunity to strike a bold note in the history of the Pennsylvania Medical Society. Change can be disconcerting and is commonly framed in the context of saying, "I am all for change, just start with the other guy." To all of you I say, seize the day!

I would like to close by acknowledging all who have helped me as I have grown both as a physician and a person. First I would like to thank the Allegheny County Medical Society, the Pennsylvania Chapter of the American College of Emergency Physicians where this all started. To all of the staff and trustees who have been my Harrisburg friends for these past 10 years, thank you. A special thanks to the past presidents who have been my friends and mentors. As Sir Isaac Newton said, "If I see farther, it is because I stand on the shoulders of giants."

To all of my colleagues, staff, and partners in the Emergency Departments back in Pittsburgh, first at Mercy Hospital and now at West Penn, who have covered and supported me, thank you.

Finally, the biggest thank you to my family, my children and wife who have been loving and supportive through all of my tenure with the Medical Society. I love all of you very much. ■

Good luck to all of you attending the 2013 House of Delegates. Thank you.


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Veterans and the Affordable Care Act

See more at coatesville.va.gov/features

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Portions of the Affordable Care Act take effect next year. Veterans receiving VA health care will not see any change in benefits or costs. However, many Veterans without health insurance are eligible for VA health care.

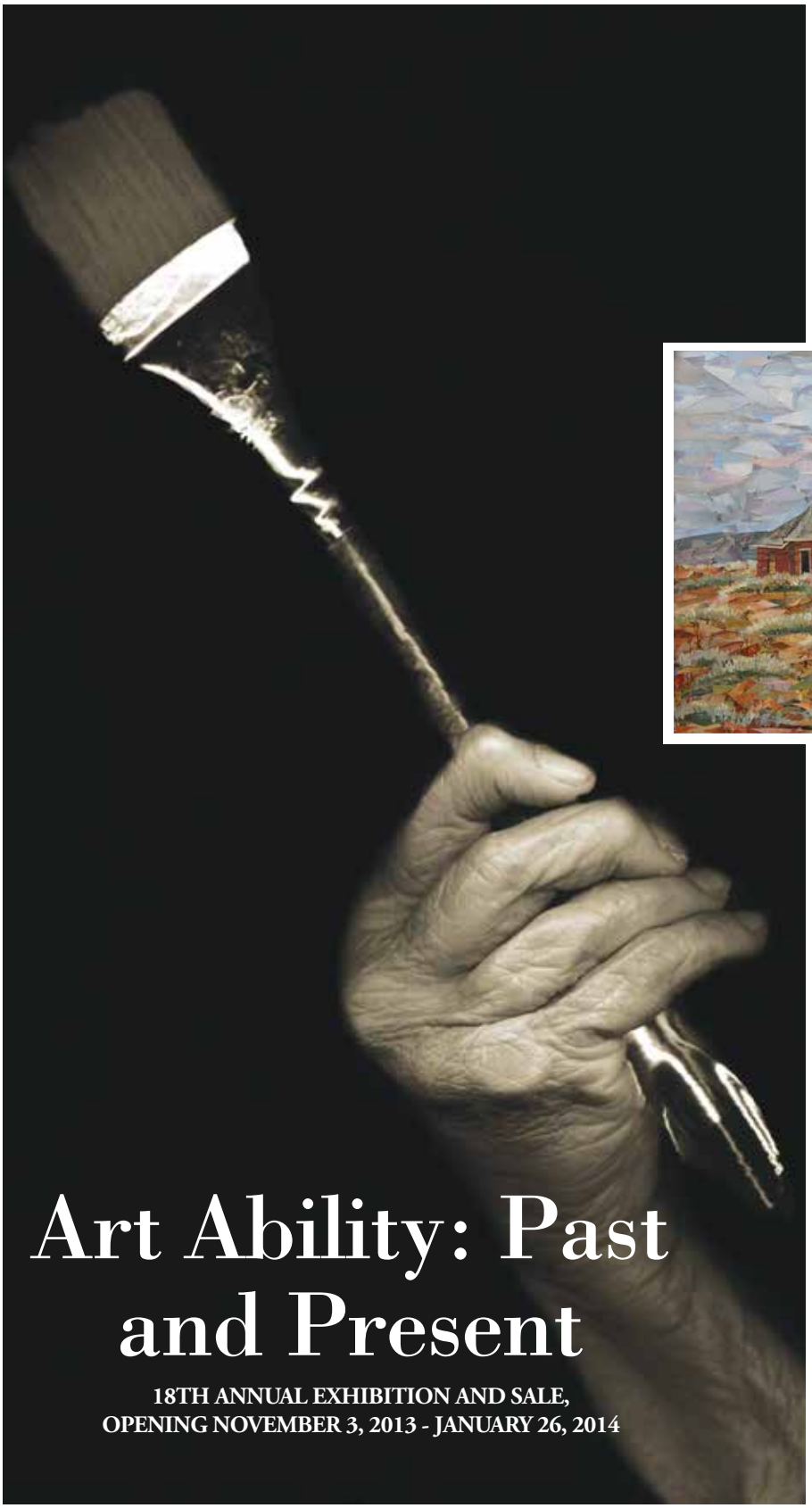
When portions of the Affordable Care Act (ACA) take effect next year, Veterans receiving health care from the Department of Veterans Affairs will see no change in their benefits or out-of-pocket costs.

However, there are more than 1.3 million Veterans and more than 950,000 spouses and children of Veterans without health insurance. Many uninsured Veterans are eligible for VA health care.

VA is working hard to ensure that enrolled Veterans know that they don't have to do anything to comply with ACA and eligible Veterans who are not enrolled should take advantage of the VA health care benefits they have earned.

