CME Inside: Immunization Schedule Update

VOLUME 11, ISSUE 1 • 2012

Perspectives

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IN THIS ISSUE

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On The Cover

Changes are ahead in family medicine if we are willing to act: well-designed and appropriately funded PCMH programs, involvement of multiple payors, common administrative and data collection rules, effective processes to improve access and quality, and lower the total cost of care. See Dr. Eidus' article on page 2.

President's View 2
Executive Vice President's View 5
Academy View 6
Clinical View 8
CME Quiz. 14
New Jersey View 15
Government Affairs View 19
Hi-Tech View 21
Resident/Student View 23
Special Projects View 25
Foundation View 27
Closing View 28

Keep Perspectives *fresh by sending us new ideas and articles. Let us hear from you, tell us what you would like to see featured in this journal. If you are interested in becoming a contributor to* Perspectives*, a peer-reviewed CME publication, please contact me in the NJAFP office (609/394-1711) or email me at editor@njafp.org.*

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OMG... What do you mean I can't multi-task?

JOHN MEDINA is a developmental molecular biologist who focuses his research on the genes involved in human brain development and the genetics of psychiatric disorders. He spends a lot of time trying to figure out how the brain processes information and how people learn. As an educator, I have a lot of interest in those same things so when I had the opportunity to hear Dr. Medina speak, I was in the front row (ok, the front row of the second section in a room filled with 4,000 other people).

One of the things that Dr. Medina spoke about was multi-tasking. Most of us figure we are pretty good at multi-tasking. We answer email while participating in a teleconference. We drive a car and talk on our (hands-free) cell phones. We are on Facebook and carrying on 3 simultaneous IM conversations while doing research for an important upcoming project. All without breaking a sweat.

Well, guess what all you type-A, multi-taskers (and I include myself in this category)… here is a "Brain Rule"… you cannot multi-task! As Dr. Medina says, "It is a myth."[1] Your brain will not let you do two things simultaneously. If you want to know why, read the paragraph below; if you could care less skip it (I won't be offended, in the words of my daughter, "You are such a geek… how can you find this stuff interesting?).

Researchers have shown that our brains are incapable of paying attention to more than one thing at a time. According to Dr. Medina, "We are biologically incapable of processing attention-rich inputs simultaneously."[1] The reason is buried in the Executive Network of our brains, which acts like a switchboard for information processing. As an example, let's say you are putting together a bookshelf. The first step your brain would take is to shift to "alert," the signal that you are about begin a task. The "alert" contains a two-part message – 1) find the neurons capable of completing the task and 2) get those neurons activated. You begin the task, trying to figure out the directions and organizing what you need, but then your cell phone rings. Now you have to disengage from the process of building the bookshelf because the rules for answering your cell phone are different than the rules for building the bookshelf. The switchboard is notified that a shift in attention is about to occur. Again the two-part alert finds the neurons capable of answering your cell phone (remember, different rules) and then activates those neurons so that you can begin the new function. These 4 steps - 1) Shift alert; 2) Rule activation for task #1; 3) Disengagement; 4) Rule activation for task #2 – have to occur, in sequence, every time you switch from one task to another.[1] It is how our brains are wired.

We can only pay attention to one input at a time. The reason this is important to know is that research has shown that when a person is interrupted (e.g. switching from building a bookshelf to answering the cell phone) it takes that person 50% longer to accomplish the task, and they are prone to making 50% more mistakes.[1] In addition, when you try to force your brain to do something it is incapable of doing (process two inputs simultaneously) you create stress, which causes your body to excrete cortisol, which creates a whole series of other problems (a subject for a different article).

So, if you want a more productive life, with less stress, focus on one thing at a time. You will make fewer mistakes, get more done and go home a happier person.

Happy Reading,

Theresa J. Barrett, MS
Managing Editor

1. Medina, J. (2008). *Brain rules: 12 principles for surviving and thriving at work, home and school.* Seattle, WA: Pear Press.

PRESIDENT'S VIEW

Does Practice Transformation Pay?

Robert Eidus, MD, MBA

Robert Eidus, MD, MBA is the President of the New Jersey Academy of Family Physicians. He is in private practice at Cranford Family Practice in Cranford, NJ. Cranford Family Practice is a division of a newly formed regional primary care group practice, Vanguard Medical Group.

This is a question that has been raised by some members of NJAFP as well as members of the NJAFP board. I often get calls from members asking if they should try to achieve NCQA PCMH recognition and if it is worth it. Indeed, one of the tenets of the Joint Principles of the Patient Centered Medical Home as approved by the AAFP, ACP, AOA, and AAP is payment reform. Note that the term used is 'payment reform' and not simply fee schedule reform. This connotes that there needs to be diversified revenue streams including fee-for-service (FFS), care coordination fees and performance-based incentives.

Recently, I was challenged to identify anyone who has participated in a PCMH program that has benefited financially. Since if you have seen one PCMH program, it is impossible to paint a broad brush stroke either positively or negatively in answer to this question. I could give several examples where PCMH programs have resulted in meaningful economic improvement for primary care practices. These would include the program in Southeast Pennsylvania, the one in Albany, New York, and the one in Michigan. Skeptics could probably come up with others that have been clunkers or identify disgruntled physicians within those programs.

Since I am writing this article on January 1, and I have the benefit of being able to compare my 2011 data with 2010, I thought that it might be beneficial to open my books to you as sort of a case study, as 2011 was the first year that I participated in any meaningful fashion in a PCMH payment model.

So let's look at a few numbers. For starters, I have a solo private practice and I employ a family nurse practitioner at 2/3 full-time and a psychiatric nurse practitioner at 1/10 full-time. Along with myself, that constitutes the revenue producers. I also have limited in-office lab services, but no other ancillary diagnostic or therapeutic services. We have a phlebotomist through a local lab. I provide the full scope of adult and pediatric immunizations and also do a fair amount of office surgery. I use a hospitalist and do very limited nursing home work. The chart below shows the change in income and expenses related to traditional fee for service reimbursement.

	2010	2011	DIFFERENCE
Office Visits	6321	6938	617
Fee for Service Revenue	$668,070	$746,909	$78,839
Incremental Operating Expenses			$82,304
Net Improvement Based on FFS Revenue			-$3,645

So this looks like the quintessential hamster care model; see more patients, get a little more money, but nothing to the bottom line. What's worse, my non-clinical revenue (traditionally these could be speaking fees, consulting arrangements, medical director fees) went down precipitously in 2011. I should acknowledge that for part of the year I was compensated by Horizon Healthcare Innovations to be a member of their physician advisory board.

	2010	2011	DIFFERENCE
Net Improvement – Based on FFS Revenue			$-3,645
Non-Practice-Based Revenue	37331	16900	$-20,431
Net Change in Office Operations from FFS and Non-Practice-Based Revenue			$-24,072

So all of a sudden, 2011 looks like a pretty bad year. Assuming that nothing else changed, I would be looking at about $24,000 less income. However, in 2011, I had the benefit of two revenue streams related to practice transformation that I did not have in the past, namely meaningful use incentives and non-FFS compensation by virtue of participating in the Horizon Healthcare Innovations and also the meaningful use incentives via the American Recovery and Reinvestment Act of 2009. In the past, I did have some revenue related to non-direct patient care. This included PQRI, Bridges to Excellence, participation in small research projects, E- prescribing incentives, etc., but I never received any care coordination fees to better manage a population. Of the $56,889, about $30,000 was from care coordination fees as a result of participating in the Horizon PCMH program.