For those who are not eligible for VA care – such as Veterans' family members – the law created a new Health Insurance Marketplace. In 2014, the Marketplace will be a new way to shop for and purchase private health insurance. People who purchase insurance through the Marketplace may be able to lower the costs of health insurance coverage by paying lower monthly premiums. For more information, visit www.healthcare.gov.

For information about VA health care and the Affordable Care Act, VA encourages Veterans and family members to visit the new website at www.va.gov/aca, or call 1-877-222-VETS (8387), Monday through Friday from 8 a.m. to 10 p.m. or Saturdays from 11a.m. to 3 p.m., Eastern time. The new website includes a Health Benefits Explorer, where Veterans can learn about the benefits they can receive if they enroll in VA care.



Art Ability: Past and Present

18TH ANNUAL EXHIBITION AND SALE, OPENING NOVEMBER 3, 2013 - JANUARY 26, 2014

The Art Ability Program offers a unique and accessible venue for artists with disabilities to display and sell their work. In addition to supporting Bryn Mawr Rehab Hospital's vision and mission to advocate for those with disabilities in our community while advancing the artistic and financial success of artists with disabilities, the art in the exhibition is used daily to motivate and treat patients at the Hospital.

Landscape 260
Sriharsha Sukla
Collage on paper, 24 x 35 inches
Courtesy-Art Ability Satellite/Sales Program

Art Ability began at Bryn Mawr Rehab Hospital in 1996 as an eight-week exhibit and sale of work by artists with disabilities. Now, in addition to the annual exhibitions, Bryn Mawr Rehab Hospital is an actively collecting institution whose permanent collection of over 300 objects is on display throughout the year serving as a showcase for, and celebration of, artists with disabilities.

At its inception, the annual exhibition and sale included approximately 40 participating artists and 200 pieces of artwork displayed. Today, the exhibit and sale is ten weeks in length and in 2011-2012 featured more than 400 pieces of art, sculpture and jewelry by 195 artists representing 32 states and 7 countries. In the 2010 exhibit, more

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A Deer and a Raccoon Walk into a Bar
Allen Bryan
Photograph, digital assembly, 22 x 40 inches
Courtesy-Art Ability Satellite/Sales Program

than 60 artists sold 134 pieces of work and $37,100 of sales proceeds were provided directly to artists. Additionally, $7,500 was awarded to 33 artists for artistic excellence.

Art Ability includes the following major components: a twelve-week annual, international juried exhibition and sale of art and fine crafts produced by individuals with disabilities held each fall; community outreach and education opportunities including satellite exhibitions and interactive demo days; our permanent collection of artwork and the incorporation of artwork into the patient experience; and a corporate art acquisition program.

In recognition of its efforts, the Art Ability Program was a recipient of a 2009 Inglis Award for Continuing Excellence from the Inglis Foundation. This award honors the performance of non-profit organizations in the Philadelphia region that enhance the quality of life for people with physical disabilities. In 2000, Art Ability Program was named a Keystone of Accessibility by Governor Tom Ridge and the Pennsylvania Council on the Arts, one of only 12 arts organizations so honored. Artists receive 80 percent of proceeds from the sale of their pieces, with 20 percent earmarked to support the Hospital's nationally-recognized patient treatment programs.

PROGRAM SPECIFICS

Annual Exhibition and Sale

Art Ability has as a primary focus an international, ten-week juried exhibition and sale of art and fine crafts that features work by artists with physical and related cognitive disabilities, and

Wild Rose
Ken Smith
Photograph, 28 x 28 inches
Courtesy-Art Ability Satellite/Sales Program

hearing and visual impairments. Participating artists express their creativity through painting, photography, sculpture, fiber arts, stained glass, jewelry and fine crafts. Through these creative modes of expression, artists are able to convey their talent, receive recognition for their work, and often also to further progress in recovering from a life-altering illness or injury.

The event is held every fall. Proceeds of the Art Ability opening reception help support Bryn Mawr Rehab Hospital patient and community programs.

Permanent Collection of Work

Pieces from the hospital's permanent Art Ability collection (230+ pieces) are displayed at wheelchair height throughout the halls of the hospital year-round for our more than 6,500 patients to enjoy. The collection provides continuous inspiration to the hospital's patients, their families and visitors. The hospital clinical staff members often incorporate utilization of Art Ability work into their daily treatment activities with patients. Staff motivates patients by using the collection as tangible evidence of their potential to return to meaningful, productive lives. Private tours are available upon request. ■

2013 Featured Artist

Mikki O'Phelan, Kaneohe, HI
Mikki is pursuing a Bachelor of Fine Arts in Electronic Arts specializing in Digital Imaging at The University of Hawaii at Manoa. She uses photography to document her body's physical changes as she lives with Rheumatoid Arthritis.
mainlinehealth.org/images

Mission Statement

Art Ability is dedicated to creating community awareness of people with disabilities, and encouraging people with disabilities to reach beyond their limitations and find fulfillment and inspiration through art.

aA art Ability

Do Patients Really Understand? The Push to Eliminate Health Illiteracy

INADEQUATE HEALTH LITERACY IS A SIGNIFICANT CONCERN IN TODAY'S HEALTH-CARE ENVIRONMENT. INDEED, MORE THAN ONE-THIRD OF AMERICANS DON'T UNDERSTAND THE BASIC MEDICAL INFORMATION THAT'S NEEDED TO MAKE INFORMED HEALTH-CARE DECISIONS.

This knowledge gap can have serious repercussions: poor medication adherence, increased mortality, and increased hospital readmissions and trips to the ER.

Individuals with inadequate health literacy can be found throughout the United States. The problem doesn't necessarily have anything to do with a lack of education. Even highly educated individuals can have difficulty understanding health education. "We need to change how staff teach so that patients can learn to care for themselves," said Carolyn Cutilli, PhD-c, director of Patient and Family Education for the University of Pennsylvania Health System. "It is important for the staff to put themselves in the patient's shoes and explain concepts in very simple terms."