	2010	2011	DIFFERENCE
Non-Direct Patient Care Revenue	$10,278	$38,889	$28,611
Meaningful Use Payment		$18,000	$18,000
Total Revenue from Practice Transformation Associated Activities	$10,278	$56,889	$46,611
Performance-Based Incentives	$0	? TBD	?

So all of a sudden, what looked like a pretty grim year has turned out to be my best. If one looks at the total increased revenue streams I made out considerably better.

Net Change In FFS Related Income	$-3,654
Net Change in Practice Transformation Associated Revenue	$46,611
Total Net Change in Practice-based Income	$42,957

Even taking away the $18,000 meaningful use incentives, it was a pretty good year. This also does not take into account any performance-based incentives related to the PCMH program because they have not been factored in yet (anticipate that being done by the end of April). It is expected that mature PCMH programs will have a significant percentage of total reimbursement related to improved clinical performance which is the main point of the PCMH model. Finally I need to point out that my PCMH reimbursement occurs only on about 35% of my entire practice population. If this performance were extended to my entire population I think that primary care in New Jersey would become distinctly more popular.

Of course there are incremental costs associated with practice transformation but these are reflected in the increased operating expenses (naturally I had to make other investments in the practice over the years, but I was able to do that in a small private practice environment). Certainly one could take some pot shots at this analysis. On the other hand, this is one of the most common questions I field from other docs – namely, "How are you making out with this PCMH business?"

Clearly to be a "game changer" for primary care, a number of things must happen. First, the PCMH programs must be well-designed and appropriately funded. Second, there must be multiple payers involved and there needs to be a common set of administrative and data collection rules. Third, on our side of the fence, we need to make sure that we have instituted effective processes to improve access, improve quality, and lower the total cost of care. There is some room for optimism with respect to multiple payer involvement. In addition to Horizon, QualCare and Aetna have indicated a willingness to step up to the plate – and we might have the opportunity to pilot the CMS advanced PCMH program which pays a care coordination fee as much as $20 per member/per month for high-risk patients in addition to performance incentives.

I know that there are and still will be skeptics. One person's experience does not prove much and we still need to see the pilots expanded to all practices that are making the necessary transformation. However, I do not see anyone willing to pay us a ruble more in fee-for-service payments for traditional primary care. Until and unless we see other models, my personal feeling is the PCMH is the best horse to ride at this time. ▲

Perspectives:
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You know that being active is essential to maintaining a healthy weight and helping reduce your cancer risk. One of the easiest ways to meet this goal is by engaging in physical activity that's fun, enjoyable, and feels like play.

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CHANGES AHEAD

Raymond J. Saputelli, MBA, CAE

Raymond J. Saputelli, MBA, CAE is the Executive Vice President of the New Jersey Academy of Family Physicians and the Executive Director of the New Jersey Academy of Family Physicians Foundation.

In his speech before the AAFP Congress of Delegates last September, AAFP President Glen Stream, MD quoted Mario Andretti, saying "If things seem under control you aren't going fast enough." I chuckled at the time, thinking "That's easy for him to say. Mario's a guy who made his living making a continuous right (or is it left?) turn at speeds usually reserved for the NJ Turnpike." I'm not laughing now. I am fairly certain that I am not the only one who feels that the pace of change – or just keeping up – has us often running at a speed that leaves us one diverted glance from a spinning trip into the sidewall. Those who really understand racing will remind me that the sport is much more than a constant left (or is it right?) turn. You must constantly and simultaneously monitor the conditions of the track, as well as your own machine's performance, the drivers around you, the instructions from your crew, and numerous other things of which I am completely unaware. Unfortunately, much like those racers, we are under a constant pressure to maintain laser-sharp focus on our goals while monitoring – and yet not being distracted by – a list of ever-changing conditions and circumstances on the healthcare "track."

Like Mario and his counterparts (Yoshi?) if we are trying to win the race, and most would agree that in the case of primary care that will require a classic come-from-behind victory, we must be prepared to take advantage of some – but perhaps not all – of the strategic opportunities that present themselves from time to time during the race. These opportunities may even include working alongside a driver who would normally not be a "friend" on the course in order to maintain or improve our position.

As we continue to blaze around our own "track" at the NJAFP at speeds that more and more often feel less controlled than we care to admit, racing towards a delivery and payment system that supports quality over quantity and rewards coordinated care over our fragmented, procedure-based system, we continue to monitor the current conditions, always looking for ways to improve our position and putting our members in the best position to ultimately win the race. Most recently that process has led us to discussions with executives from United Healthcare, the payer that is the most regular focus of member frustration and anxiety over the past several years. A recent letter from NJAFP President Bob Eidus, MD to United EVP and CEO Reed Tuckson noted the following

While payment is always a top concern, one of the most egregious and consistently noted problems with UHC in member calls and emails to the NJAFP office has been the lack of local presence and responsiveness.

Continued on page 26

United Healthcare: Physician Advocate Contacts By County

Vincent Conti	Director	732 623-1897	vincent_J_conti@uhc.com
Physician Advocates (PAs)	**TERRITORY**	**TELEPHONE**	**EMAIL ADDRESS**
Josh Jones - Team Lead	Cape May, Cumberland, Atlantic, Burlington, Camden, Gloucester & Salem	856-299-4891	joshua_d_jones@uhc.com
Cory Betcher	Monmouth & Ocean	732 623-1116	cory_a_betcher@uhc.com
Monica Harris	Middlesex, Mercer, Warren & Sussex	732 623-1119	monica_d_harris@uhc.com
Margarida Pereira - Team Lead	Bergen & Hunterdon	732-623-1951	margarida_c_pereira@uhc.com
Kim Storey	Essex, Union & Somerset	732 623-1825	kimberly_d_storey@uhc.com
Lynda Jackson-Sealy	Morris, Passaic & Hudson	732 623-1121	lynda_jackson-sealy@uhc.com

Letter to the Editor

Living in the Inform(ed)ation Age

IT HAS BEEN SAID that we are now living in the Information Age. With social media like Twitter and Facebook and devices like iPhones, it is now easier than ever to get information (and lots of it) almost instantaneously. The World Wide Web provides 24/7 access to a world's worth of information, but it often can lead to information overload. Even the healthcare industry, which has always been one of the slowest to adapt to the changing times, is suddenly being thrust forward into electronic health records, health information exchange, and telemedicine. However, there is a difference between having information and being informed. It is this distinction that I believe is the cause for some concern.

Meaningful Use, HIPAA, ICD-10, Health Information Exchange, ACO, and the list goes on. What do all of these things have in common? They are becoming the growing trends in the industry (some of which are required) and yet I'm not sure how many people actually have a grasp on what they are. Of course everyone knows about them, has been to a conference where this is the featured topic, gets email newsletters that discuss them, and probably has even spoken with others about them. But how many in the industry are actually **informed** as to what these programs and initiatives mean and what needs to be done about them? Nothing is going to stop them from happening, but forward movement is quickly outracing education. Without an informed workforce, the gap between the goals that are being set and what people are actually educated about is going to get wider.

Take a look at the Meaningful Use Incentive Program for instance. We are already in the midst of trying to implement electronic health record (EHR) systems in the hope of receiving some incentive money to offset the cost of the implementation. The idea is wonderful in that we are trying to progress as an industry by means of incentive. However, we are in year-two of the program and I still have a number of people asking me to help them understand what is required of them. Nothing is stopping Meaningful Use now and the expectations are only going to go higher, but a very large percentage of the industry still does not have a grasp on what they need to do. To make matters worse, many of those people are just rushing into implementing an EHR in order to not get left behind and the adverse effects of poor planning are costing them more than what they hope to gain in incentive money! This is not just happening in the realm of EHRs either.

The deadline for ICD-10 compliance is getting closer and yet many organizations still are not prepared. According to an article in *Physicians Practice Magazine* last August, a technological survey of physicians in New Jersey acknowledged that only 36% of those who responded were ready for the transition to ICD-10. Compliance is required by October of next year and the majority of organizations are not ready for the transition. This not only impacts physician practices but also vendors since they have to incorporate the new codes into their systems.

HIPAA is another area where regulations exist, but many organizations, particularly smaller practices, are not well informed. The HITECH Act of 2009 made many changes to HIPAA regulations and yet most offices have not updated their manual. A federal audit program has already begun which most are aware of, but few know how to prepare themselves for. With protected health information so accessible via remote login, tablet computers, and smart phones, it is even more crucial that patient data is safeguarded appropriately. Again, there exists a large gap between what is expected, in this case through federal regulation, and what the industry is actually informed about.

There are dozens more initiatives and programs that are taking place in healthcare right now that organizations are trying to jump on board with, but do not have the proper education as a foundation. It is not that the information does not exist; it is that there is so much of it that it is not being utilized to its fullest potential. We must close the gap between goals and expectations and the level to which we are actually informed. This can be done through self-education or taking advantage of the numerous webinars, conferences, white papers, and other resources that are readily available and at your disposal. It is a lot of work to stay informed but, to quote Vince Lombardi, "the only place that success comes before work is in the dictionary."

– Tim Pacek
Senior HIT Consultant
Health Informatics Consulting

CME Test Answers: 1. T; 2. F; 3. T; 4. F; 5. T; 6. T; 7. T; 8. F

What Have You Done For Me Lately?

On January 30, 2012, NJAFP EVP, **Ray Saputelli, MBA, CAE** and Government Affairs Director, **Claudine Leone, Esq.**, testified before the Senate Health Committee on legislation that requires the Commissioner of the NJ Department of Health and Senior Services to convene a strategic planning summit to analyze the State's physician workforce supply. The NJAFP provided the Committee with information specific to the workforce challenges for family medicine in New Jersey and discussed areas in which NJAFP believes NJ can make improvements to train and retain family physicians in the state.

In February 2012, **Claudine Leone**, met with representatives from the New Jersey Department of Banking and Insurance to review health plan compliance with the Department's Health ID card regulations. One of the requirements of the regulations states that the health plan must identify whether the plan is state regulated or a self-insured. The NJAFP is continuing to work with the Department to monitor compliance with these regulations. This distinction is helpful to better understand which set of rules the plan is playing under: state or federal ERISA regulations.

NJAFP met with Governor Christie's health policy staff in February 2012 to address proposed regulations by the NJ Board of Chiropractic Examiners that would expand their scope of practice to allow chiropractors to provide pre-participation physicals. The Legislature was clear in its last review of the chiropractors' scope of practice statute that it did not and should not include pre-participation physicals. The Governor's office is in agreement with the legislative intent and we expect this language will be removed from the proposed regulation prior to its adoption.

News You Can Use

Did you know that Google has a crisis response team? The Google Crisis Response team works on providing critical emergency information during crises. The goal of the team is to surface emergency information through the online tools you use every day, when that information is relevant and useful. Public Alerts on Google Maps, relevant weather, public safety, and earthquake alerts from the US National Oceanic and Atmospheric Administration (NOAA), the National Weather Service, and the US Geological Survey (USGS) will be accessible when you search on Google Maps. For more information on this service visit http://blog.google.org/2012/01/ public-alerts-now-on-google-maps.html.

New Jersey Medicaid Reminder

The CMS mandate for ICD-10 Diagnosis and Surgical Procedure code implementation is quickly approaching. This mandate requires all providers to transition to the new ICD-10 codes and exclusively use only these new codes for date of service beginning October 1, 2013. Health and Human Services Secretary Kathleen G. Sebelius recently announced that HHS will initiate a process to postpone the date of compliance for all healthcare entities. The State of New Jersey Medicaid will await further CMS guidelines before formally announcing our compliance timeline for testing and implementation. We are still proceeding with our review and readiness of the New Jersey Medicaid Management Information System to ensure a complete and orderly transition once the new compliance date has been established. But we still ask, "Are you preparing?" Information concerning ICD-10 and how it affects NJMMIS and your Medicaid Submission can be found at www.njmmis.com under the "Headlines – Web Announcement."

Atlantic Health Partners Can Help Your Practice with the 2012-13 Flu Season

Atlantic Health Partners offers NJAFP members the overall best purchasing terms for Sanofi's Fluzone, Merck's Afluria, and MedImmune's Flumist. As the leading vaccine buying group in the country, Atlantic can assist your practice with reserving flu doses for the upcoming flu season, including Sanofi's High-Dose and Intradermal Fluzone.

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We encourage you to contact Atlantic to determine how their program can be of benefit to your practice. You can reach Jeff or Cindy at 1-800-741-2044 (Eastern Time) or at info@atlantichealthpartners.com.

CME

Update on the 2012 Immunization Schedule

This article is a summary of the Recommended Adult Immunization Schedule — United States, 2012 published in the MMWR 2012;61(4). To read the full article visit http://www.cdc.gov/mmwr/preview/ mmwrhtml/mm6104a9.htm

The Advisory Committee on Immunization Practices (ACIP) has reviewed and updated the recommended adult immunization schedule for 2012. ACIP updates the immunization schedules to ensure that they reflect current recommendations for licensed vaccines.

In October 2011, ACIP approved the adult immunization schedule for 2012. This new schedule includes several changes from 2011. One change is the addition of information on specific vaccine recommendations for travelers. A table summarizing precautions and contraindications for vaccines has also been added.

Footnotes for the following vaccines have been changed:

Tdap (tetanus, diphtheria, and acellular pertussis) and Td (tetanus, diphtheria): Changes to recommendations on when and to whom the vaccine should be given

HPV (human papillomavirus (HPV): Updated to include routine vaccination for males

Hepatitis B: Updated to include unvaccinated males 22–26 years of age who are immunocompromised, or test positive for human immunodeficiency virus (HIV) infection, or who have sex with men

Hepatitis B: Recommendation to vaccinate diabetic adults <60 years of age as soon as possible after diabetes is diagnosed. In addition, at the discretion of the treating clinician, vaccinate diabetic adults > 60 years based on a patient's likely need for assisted blood glucose monitoring, likelihood of acquiring hepatitis B, and likelihood of immune response to vaccination.

Zoster: Noted that FDA recently approved vaccine for persons > 50 years of age. ACIP continues to recommend that vaccination begin at age 60 years.

Influenza: Revised to specify age indications for the different licensed formulations of trivalent inactivated influenza vaccine (TIV).

MMR: Simplified to focus only on routine use in adults

MCV4 (quadrivalent meningococcal conjugate vaccine) and MPSV4 (meningococcal polysaccharide vaccine): Additional information on the use of vaccine for specific age and risk groups was added.

HPV vaccine, varicella vaccine, and pneumococcal polysaccharide vaccine (PPSV): Minor clarifications made to the footnotes

Additional information is available on the following websites:

Immunization schedule (in English and Spanish): http://www.cdc.gov/vaccines/recs/schedules/adult-schedule.htm

Adult vaccination: http://www.cdc.gov/vaccines/default.htm

ACIP statements for specific vaccines: http://www.cdc.gov/vaccines/pubs/acip-list.htm

Reporting of adverse events: http://www.vaers.hhs.gov or call 800-822-7967

References

CDC. Epidemiology and prevention of vaccine-preventable diseases. Atkinson W, Wolfe S, Hamborsky J, eds. 12th ed. Washington DC: Public Health Foundation; 2011.