At the Hospital of the University of Pennsylvania, improving health literacy has become a major focus over the last few years as health systems work to reduce patient readmissions and improve patient satisfaction and care. Several resources are already available on HUP's internal website to help staff meet the health literacy needs of patients; courses are offered to increase staff awareness of health literacy and provide tools to improve patient understanding, such as the teach-back approach (patients explain instructions in their own words). "We're in the midst of a health care transformation, and health literacy is a fundamental part of that process," said HUP's Chief Nurse Executive Victoria Rich, PhD, RN, FAAN, who will speak to the issue of health literacy at the upcoming annual Cultural Diversity Conference this month at Penn Presbyterian Medical Center. "As providers, it's imperative that we acknowledge the unique culture, language and health literacy of diverse populations so that we can help promote better health care for patients across the nation."

Some clinical areas, though, have taken the challenge to the next level. With a focus on reducing heart failure readmissions, the staff on two patient-care units – Silverstein 10 and the cardiac intermediate care unit (CICU) – have developed their own tools to ensure that these patients not only understand what their providers are telling them but remember it as well.

One tool that all of their patients receive — the "Cardiac Surgery Journey" welcome sheet – describes every step of their progress as an inpatient, from arrival at the hospital to surgery to recovery in the CICU and on Silverstein 10, and, ultimately, discharge. "At each step, the sheet describes what needs to

Continued on page 14

be done to continue onto the next," said Tanya Johnson-Coleman, RN, BSN, MHA, Ed, a nurse on Silverstein 10. In creating the map, "we tried to answer questions that patients always ask, especially what needs to happen before they're discharged. I think it helps to alleviate the stress and anxiety patients have from not knowing."

The staff also created medication cards –– as well as a Penn Heart Vascular Medication Reference Guide -- to help patients better understand their medications, including why they're taken and potential side effects. The ring of cards is placed by the patient's bed for easy access, but staff nurses review meds as well, focusing on one medication each day. There is also an in-unit 'class' for patients and families which focuses on medications, procedures and problems they might encounter after discharge.

The challenge to increase health literacy is also being tackled by Penn's Center for Innovation. Adam Lang, Innovation manager, and his team explored how improved discharge instructions could better prepare heart failure patients to take care of themselves once they got home from the hospital. The original instructions, he said, "were four to five pages of all text with no prioritization of information. The advice at the end was the same for every patient, regardless of diagnosis."

In creating a new prototype design, the team "organized and prioritized the information and kept it to one sheet," said Matt Vandertuyn, Innovation Experience designer. "The information is easier to understand and the design is much more visually appealing." Although the design is still in the development stage, it has gotten positive feedback from both patients and nurses.

These efforts – and many others in use throughout the hospital – will not only keep our patients healthy but also have a financial impact. One section of the HCAHPS survey, which measures patients' perception of their hospital experience, focuses on communications between doctors and nurses and their patients. The results are tied to a hospital's payment from the CMS (Centers for Medicare and Medicaid Services). The Joint Commission also has multiple criteria for patient and family education. Said Lynn Washington, RN, Cardiovascular nurse navigator, a leader in HUP's Patient and Family Education Committee, "We have to do a better job at assessing patients' comprehension of what is important for them to know and what will motivate the behavior changes needed to improve their health and make more informed choices. I often tell my patients, 'If you didn't understand, it's because I didn't do my job.'" ■

The Chester County Health Care Partnership

The health care industry is an important component of both the business and residential communities in Chester County. To address the workforce needs of this specific segment, the Chester County Health Care Partnership (CCHCP) was formed. The Partnership shares best practices, talent development/recruiting information, program ideas on trends and issues, and training grants to stabilize and strengthen the local workforce and enhance patient care. CCHCP is comprised of over 60 organizations including hospitals, continuing care retirement communities, home health companies, acute rehabilitation facilities, educational institutions, and county development offices sharing the goal of improving the quality of health care delivery in Chester County and the surrounding region.

Sustainability for this Industry Partnership comes from private sector contributions, both cash and in-kind, federal, state and local grant support including the Chester County Workforce Investment Board/PA Department of Labor and Industry, and the efforts of numerous volunteers. ■

Chester County Health Care Partnership

For more information
Patti VanCleave at 610.321.8212
pvancleave@cceconomicdevelopment.com

Pennsylvania Medical Society Legislative Update

BY SCOT CHADWICK, LEGISLATIVE COUNSEL, PAMED

Following the enactment of the annual state budget on June 30th, the Pennsylvania General Assembly recessed for the balance of the summer and returned to Harrisburg on September 23rd. We anticipate a busy fall, though the legislative appetite for controversial issues will wane as the year winds down and members start gearing up for next year's elections in their newly-reapportioned districts.

Speaking of the 2013-2014 state budget, this was the third consecutive year during Governor Tom Corbett's administration that the annual spending plan was completed on time. The $28.4 billion budget represents a 2.3 percent spending increase over the prior fiscal year.

While the budget was finalized in a timely manner, the legislature failed to address three of the Governor's major priorities: tackling Pennsylvania's transportation infrastructure needs, liquor privatization, and pension reform. Medicaid expansion also remains unresolved, as the House stripped language within the Welfare Code requiring Governor Corbett to move forward with an expansion of Medicaid under the Affordable Care Act.

Moving on to other health care-related issues, sooner or later all tort reform initiatives have to pass through the Senate Judiciary Committee, where they generally never see the light of day. That problem has been solved this session, at least for the Pennsylvania Medical Society (PAMED's) apology bill. Senator Pat Vance (R-Cumberland) shrewdly attached the measure to a bill (SB 379) extending the life of the CHIP program, which was referred instead to the Senate Banking and Insurance Committee, chaired by tort reform champion Don White (R-Indiana). Senator White's committee promptly approved the measure, and the Senate subsequently amended and passed it 50-0. The House Judiciary Committee gave its stamp of approval in late June, and a House vote is anticipated early this fall. The bill would make physician apologies and other benevolent gestures (except outright admissions of fault or negligence) to patients after a poor outcome inadmissible by plaintiffs in medical liability lawsuits.

Scope of practice is always on the front burner in Harrisburg, where non-physician providers regularly seek legislative permission to expand what they can do. In July, Senator Vance introduced Senate Bill 1063, legislation that would entitle CRNPs to practice independently, to be recognized as primary care providers under managed care and other health care plans, and to be reimbursed directly by insurers and other third-party payers. The proposal would also take priority over the authority of the Department of Health and the Department of Public Welfare to regulate the types of health care professionals who are eligible for medical staff membership or clinical privileges, along with the authority of a health care facility to determine the scope of practice and supervision or other oversight requirements for health care professionals practicing within the facility. PAMED opposes the measure and is considering an alternative proposal focusing on the team-based patient care model.

Another key initiative for PAMED is the creation of a statewide controlled substance database (CSDB.) Representative Gene DiGirolamo (R-Bucks) has introduced House Bill 317, legislation that would require dispensers (primarily pharmacists) to enter filled prescriptions of scheduled drugs into the database and permit physicians to access information regarding their patients. Rep. DiGirolamo introduced similar legislation last session, which was approved by the House Human Services Committee but went no further. However, PAMED's "Pills for Ills, Not Thrills" campaign has generated significant support for a CSDB in the governor's office and legislature, and we are optimistic that a good bill can be enacted this year. ■

Clam Bake attendees enjoy live harp music and hors d'oeuvres.

Chester County Medical Society Hosts Annual Clam Bake

The Chester County Medical Society (CCMS) hosted its annual legislative thank-you dinner and "Clam Bake" on Friday, September 20, 2013 at the Radley Run Country Club. Special guests included Congressman Joe Pitts, Senator Andy Dinniman, Representatives Warren Kampf, Dan Truitt, and Duane Milne, and Commissioner Terence Farrell. CCMS also welcomed hospital executives, CCMS members and non-members, Dr. C. Richard Schott, President of the Pennsylvania Medical Society (PAMED), and Michael R. Fraser, PhD, CAE, the new Executive Vice President of PAMED.

The agenda for the evening included the CCMS president's installation, presentation of the CCMS Darlington Scholarship, and a legislative dialogue. All guests enjoyed live harp music, cocktails, and clam hors d'oeuvres.

Following a buffet dinner, CCMS President Dr. Mian A. Jan presented the 2013-2016 election slate and called for a vote of the members who were present. The election was unanimous.

Dr. Mian A. Jan, CCMS Immediate Past President, accepts a plaque for his service from new CCMS President, Dr. Winslow W. Murdoch.

Dr. Jan then introduced Dr. Winslow W. Murdoch as the new president of the Society. Dr. Murdoch reviewed CCMS' accomplishments during Dr. Jan's presidency and spoke briefly about his vision for his own term.

Dr. John Maher was the editor for *Chester County Medicine,* CCMS' quarterly newsletter, for many years and recently retired from the editorship. He was thanked and presented with a gift in appreciation for his many years of service.

Dr. Mian A. Jan presents the 2013 CCMS Darlington Scholarship to recipient Grant B. Hubbard.

Next, Dr. Jan gave an overview of the CCMS Darlington Scholarship that honors Dr. William Darlington, the first president of the Chester County

Continued on page 18

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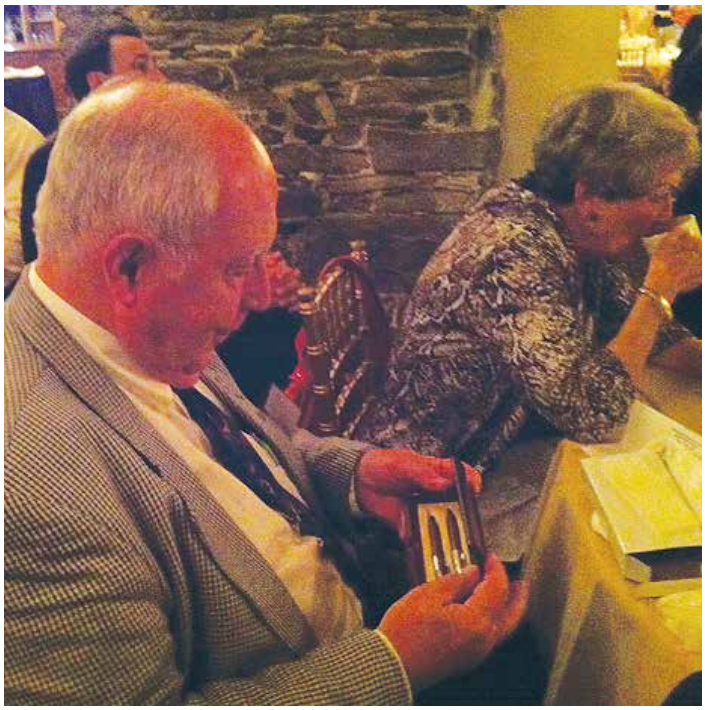
Medical Society from 1828 to 1852. The 2013 Darlington Scholarship was presented to Grant B. Hubbard of West Chester University, who then addressed the audience about his appreciation for the scholarship.

Finally, Dr. Murdoch introduced former legislator Curt Schroder and publicly thanked him for his support of physician issues. Each legislator in attendance briefly addressed the audience and Dr. C. Richard Schott was invited to share a few words. ■

Attendees thank Dr. Jan for his tenure as CCMS president.

Pennsylvania Medical Society President C. Richard Schott, MD, addresses attendees of the 2013 Clam Bake.