CME

NJAFP offers CME online

Several unique e-learning programs are available on the NJAFP website, ranging from programs in cultural competency to performance in practice programs centered on improving colorectal cancer screening rates. Visit www.njafp.org and click on the education tab.

Recommended Adult Immunization Schedule—United States - 2012

Note: These recommendations must be read with the footnotes that follow containing number of doses, intervals between doses, and other important information.

Figure 1. Recommended adult immunization schedule, by vaccine and age group[1]

VACCINE ▼ AGE GROUP ►	19-21 years	22-26 years	27-49 years	50-59 years	60-64 years	≥ 65 years
Influenza [2]	1 dose annually					
Tetanus, diphtheria, pertussis (Td/Tdap) [3,*]	Substitute 1-time dose of Tdap for Td booster; then boost with Td every 10 yrs					Td/Tdap[3]
Varicella [4,*]	2 Doses					
Human papillomavirus (HPV) Female [5,*]	3 doses					
Human papillomavirus (HPV) Male [5,*]	3 doses					
Zoster [6]					1 dose	
Measles, mumps, rubella (MMR) [7,*]	1 or 2 doses			1 dose		
Pneumococcal (polysaccharide) [8,9]	1 or 2 doses					1 dose
Meningococcal [10,*]	1 or more doses					
Hepatitis A [11,*]	2 doses					
Hepatitis B [12,*]	3 doses					

*Covered by the Vaccine Injury Compensation Program

- For all persons in this category who meet the age requirements and who lack documentation of vaccination or have no evidence of previous infection
- Recommended if some other risk factor is present (e.g., on the basis of medical, occupational, lifestyle, or other indications)
- Tdap recommended for ≥65 if contact with <12 month old child. Either Td or Tdap can be used if no infant contact
- No recommendation

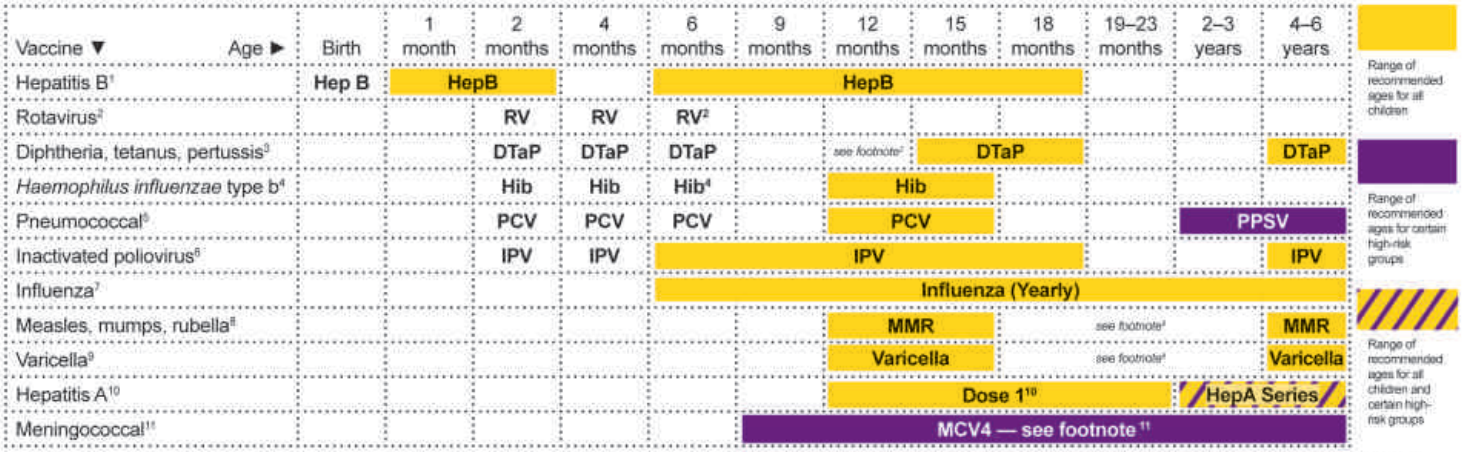
Report all clinically significant postvaccination reactions to the Vaccine Adverse Event Reporting System (VAERS). Reporting forms and instructions on filing a VAERS report are available at www.vaers.hhs.gov or by telephone, 800-822-7967.

Information on how to file a Vaccine Injury Compensation Program claim is available at www.hrsa.gov/vaccinecompensation or by telephone, 800-338-2382. To file a claim for vaccine injury, contact the U.S. Court of Federal Claims, 717 Madison Place, N.W., Washington, D.C. 20005; telephone, 202-357-6400.

Additional information about the vaccines in this schedule, extent of available data, and contraindications for vaccination is also available at www.cdc.gov/vaccines or from the CDC-INFO Contact Center at 800-CDC-INFO (800-232-4636) in English and Spanish, 8:00 a.m. - 8:00 p.m. Eastern Time, Monday - Friday, excluding holidays.

Use of trade names and commercial sources is for identification only and does not imply endorsement by the U.S. Department of Health and Human Services.

FIGURE 1: Recommended immunization schedule for persons aged 0 through 6 years—United States, 2012 (for those who fall behind or start late, see the catch-up schedule [Figure 3])



This schedule includes recommendations in effect as of December 23, 2011. Any dose not administered at the recommended age should be administered at a subsequent visit, when indicated and feasible. The use of a combination vaccine generally is preferred over separate injections of its equivalent component vaccines. Vaccination providers should consult the relevant Advisory Committee on Immunization Practices (ACIP) statement for detailed recommendations, available online at http://www.cdc.gov/vaccines/pubs/acip-list.htm. Clinically significant adverse events that follow vaccination should be reported to the Vaccine Adverse Event Reporting System (VAERS) online (http://www.vaers.hhs.gov) or by telephone (800-822-7967).

1. **Hepatitis B (HepB) vaccine.** (Minimum age: birth)
   At birth:
   - Administer monovalent HepB vaccine to all newborns before hospital discharge.
   - For infants born to hepatitis B surface antigen (HBsAg)–positive mothers, administer HepB vaccine and 0.5 mL of hepatitis B immune globulin (HBIG) within 12 hours of birth. These infants should be tested for HBsAg and antibody to HBsAg (anti-HBs) 1 to 2 months after receiving the last dose of the series.
   - If mother's HBsAg status is unknown, within 12 hours of birth administer HepB vaccine for infants weighing ≥2,000 grams, and HepB vaccine plus HBIG for infants weighing <2,000 grams. Determine mother's HBsAg status as soon as possible and, if she is HBsAg-positive, administer HBIG for infants weighing ≥2,000 grams (no later than age 1 week).