Dr. John Maher, long time CCMS newsletter editor, receives a thank-you gift for his service to the Society.

New Pennsylvania Medical Society Executive Vice President Michael R. Fraser dines with Clam Bake guests.

NATIONAL VETERANS WHEELCHAIR GAMES

August 12-17, 2014
Philadelphia, PA.

The National Veterans Wheelchair Games (NVWG) is a sports and rehabilitation program for military service veterans who use wheelchairs for sports competition due to spinal cord injuries, amputations or certain neurological problems.

Attracting more than 500 athletes each year, the NVWG is the largest annual wheelchair sports event in the world.

The presenters of this event are committed to improving the quality of life for veterans with disabilities and fostering better health through sports competition. While past Games have produced a number of national and world-class champions, the Games also provide opportunities for newly-disabled veterans to gain sports skills and be exposed to other wheelchair athletes. Typically, one quarter of the competitors have never before participated in any type of organized wheelchair sports competition.

Presenters

U.S. Department of Veterans Affairs (VA) and Paralyzed Veterans of America (PVA), with financial assistance from corporate, civic and veteran service organizations.

Events

Competitive events at the National Veterans Wheelchair Games include air guns, archery, basketball, bowling, field events, handcycling, a motorized wheelchair rally, nine-ball, power soccer, quad rugby, slalom, softball, swimming, table tennis, track, trapshooting and weightlifting. Athletes compete in all events against others with similar athletic ability, competitive experience or age.

Admission

Free. The public is most welcome. The 2014 National Veterans Wheelchair Games will take place in the heart of Philadelphia. A city culturally diverse and rich in history, Veterans will have an opportunity to make history of their own Aug. 12-17 next year. ■

Five Inadvertent HIPAA Violations by Physicians

BY TRACEY HAAS, DO, MPH, AND CO-FOUNDER, DOCBOOKMD

Doctors do not plan ahead to violate HIPAA, but in this digital age, they may be doing it because they did not plan ahead. The recent final rule of the HITECH Act outlines that even if the physician is unaware of the violation, he or she may be fined a civil penalty of $100 - $50,000 per violation. It is time for even the most resistant doctors to pay attention to how they handle protected health information (PHI). Here, we will outline five common ways physicians are breaking HIPAA/HITECH privacy and security rules, and may not even know it.

1.) Texting PHI to members of your care team. It's a simple scenario: you've just left the office, and your nurse texts you that Mr. Smith is having a reaction to the medication you've just prescribed. She has included his name and phone number in the text. You may know that texting PHI is not legal, but feel justified because it is a serious medical issue. Perhaps you even believe that deleting the text right away will protect you – and Mr. Smith. In reality, this text message with PHI has just passed from your nurse's phone, through her phone carrier, to your phone carrier, and then to you – four vulnerable points where this unencrypted message could either be intercepted or breached. In a secure messaging app, this type of message must be encrypted as it passes through all four points of contact. Ideally, both sender and recipient should be verified and have signed a business associate agreement (BAA).

2.) Taking a photo of a patient on your mobile phone. To some this will sound silly, to others, it is as common as verifying a rash with a colleague or following the margins of a cellulitis day by day. Simple enough, but if these photos are viewed by eyes they are not intended for, you may be in violation of your patient's privacy. It's important to be aware of where and how patient information and images are stored. Apps that allow you to take a secure photo are just as important as sending the message securely. DocbookMD allows photos to be taken within the secure messaging app itself – never stored on your phone or within your phone's photo album. Always use this type of feature when taking any photo of a patient or patient information.

3.) Receiving text messages from your answering service. Many physicians believe if they receive a text message from a third party, like an answering service, they are not responsible for any violation of HIPAA – this is simply not true. Many services do send a patient's name, phone number and chief complaint via SMS text. The answering service may verify it is encrypted on their end, but if PHI pops onto the physician's screen, it is certainly not secure on his or her end – and this is where the physician's responsibility lies. Talk with your answering service today to see how they are protecting you at both ends of the communication.

4.) Allowing your child to borrow your phone that contains PHI. Many folks allow their kids to play with their phones – maybe play games on apps while in the car. If your phone has an app that can access PHI, then you may be guilty of a HIPAA breach if the information is viewed by or sent to someone it is not intended for. The simple fix is to utilize the pin-lock feature on your messaging app – and for double-protection, always password protect your phone!

5.) Not reporting a lost or stolen device that contains PHI. Losing your smartphone or tablet is a pain for many reasons, but did you know that if you have patient information on that device, you could be held responsible for a HIPAA breach if you do not report the loss right away? The ability to remotely disable an app that contains or handles PHI is an absolute must for technology that handles communications in the medical space. Be sure to ask for this feature from any company claiming to help you be HIPAA-compliant in the mobile world.

Remember, being HIPAA-compliant is an active process. A device can claim to be HIPAA secure, but it is a person who must ensure compliance.

DocbookMD partners with your local medical society to bring you a free, HIPAA-secure messaging app that uniquely provides you extra security to avoid each of these potential pitfalls. Do not hesitate to reach out to us today for more information at docbookmd.com or1-888-930-2048. ■

References: The ONC's official site for mobile devices and HIPAA: http://www.healthit.gov/providers- professionals/your-mobile-device-and-health-information.

BRCA Genes and Breast Cancer

In the fight against breast cancer, preventative measures are important. Women are regularly reminded that the best defense against cancer is following healthy habits like eating well, exercising, and scheduling regular breast exams and mammograms. But for some women, preventative measures aren't always enough.

Five to ten percent of all breast cancer cases diagnosed in the United States are a result of inherited gene mutations, which are passed down to us and can't be controlled through typical breast cancer prevention behaviors. The most common genetic mutations that affect breast cancer risk are BRCA1 and BRCA2.