   Doses after the birth dose:
   - The second dose should be administered at age 1 to 2 months. Monovalent HepB vaccine should be used for doses administered before age 6 weeks.
   - Administration of a total of 4 doses of HepB vaccine is permissible when a combination vaccine containing HepB is administered after the birth dose.
   - Infants who did not receive a birth dose should receive 3 doses of a HepB-containing vaccine starting as soon as feasible (Figure 3).
   - The minimum interval between dose 1 and dose 2 is 4 weeks, and between dose 2 and 3 is 8 weeks. The final (third or fourth) dose in the HepB vaccine series should be administered no earlier than age 24 weeks and at least 16 weeks after the first dose.
2. **Rotavirus (RV) vaccines.** (Minimum age: 6 weeks for both RV-1 [Rotarix] and RV-5 [Rota Teq])
   - The maximum age for the first dose in the series is 14 weeks, 6 days; and 8 months, 0 days for the final dose in the series. Vaccination should not be initiated for infants aged 15 weeks, 0 days or older.
   - If RV-1 (Rotarix) is administered at ages 2 and 4 months, a dose at 6 months is not indicated.
3. **Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine.** (Minimum age: 6 weeks)
   - The fourth dose may be administered as early as age 12 months, provided at least 6 months have elapsed since the third dose.
4. ***Haemophilus influenzae* type b (Hib) conjugate vaccine.** (Minimum age: 6 weeks)
   - If PRP-OMP (PedvaxHIB or Comvax [HepB-Hib]) is administered at ages 2 and 4 months, a dose at age 6 months is not indicated.
   - Hiberix should only be used for the booster (final) dose in children aged 12 months through 4 years.
5. **Pneumococcal vaccines.** (Minimum age: 6 weeks for pneumococcal conjugate vaccine [PCV]; 2 years for pneumococcal polysaccharide vaccine [PPSV])
   - Administer 1 dose of PCV to all healthy children aged 24 through 59 months who are not completely vaccinated for their age.
   - For children who have received an age-appropriate series of 7-valent PCV (PCV7), a single supplemental dose of 13-valent PCV (PCV13) is recommended for:
     — All children aged 14 through 59 months
     — Children aged 60 through 71 months with underlying medical conditions.
   - Administer PPSV at least 8 weeks after last dose of PCV to children aged 2 years or older with certain underlying medical conditions, including a cochlear implant. See *MMWR* 2010:59(No. RR-11), available at http://www.cdc.gov/mmwr/pdf/rr/rr5911.pdf.
6. **Inactivated poliovirus vaccine (IPV).** (Minimum age: 6 weeks)
   - If 4 or more doses are administered before age 4 years, an additional dose should be administered at age 4 through 6 years.
   - The final dose in the series should be administered on or after the fourth birthday and at least 6 months after the previous dose.
7. **Influenza vaccines.** (Minimum age: 6 months for trivalent inactivated influenza vaccine [TIV]; 2 years for live, attenuated influenza vaccine [LAIV])
   - For most healthy children aged 2 years and older, either LAIV or TIV may be used. However, LAIV should not be administered to some children, including 1) children with asthma, 2) children 2 through 4 years who had wheezing in the past 12 months, or 3) children who have any other underlying medical conditions that predispose them to influenza complications. For all other contraindications to use of LAIV, see *MMWR* 2010;59(No. RR-8), available at http://www.cdc.gov/mmwr/pdf/rr/rr5908.pdf.
   - For children aged 6 months through 8 years:
     — For the 2011–12 season, administer 2 doses (separated by at least 4 weeks) to those who did not receive at least 1 dose of the 2010–11 vaccine. Those who received at least 1 dose of the 2010–11 vaccine require 1 dose for the 2011–12 season.
     — For the 2012–13 season, follow dosing guidelines in the 2012 ACIP influenza vaccine recommendations.
8. **Measles, mumps, and rubella (MMR) vaccine.** (Minimum age: 12 months)
   - The second dose may be administered before age 4 years, provided at least 4 weeks have elapsed since the first dose.
   - Administer MMR vaccine to infants aged 6 through 11 months who are traveling internationally. These children should be revaccinated with 2 doses of MMR vaccine, the first at ages 12 through 15 months and at least 4 weeks after the previous dose, and the second at ages 4 through 6 years.
9. **Varicella (VAR) vaccine.** (Minimum age: 12 months)
   - The second dose may be administered before age 4 years, provided at least 3 months have elapsed since the first dose.
   - For children aged 12 months through 12 years, the recommended minimum interval between doses is 3 months. However, if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid.
10. **Hepatitis A (HepA) vaccine.** (Minimum age: 12 months)
    - Administer the second (final) dose 6 to18 months after the first.
    - Unvaccinated children 24 months and older at high risk should be vaccinated. See *MMWR* 2006;55(No. RR-7), available at http://www.cdc.gov/mmwr/pdf/rr/rr5507.pdf.
    - A 2-dose HepA vaccine series is recommended for anyone aged 24 months and older, previously unvaccinated, for whom immunity against hepatitis A virus infection is desired.
11. **Meningococcal conjugate vaccines, quadrivalent (MCV4).** (Minimum age: 9 months for Menactra [MCV4-D], 2 years for Menveo [MCV4-CRM])
    - For children aged 9 through 23 months 1) with persistent complement component deficiency; 2) who are residents of or travelers to countries with hyperendemic or epidemic disease; or 3) who are present during outbreaks caused by a vaccine serogroup, administer 2 primary doses of MCV4-D, ideally at ages 9 months and 12 months or at least 8 weeks apart.
    - For children aged 24 months and older with 1) persistent complement component deficiency who have not been previously vaccinated; or 2) anatomic/functional asplenia, administer 2 primary doses of either MCV4 at least 8 weeks apart.
    - For children with anatomic/functional asplenia, if MCV4-D (Menactra) is used, administer at a minimum age of 2 years and at least 4 weeks after completion of all PCV oses.
    - See *MMWR* 2011;60:72–6, available at http://www.cdc.gov/mmwr/pdf/wk/mm6003. pdf, and Vaccines for Children Program resolution No. 6/11-1, available at http://www. cdc.gov/vaccines/programs/vfc/downloads/resolutions/06-11mening-mcv.pdf, and *MMWR* 2011;60:1391–2, available at http://www.cdc.gov/mmwr/pdf/wk/mm6040. pdf, for further guidance, including revaccination guidelines.

This schedule is approved by the Advisory Committee on Immunization Practices (http://www.cdc.gov/vaccines/recs/acip), the American Academy of Pediatrics (http://www.aap.org), and the American Academy of Family Physicians (http://www.aafp.org).
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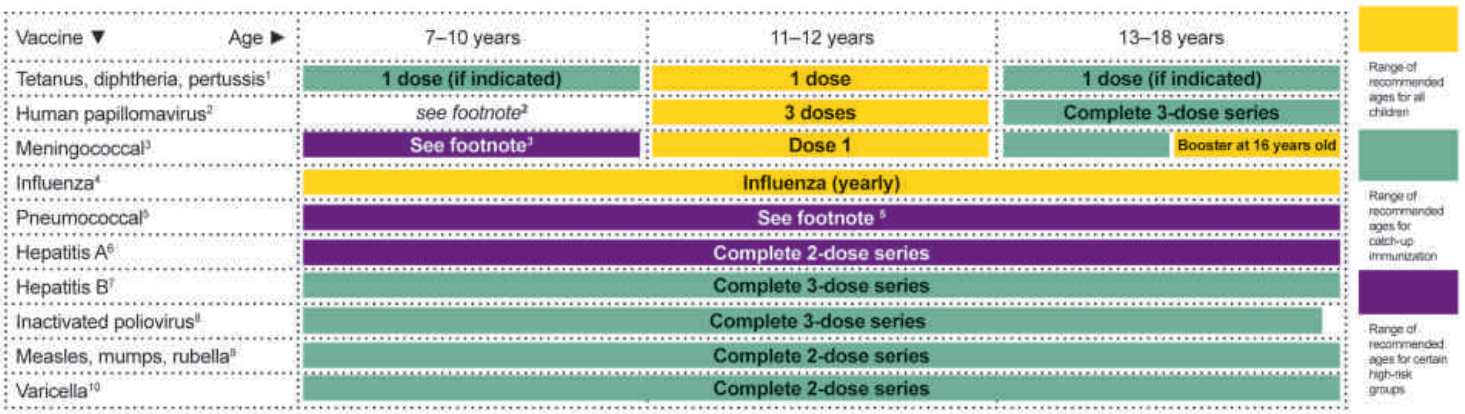
FIGURE 2: Recommended immunization schedule for persons aged 7 through 18 years—United States, 2012 (for those who fall behind or start late, see the schedule below and the catch-up schedule [Figure 3])



This schedule includes recommendations in effect as of December 23, 2011. Any dose not administered at the recommended age should be administered at a subsequent visit, when indicated and feasible. The use of a combination vaccine generally is preferred over separate injections of its equivalent component vaccines. Vaccination providers should consult the relevant Advisory Committee on Immunization Practices (ACIP) statement for detailed recommendations, available online at http://www.cdc.gov/vaccines/pubs/acip-list.htm. Clinically significant adverse events that follow vaccination should be reported to the Vaccine Adverse Event Reporting System (VAERS) online (http://www.vaers.hhs.gov) or by telephone (800-822-7967).