"BRCA1 and BRCA2, which can be passed down from either your mother or father, can cause a 40 to 85 percent higher chance of developing breast cancer," explains Andrea Barrio, MD, breast surgeon at Bryn Mawr Hospital.

Although BRCA1 and BRCA2 can increase a woman's chances for being diagnosed with breast cancer, Dr. Barrio says that most women who develop breast cancer do not carry the breast cancer gene. But still, women want to know: Am I at risk? How will I know?

Genetic testing can clue you in to whether or not you're affected by either BRCA1 or BRCA2. Women with a personal or family history of breast or ovarian cancer, especially at a young age, should talk to their doctor about genetic testing.

"Without a history of breast or ovarian cancers, genetic testing typically isn't necessary. Still, pay attention to symptoms of these cancers so that you can talk to your doctor about anything out of the ordinary. The earlier cancer is detected, the earlier it can be treated," says Dr. Barrio.

Women age 40 and over should schedule annual mammograms to detect abnormalities before they become more serious, but breast self-exams can be conducted by women under age 40 and in between mammograms to keep an eye out for lumps or abnormalities.

For more information on breast health services or genetic testing options, visit our website at mainlinehealth.org. ■

Posted by Main Line Health.

Chester County Medical Society Members Meet with Congressman Joe Pitts

BY MIAN A. JAN, MD, CHESTER COUNTY MEDICAL SOCIETY IMMEDIATE PAST PRESIDENT

On August 21, 2013, a large group of physicians, including hospital-based and private practitioners as well as primary care specialists, recently had the opportunity to meet with Congressman Joe Pitts, Chairman of the Subcommittee on Health. Congressman Pitts spoke to the group about the bipartisan proposal to repeal and reform physician payments under Medicare (HR 2810), the essentials of which follow:

Repeal Flawed Medicare Sustainable Growth Rate (SGR) Formula

For the past decade, Congress has had to override the SGR formula to avert deep cuts to Medicare physicians caused by flaws in the formula. This legislation would permanently repeal the current Medicare SGR mechanism that places a global cap on Medicare spending on provider services.

Period of Stability

HR 2810 would provide an annual statutory update of 0.5% per year for 2014 through 2018. During this time, the current law payment incentives such as the Physician Quality Reporting Program (PQRS) and the Electronic Health Record (EHR) Incentive Program would continue. Also during this time, quality measure development would continue to ensure robust availability of measures for rewarding provider performance.

Rewarding Performance

Beginning in 2019, providers would receive an annual update of 0.5%. However, physicians practicing in fee-for-service would receive an additional update adjustment based on quality performance under a new Quality Update Incentive Program (QUIP). Performance under the QUIP would be assessed based on quality measures and clinical practice improvement activities. These measures and activities could be those which are currently in use or some that will be newly developed. Rather than leaving it to Washington, providers and other stakeholders would be included in the development and selection of measures and activities used in the QUIP. Provider performance would be assessed among peer cohorts of like providers delivering like services. All

providers could achieve the maximum update. High performing providers who exceed their specialty-defined threshold would earn a 1% bonus payment while low performing providers who fail to meet their lowest specialty-defined threshold would see a 1% reduction in payments.

Providers who do not report any quality information would receive the current 2% reduction in payment under PQRS, and an additional 3% reduction under QUIP. Other incentive programs in title XVIII would remain in place.

Alternative Payment Models (APMs)

New models of care are already under development; many of these new models show great promise for care coordination, keep people healthy, and encourage collaboration and shared accountability across the care continuum. Beginning in 2019, this legislation would establish an additional avenue for the development, testing, and approval of APMs. Under this new process, providers and other stakeholders could submit proposals for new models to an independent entity that would review proposals and make recommendations to the Secretary for models to move forward as either a demonstration or as a permanent program. The independent entity would report and offer recommendations on models at least quarterly. Models adopted as demonstrations would be evaluated by an independent third party to gauge their success in improving care or reducing (or not increasing) costs.

Supporting Care Coordination and Medical Homes

To support care coordination and development of patient-centered medical homes, the legislation would establish new payment codes for complex chronic care management. HR 2810 would ensure that Medicare payment is available for care coordination services performed by physicians who are certified as a Level III Medical Home by the National Committee on Quality Assurance, are recognized as a patient-centered specialty practice by the National Committee on Quality Assurance, have received equivalent certification, or meet other comparable qualifications.

Expanded Data Availability for Care Improvement

To assist providers in developing new models of care and improving quality and patient care, the legislation would expand access to Medicare data for certain certified entities. The legislation would eliminate the roadblocks that prevented these entities from directly sharing with providers in order to facilitate the development of alternative payment models and care improvement.

Improving Payment Accuracy

A lack of accurate and meaningful data on costs has hampered the ability of Medicare to review the accuracy of payments for services and identify which services are improperly valued. HR 2810 would ensure that providers could be compensated for the cost of submitting such data. The legislation would also direct Medicare to identify improperly valued services under the fee schedule that would result in a net reduction of up to 1% of the projected amount of expenditures for a year during 2016 through 2018. At the end of each of the three years the baseline would reset such that the 1% reduction would not be compounded.

Rule of Construction Regarding Standards of Care

HR 2810 would provide that the development, recognition, or implementation of any guideline under any federal health care provision under the Affordable Care Act, Medicare, or Medicaid could not be construed to establish the standard of care or duty of care owned by a health care provider to a patient in any medical malpractice or medical product liability action or claim.

The group enjoyed a robust discussion with Congressman Joe Pitts. We talked about some of the concerns that the Society and physicians have about HR 2810.

The concerns are as follows:

- Payment updates must allow physician practices to keep pace with the cost of caring for our nation's senior and disabled population.
- The proposed 0.5% positive update is inadequate and less than the Medicare Economic Index.
- Congress should ensure that physicians have the resources to make necessary investments in practices to improve care.