1. **Tetanus and diphtheria toxoids and acellular pertussis (Tdap) vaccine.** (Minimum age: 10 years for Boostrix and 11 years for Adacel)
   - Persons aged 11 through 18 years who have not received Tdap vaccine should receive a dose followed by tetanus and diphtheria toxoids (Td) booster doses every 10 years thereafter.
   - Tdap vaccine should be substituted for a single dose of Td in the catch-up series for children aged 7 through 10 years. Refer to the catch-up schedule if additional doses of tetanus and diphtheria toxoid–containing vaccine are needed.
   - Tdap vaccine can be administered regardless of the interval since the last tetanus and diphtheria toxoid–containing vaccine.
2. **Human papillomavirus (HPV) vaccines (HPV4 [Gardasil] and HPV2 [Cervarix]).** (Minimum age: 9 years)
   - Either HPV4 or HPV2 is recommended in a 3-dose series for females aged 11 or 12 years. HPV4 is recommended in a 3-dose series for males aged 11 or 12 years.
   - The vaccine series can be started beginning at age 9 years.
   - Administer the second dose 1 to 2 months after the first dose and the third dose 6 months after the first dose (at least 24 weeks after the first dose).
   - See *MMWR* 2010;59:626–32, available at http://www.cdc.gov/mmwr/pdf/wk/mm5920.pdf.
3. **Meningococcal conjugate vaccines, quadrivalent (MCV4).**
   - Administer MCV4 at age 11 through 12 years with a booster dose at age 16 years.
   - Administer MCV4 at age 13 through 18 years if patient is not previously vaccinated.
   - If the first dose is administered at age 13 through 15 years, a booster dose should be administered at age 16 through 18 years with a minimum interval of at least 8 weeks after the preceding dose.
   - If the first dose is administered at age 16 years or older, a booster dose is not needed.
   - Administer 2 primary doses at least 8 weeks apart to previously unvaccinated persons with persistent complement component deficiency or anatomic/functional asplenia, and 1 dose every 5 years thereafter.
   - Adolescents aged 11 through 18 years with human immunodeficiency virus (HIV) infection should receive a 2-dose primary series of MCV4, at least 8 weeks apart.
   - See *MMWR* 2011;60:72–76, available at http://www.cdc.gov/mmwr/pdf/wk/mm6003.pdf, and Vaccines for Children Program resolution No. 6/11-1, available at http://www.cdc.gov/vaccines/programs/vfc/downloads/resolutions/06-11mening-mcv.pdf, for further guidelines.
4. **Influenza vaccines (trivalent inactivated influenza vaccine [TIV] and live, attenuated influenza vaccine [LAIV]).**
   - For most healthy, nonpregnant persons, either LAIV or TIV may be used, except LAIV should not be used for some persons, including those with asthma or any other underlying medical conditions that predispose them to influenza complications. For all other contraindications to use of LAIV, see *MMWR* 2010;59(No.RR-8), available at http://www.cdc.gov/mmwr/pdf/rr/rr5908.pdf.
   - Administer 1 dose to persons aged 9 years and older.
   - For children aged 6 months through 8 years:
     — For the 2011–12 season, administer 2 doses (separated by at least 4 weeks) to those who did not receive at least 1 dose of the 2010–11 vaccine. Those who received at least 1 dose of the 2010–11 vaccine require 1 dose for the 2011–12 season.
     — For the 2012–13 season, follow dosing guidelines in the 2012 ACIP influenza vaccine recommendations.
5. **Pneumococcal vaccines (pneumococcal conjugate vaccine [PCV] and pneumococcal polysaccharide vaccine [PPSV]).**
   - A single dose of PCV may be administered to children aged 6 through 18 years who have anatomic/functional asplenia, HIV infection or other immunocompromising condition, cochlear implant, or cerebral spinal fluid leak. See *MMWR* 2010:59(No. RR-11), available at http://www.cdc.gov/mmwr/pdf/rr/rr5911.pdf.
   - Administer PPSV at least 8 weeks after the last dose of PCV to children aged 2 years or older with certain underlying medical conditions, including a cochlear implant. A single revaccination should be administered after 5 years to children with anatomic/functional asplenia or an immunocompromising condition.
6. **Hepatitis A (HepA) vaccine.**
   - HepA vaccine is recommended for children older than 23 months who live in areas where vaccination programs target older children, who are at increased risk for infection, or for whom immunity against hepatitis A virus infection is desired. See *MMWR* 2006;55(No. RR-7), available at http://www.cdc.gov/mmwr/pdf/rr/rr5507.pdf.
   - Administer 2 doses at least 6 months apart to unvaccinated persons.
7. **Hepatitis B (HepB) vaccine.**
   - Administer the 3-dose series to those not previously vaccinated.
   - For those with incomplete vaccination, follow the catch-up recommendations (Figure 3).
   - A 2-dose series (doses separated by at least 4 months) of adult formulation Recombivax HB is licensed for use in children aged 11 through 15 years.
8. **Inactivated poliovirus vaccine (IPV).**
   - The final dose in the series should be administered at least 6 months after the previous dose.
   - If both OPV and IPV were administered as part of a series, a total of 4 doses should be administered, regardless of the child's current age.
   - IPV is not routinely recommended for U.S. residents aged18 years or older.
9. **Measles, mumps, and rubella (MMR) vaccine.**
   - The minimum interval between the 2 doses of MMR vaccine is 4 weeks.
10. **Varicella (VAR) vaccine.**
    - For persons without evidence of immunity (see *MMWR* 2007;56[No. RR-4], available at http://www.cdc.gov/mmwr/pdf/rr/rr5604.pdf), administer 2 doses if not previously vaccinated or the second dose if only 1 dose has been administered.
    - For persons aged 7 through 12 years, the recommended minimum interval between doses is 3 months. However, if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid.
    - For persons aged 13 years and older, the minimum interval between doses is 4 weeks.