Existing burdens and penalties must be reduced

PQRS physician quality reporting program requirements and penalties remain in effect while the bill proposes to add further potential penalties. Congress should streamline these administrative and financial challenges that divert resources from practice improvement and employee payroll.

New systems should not be overly burdensome or duplicative of current efforts

The proposed new quality reporting system is complex and would be in addition to the existing reporting system. Congress should not introduce new administrative burdens that take physicians' time away from our patients.

Physicians must have the opportunity to lead in the development of quality metrics and alternative payment and delivery models.

Physicians are best able to determine what is appropriate for their type,

Continued on page 24

location and specialty of practice. Congress should assure that physicians are able to design quality measures and systems of care that optimally serve their patients through innovative health care delivery models.

Budget neutrality should be preserved for the overall physician reimbursement pool

Unlike every other provider group, physicians are currently subject to budget neutrality that requires an offset for each increase in funds for a physician service. When funds are trimmed from an overvalued service, budget neutrality enables CMS to redistribute savings to undervalued services such as care coordination and chronic disease management services, as well as to new services when they are incorporated into the fee schedule. Congress should maintain budget neutrality related to misvalued codes.

I have tried my best to explain HR 2810 and its ramifications and potential drawbacks. While HR 2810 is a step in the right direction, some of the concerns that we raised may need to be addressed, and Congressman Pitts was very open to discussion. It's imperative that the physician be involved in the process, for survival of medicine as it is practiced in the United States depends on it. I personally, and on behalf of Medical Society and physicians, want to thank Congressman Pitts for his efforts in this matter. He has been a proponent of many of our causes. I also want to thank the physicians who took time out of their busy schedule to attend the meeting. ■

Mian A. Jan, MD Health Symposiums

Mian A. Jan, MD, Immediate Past President of the Chester County Medical Society and a Commissioner for Asian Americans in West Chester, has been giving health symposiums to various groups in Chester County for more than 20 years. Dr. Jan's presentations center on heart-related topics such as heart disease, metabolic syndrome, risk factor modification, coronary artery disease, and recent advances in cardiology.

Dr. Jan's most recent symposium was given at the Sharma Temple in Downingtown and was attended by over one hundred people. The lecture covered prevention, diagnosis and treatment of heart disease. Another symposium at the Sharma Temple is planned for this fall. The date is still pending. ■

Pennsylvania's Physicians' Health Programs

The Physicians' Health Programs (PHP), a program of The Foundation of the Pennsylvania Medical Society, provides support and advocacy to physicians struggling with addiction or physical or mental challenges. The program also offers information and support to families of impaired physicians and encourages their involvement in the physician recovery process. The PHP is funded by grants and contributions from physicians, hospitals, and others interested in physician health issues.

The PHP began as a volunteer-based impaired physician program in 1970. Physician volunteers handled the casework with assistance from a part-time Pennsylvania Medical Society staff member. In the 1980s, the Medical Society responded to the growing need for services by hiring a medical director and case managers. Since then, the program has grown significantly in reputation and in services. It is now one of the largest and most fully-developed physicians' health programs in the country. The PHP has a cooperative working relationship with the State Board of Medicine, State Board of Osteopathic Medicine, and the Pennsylvania Medical Society, and is contracted by the Pennsylvania Dental Society to assist all licensed dental professionals. Many hospitals, medical staffs, and managed care organizations in Pennsylvania use the services offered by the PHP.

Educational Programs and Materials

PHP staff is available to give presentations upon request to medical students, residents, medical staffs or hospital administrations, county medical societies, and others interested in learning more about impairment issues. Staff will tailor a presentation to address an organization's issues. Some areas of concern might include:

- What Constitutes Impairment and How to Recognize It
- Signs and Symptoms of Addiction in Health Care Professionals
- Addiction and Depression
- Establishing a Physicians' Health Committee for Your Hospital

A Physicians' Health Programs Case Study

Mike, an internal medicine resident, was referred to the Pennsylvania Physicians' Health Programs because a colleague cared enough about him to reach out for help.

When Mike arrived at the hospital with alcohol on his breath, the hospital Physician Health Committee contacted the PHP with the name of a potential referral. They placed him on administrative leave and informed him of the need to contact the PHP within five days.

Mike contacted the PHP and spoke with our case manager about completing an evaluation, all the while denying there was any problem. A PHP representative informed Mike that he was referred because there was concern about his behavior in the hospital. Colleagues reported tardiness, sloppiness and "partying" at night. Like many individuals who are addicted, Mike didn't see the effects of his alcoholism as interfering with his ability to practice medicine. He also did not see the toll it was personally taking on him. The PHP evaluation included collateral contacts, toxicology screens, and other testing measures performed to determine if there was a diagnosis. PHP determined that Mike met the criteria for a diagnosis of alcohol dependence.

The PHP medical director informed Mike that inpatient treatment would be the most appropriate and provided him several PHP-approved treatment centers from which to choose. After completing ten weeks of treatment, Mike presented to the PHP office and signed a five-year monitoring agreement that included individual and group therapy, toxicology and Phosphatidylethanol (PEth) testing, 12-step meeting attendance, quarterly reports from a peer and workplace monitor, and monthly check-in calls to the PHP office.

Mike eventually admitted that treatment was probably the best thing that he had done for himself. He felt that he got his life back and it was so much better than before. He appreciated that the PHP was there for him and he was able to obtain advocacy that he was compliant with his agreement and was safe and sober to continue to practice medicine.

Since 1985, the PHP has helped more than 2,000 physicians "enjoy life without drugs or alcohol" and continue to be successful physicians. ■

To publish photos of new CCMS member physicians, please submit digital copies to admin@chestercms.org

Welcome New Members...

CCMS is pleased to welcome the following individuals who joined the Society in 2013:

Brian Keith Abaluck, MD
Deanna Brasile, DO
Ashish Chawla, MD
Eric M. Garfinkel
Aaron M. Giltner, MD
Albert K. Hahm, MD
Amin Kazemi, MD
Kellen K. Kovalovich, MD
Nirav N. Mehta, MD
Herman D. Movsowitz, MD
Christopher O. Olukoga, MD
Susan Jennifer Sees, MD
Kevin E. Shinal, MD
Kimberly J. Smallwood
Steven Emil Szebenyi, MD
Richard P. Tucci, MD
Brian Frederic Wilner, MD

Frontline Groups

Frontline Groups are truly special and significant for membership. Groups with a 100 percent membership are recognized. They are 100 percent committed and we are thankful.

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- Gateway Family Practice Downingtown
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- Paoli Hematology Oncology Associates PC
- Plastic & Reconstructive Surgery of Chester Co PC
- Village Family Medicine
- Brandywine Gastroenterology Assoc Ltd
- Great Valley Medical Associates PC
- Wade Townend Pediatric Associates
- Academic Urology-West Chester
- Chester County Eye Care Associates PC
- Clinical Renal Associates-Exton
- Gateway Internal Medicine Of West Chester
- Gateway Medical Colonial Family Practice
- Gateway Myers Squire & Limpert
- Devon Family Practice LLP
- Cardiology Consultants of Phila-Paoli
- Main Line Gastroenterology Associates
- Cardiology Consultants of Phila-West Chester
- Medical Inpatient Care Associates

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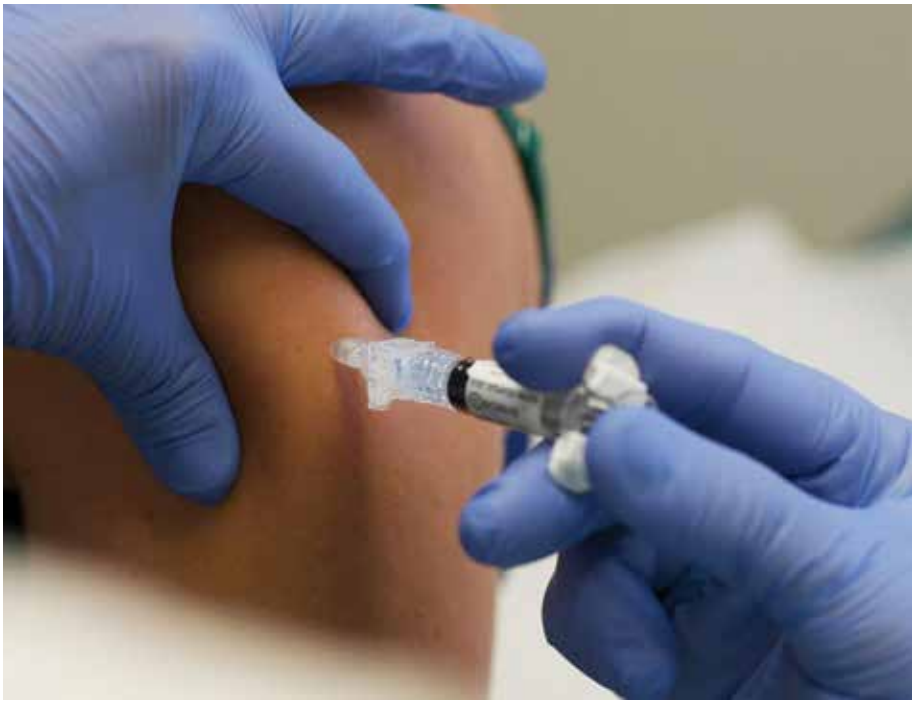

Public Health Notice: Flu

THE FOLLOWING WEB CONTENT WAS GATHERED FROM THE JANUARY 2013 HEALTH BULLETIN PUBLISHED BY THE PHILADELPHIA DEPARTMENT OF PUBLIC HEALTH.

Vaccines are the best way to prevent the flu. Some symptoms of the flu can include sore throat, coughing, runny nose, fever, chills, headaches, tiredness, body pain, vomiting and diarrhea.

If you get the flu vaccine, it can help keep you and others from getting sick. It is important to get a vaccine before you get sick.

How is flu spread?

Flu is spread from person to person through coughing or sneezing of sick people. Sometimes people can get the flu by touching something like a door knob that has flu germs on it and then touching their mouth, nose or eyes before washing their hands.

How do I prevent the flu?

- **Get vaccinated.**
  A flu vaccine is the best way to prevent the flu.
- **Wash your hands!**
  It will help protect you from germs.
- **Avoid being around sick people.**
  You can get the flu if a sick person coughs or sneezes around you.
- **Try not to touch your face.**
  Germs spread when a person touches something that has germs on it and then touches their eyes, nose or mouth.
- **Practice other good health habits.**
  Get plenty of sleep, stay physically active, manage your stress, drink fluids and eat healthy.

What should I do if I get the flu?

- **Stay home when you are sick.**
  When you are sick, stay home from work and school to protect others from getting sick. Wear a facemask or handkerchief to cover your mouth and nose if you have to go out.
- **Cover your cough.**
  Cover your nose and mouth with a tissue when you cough or sneeze and then throw away the tissue.
- **Do not allow visitors.**
  Ask friends and family not to visit while someone is sick at home.
- **Take care of yourself.**
  Drink plenty of fluids and rest as much as possible.

- **Go to the emergency room if you get very sick.**
  Go to the emergency room if you have any of the following warning signs:

- **Trouble breathing**
- **Blue or gray skin color**
- **Not waking up**
- **Cough and fever get worse**
- **Severe dizziness**
- **Confusion**
- **Pain in the chest**
- **Not drinking enough fluids**

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