This schedule is approved by the Advisory Committee on Immunization Practices (http://www.cdc.gov/vaccines/recs/acip), the American Academy of Pediatrics (http://www.aap.org), and the American Academy of Family Physicians (http://www.aafp.org).
Department of Health and Human Services • Centers for Disease Control and Prevention

FIGURE 3. Catch-up immunization schedule for persons aged 4 months through 18 years who start late or who are more than 1 month behind —United States • 2012

The figure below provides catch-up schedules and minimum intervals between doses for children whose vaccinations have been delayed. A vaccine series does not need to be restarted, regardless of the time that has elapsed between doses. Use the section appropriate for the child's age. **Always use this table in conjunction with the accompanying childhood and adolescent immunization schedules (Figures 1 and 2) and their respective footnotes.**

Persons aged 4 months through 6 years					
Vaccine	Minimum Age for Dose 1	Minimum Interval Between Doses			
		Dose 1 to dose 2	Dose 2 to dose 3	Dose 3 to dose 4	Dose 4 to dose 5
Hepatitis B	Birth	4 weeks	8 weeks and at least 16 weeks after first dose; minimum age for the final dose is 24 weeks		
Rotavirus[1]	6 weeks	4 weeks	4 weeks[1]		
Diphtheria, tetanus, pertussis[2]	6 weeks	4 weeks	4 weeks	6 months	6 months[2]
Haemophilus influenzae type b[3]	6 weeks	4 weeks if first dose administered at younger than age 12 months 8 weeks (as final dose) if first dose administered at age 12–14 months No further doses needed if first dose administered at age 15 months or older	4 weeks[3] if current age is younger than 12 months 8 weeks (as final dose)[3] if current age is 12 months or older and first dose administered at younger than age 12 months and second dose administered at younger than 15 months No further doses needed if previous dose administered at age 15 months or older	8 weeks (as final dose) This dose only necessary for children aged 12 months through 59 months who received 3 doses before age 12 months	
Pneumococcal[4]	6 weeks	4 weeks if first dose administered at younger than age 12 months 8 weeks (as final dose for healthy children) if first dose administered at age 12 months or older or current age 24 through 59 months No further doses needed for healthy children if first dose administered at age 24 months or older	4 weeks if current age is younger than 12 months 8 weeks (as final dose for healthy children) if current age is 12 months or older No further doses needed for healthy children if previous dose administered at age 24 months or older	8 weeks (as final dose) This dose only necessary for children aged 12 months through 59 months who received 3 doses before age 12 months or for children at high risk who received 3 doses at any age	
Inactivated poliovirus[5]	6 weeks	4 weeks	4 weeks	6 months[5] minimum age 4 years for final dose	
Meningococcal[6]	9 months	8 weeks[6]			
Measles, mumps, rubella[7]	12 months	4 weeks			
Varicella[8]	12 months	3 months			
Hepatitis A	12 months	6 months			
Persons aged 7 through 18 years					
Tetanus, diphtheria/ tetanus, diphtheria, pertussis[9]	7 years[9]	4 weeks	4 weeks if first dose administered at younger than age 12 months 6 months if first dose administered at 12 months or older	6 months if first dose administered at younger than age 12 months	
Human papillomavirus[10]	9 years	Routine dosing intervals are recommended[10]			
Hepatitis A	12 months	6 months			
Hepatitis B	Birth	4 weeks	8 weeks (and at least 16 weeks after first dose)		
Inactivated poliovirus[5]	6 weeks	4 weeks	4 weeks[5]	6 months[5]	
Meningococcal[6]	9 months	8 weeks[6]			
Measles, mumps, rubella[7]	12 months	4 weeks			
Varicella[8]	12 months	3 months if person is younger than age 13 years 4 weeks if person is aged 13 years or older			

1. **Rotavirus (RV) vaccines (RV-1 [Rotarix] and RV-5 [Rota Teq]).**
   - The maximum age for the first dose in the series is 14 weeks, 6 days; and 8 months, 0 days for the final dose in the series. Vaccination should not be initiated for infants aged 15 weeks, 0 days or older.
   - If RV-1 was administered for the first and second doses, a third dose is not indicated.
2. **Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine.**
   - The fifth dose is not necessary if the fourth dose was administered at age 4 years or older.
3. ***Haemophilus influenzae* type b (Hib) conjugate vaccine.**
   - Hib vaccine should be considered for unvaccinated persons aged 5 years or older who have sickle cell disease, leukemia, human immunodeficiency virus (HIV) infection, or anatomic/functional asplenia.
   - If the first 2 doses were PRP-OMP (PedvaxHIB or Comvax) and were administered at age 11 months or younger, the third (and final) dose should be administered at age 12 through 15 months and at least 8 weeks after the second dose.
   - If the first dose was administered at age 7 through 11 months, administer the second dose at least 4 weeks later and a final dose at age 12 through 15 months.
4. **Pneumococcal vaccines.** (Minimum age: 6 weeks for pneumococcal conjugate vaccine [PCV]; 2 years for pneumococcal polysaccharide vaccine [PPSV])
   - For children aged 24 through 71 months with underlying medical conditions, administer 1 dose of PCV if 3 doses of PCV were received previously, or administer 2 doses of PCV at least 8 weeks apart if fewer than 3 doses of PCV were received previously.
   - A single dose of PCV may be administered to certain children aged 6 through 18 years with underlying medical conditions. See age-specific schedules for details.
   - Administer PPSV to children aged 2 years or older with certain underlying medical conditions. See *MMWR* 2010:59(No. RR-11), available at http://www.cdc.gov/mmwr/pdf/rr/rr5911.pdf.
5. **Inactivated poliovirus vaccine (IPV).**
   - A fourth dose is not necessary if the third dose was administered at age 4 years or older and at least 6 months after the previous dose.
   - In the first 6 months of life, minimum age and minimum intervals are only recommended if the person is at risk for imminent exposure to circulating poliovirus (i.e., travel to a polio-endemic region or during an outbreak).
   - IPV is not routinely recommended for U.S. residents aged 18 years or older.
6. **Meningococcal conjugate vaccines, quadrivalent (MCV4).** (Minimum age: 9 months for Menactra [MCV4-D]; 2 years for Menveo [MCV4-CRM])
   - See Figure 1 ("Recommended immunization schedule for persons aged 0 through 6 years") and Figure 2 ("Recommended immunization schedule for persons aged 7 through 18 years") for further guidance.
7. **Measles, mumps, and rubella (MMR) vaccine.**
   - Administer the second dose routinely at age 4 through 6 years.
8. **Varicella (VAR) vaccine.**
   - Administer the second dose routinely at age 4 through 6 years. If the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid.
9. **Tetanus and diphtheria toxoids (Td) and tetanus and diphtheria toxoids and acellular pertussis (Tdap) vaccines.**
   - For children aged 7 through 10 years who are not fully immunized with the childhood DTaP vaccine series, Tdap vaccine should be substituted for a single dose of Td vaccine in the catch-up series; if additional doses are needed, use Td vaccine. For these children, an adolescent Tdap vaccine dose should not be given.
   - An inadvertent dose of DTaP vaccine administered to children aged 7 through 10 years can count as part of the catch-up series. This dose can count as the adolescent Tdap dose, or the child can later receive a Tdap booster dose at age 11–12 years.
10. **Human papillomavirus (HPV) vaccines (HPV4 [Gardasil] and HPV2 [Cervarix]).**
    - Administer the vaccine series to females (either HPV2 or HPV4) and males (HPV4) at age 13 through 18 years if patient is not previously vaccinated.
    - Use recommended routine dosing intervals for vaccine series catch-up; see Figure 2 ("Recommended immunization schedule for persons aged 7 through 18 years").

Clinically significant adverse events that follow vaccination should be reported to the Vaccine Adverse Event Reporting System (VAERS) online (http://www.vaers.hhs.gov) or by telephone (800-822-7967). Suspected cases of vaccine-preventable diseases should be reported to the state or local health department. Additional information, including precautions and contraindications for vaccination, is available from CDC online (http://www.cdc.gov/vaccines) or by telephone (800-CDC-INFO [800-232-4636]).

CME

"B" Informed

Get the Facts about Hepatitis B

John J. Moore, D.O. FAAFP and New Jersey Department of Health and Senior Services

The Centers for Disease Control and Prevention (CDC) recommends that hepatitis B virus (HBV) vaccine be administered to infants soon after birth and before hospital discharge.[1] They are not alone in this recommendation. The American Academy of Pediatrics (AAP) and the American Academy of Family Physicians (AAFP) also endorse this recommendation.[2] Parents are often uninformed regarding the risks of contracting this disease and may question why their infant needs to receive a vaccination at such a young age. Parents can appreciate the benefits of vaccinating them at birth when they understand the chronic long term effects of liver failure, cirrhosis, and liver cancer; the unique risks that this virus poses to their infant child; and the safety of the vaccine against this deadly disease.

According to information provided by the Immunization Action Coalition and the CDC, an estimated 1.25 million people are chronically infected with the hepatitis B virus (HBV) in the United States alone, resulting in an estimated 2,000-4,000 deaths each year.[3] Infants infected at birth have a greater than 90% chance of becoming chronically infected with HBV leading to liver cancer, cirrhosis, and liver failure in 25% of these infants when they become adults.[2] Everyone can appreciate that children born to the 24,000 women each year with chronic HBV infection are at risk of infection.[2] Through routine screening of all pregnant women followed by timely administration of HBV vaccine and HBV immune globulin to infants born to chronically infected mothers, most children can be spared a lifetime of infection.

However, many parents don't realize that approximately 66% of childhood transmission of HBV occurs in infants whose mothers are HBV negative but who are exposed postnatally from another family member or caretaker with chronic HBV infection or who are inadvertently exposed outside the home.

Parents need to understand that the HBV can be spread by infectious blood and body fluids and not just through sex or through birth to an infected mother. A child may be at risk when coming into contact with blood from an infected person; this can occur if the infected person suffers a scrape, cut, or nose bleed. These are realistic opportunities for exposure since the CDC has stated that the virus remains viable and infectious in the environment for at least 7 days and can remain present on inanimate objects absent of visible blood.[4] Since only 7 out of 10 infected adults show any signs or symptoms, and infected children under age 5 rarely show any symptoms at all,[5] it is obvious how the infected population can easily, and unknowingly, be transmitting the disease to others. People have tried to estimate the number of children under the age of ten who were infected with HBV before the widespread use of the HBV vaccine. Data on the prevalence of disease from the National Health and Nutrition Examination Surveys have provided estimates of the number of early HBV infections. Based on these data, approximately 15,000 children born to hepatitis B surface antigen (HbsAg) positive women are estimated to be infected annually. Of note, an additional 16,000 children under 10 years of age were infected with HBV beyond the postnatal period each year before routine infant vaccination was recommended in 1991.[6] This study by Armstrong, et al.[7] concluded that thousands of children were infected each year with HBV before routine infant HBV immunization, placing them at high risk of death from cirrhosis or hepatocellular carcinoma later in life.

Barbara Montana, MD, MPH, FACP, the Medical Director of the New Jersey Department of Health and Senior Services Communicable Disease Service explains, "There are so many parents and healthcare professionals who mistakenly think this vaccine is given at birth for a sexually-acquired infection that might be contracted later in life. But the most important reason for the vaccine is to prevent HBV infection early in life. HBV infection has possible life-long complications of chronic disease in the form of liver failure and liver cancer that affect so many who are infected at birth or within the first years of life."

The universal HBV birth dose to all infants also acts as a safety net and reduces the risk for perinatal infection in infants whose mothers' infection status is either unknown or incorrectly documented at the time of delivery.[8] Sometimes there may be errors or delays in documenting, testing and reporting maternal HBV status which place unvaccinated infants at risk. Delaying HBV vaccination until a follow-up office visit will be too late to prevent HBV transmission.

The HBV vaccine has been demonstrated to be safe when administered to infants, children, adolescents and adults.[4] Since 1982, an estimated 70 million adolescents and adults and 50 million infants and children in the United States have received at least one dose of HBV vaccine;[3] a billion doses of HBV vaccine have been given worldwide.[9] Vaccination causes a sore arm occasionally, but serious reactions are very rare.

According to the 2010 National Immunization Survey, approximately 37% of newborns in New Jersey receive the birth dose of HBV vaccine compared to the national average of approximately 64%.[10] Birthing hospitals and healthcare professionals must do their part to ensure that all newborns are being protected against HBV by ensuring that there are written policies and procedures and standing orders for administration of the HBV vaccine at birth in accordance with the CDC, AAP and AAFP recommendations.

Continued on next page

For more information about HBV, please visit:
CDC Viral Hepatitis Home Page:
http://www.cdc.gov/hepatitis/index.htm

Immunization Action Coalition (IAC):
www.immunize.org/birthdose

NJ Department of Health and Senior Services Vaccine Preventable Disease Program:
http://nj.gov/health/cd/hepatitisb_perinatal/index.shtml

"B" Informed *continued*

References

1. Mast EE, Margolis HS, Fiore AE, Brink EW, Goldstein ST, Wang SA, Alter MJ. A comprehensive immunization strategy to eliminate transmission of hepatitis B virus infection in the United States. *MMWR*.2005;54(RR16):1-23.
2. Wexler DL. Give the birth dose: Hepatitis B vaccine at birth saves lives. In Immunization Action Coalition (Ed.). St. Paul, MN; 2009.
3. Immunization Action Coalition. Ask the Experts: Hepatitis B. 2009. http://www.immunize.org/askexperts/experts_hepb.asp#chronic. Accessed March 2012.
4. Mast EE, Weinbaum CM, Fiore AE, Alter MJ, Bell BP, Finelli L, Ward JW. A comprehensive immunization strategy to eliminate transmission of hepatitis B virus infection in the United States: Recommendations of the advisory committee on immunization practices (ACIP) Part II: immunization of adults. *MMWR*.2006;55(RR-16):1-33.
5. Immunization Action Coalition. Hepititis B. 2012. *Vaccine Information* http://www.vaccineinformation.org/hepb/qandadis.asp Accessed March 2012.
6. Finelli L, Bell BP. Chapter 4: Hepatitis B. In SW Roush, L McIntyre & LM Baldy (Eds.), *VPD Surveillance Manual, 5th Edition, 2011*. Centers for Disease Control and Prevention. Atlanta GA; 2011.
7. Armstrong GL, Mast EE, Wojcznski M, Margolis HS. Childhood hepatitis B virus infections in the United States before hepatitis B immunization. *Pediatrics*. 2001;108(5):1123-1128.
8. Cooper A, Yusuf H, Rodewald L, Malik T, Pollard R, Pickering L. Attitudes, practices, and preferences of pediatricians regarding initiation of hepatitis B immunization at birth. *Pediatrics*. 2001;108(e98): doi.10.1542/peds.108.6.e98.
9. World Health Organization. 2011. Hepatitis B. *Immunization, Vaccines and Biologicals* http://www.who.int/immunization/topics/hepatitis_b/en/index.html. Accessed March 2012.
10. NJ Department of Health and Senior Services. 2012. Protecting infants from hepatitis B *Health Matters.* Trenton, NJ: Office of the Commissioner. ▲

CME QUIZ

Instructions: Read the articles designated with the CME icon and answer each of the quiz questions. Mail or fax this form within one year from date of issue to: NJAFP CME Quiz, 224 West State Street, Trenton, NJ 08608 • Fax: 609/394-7712

Perspectives: A View of Family Medicine in New Jersey has been reviewed and is acceptable for up to 4 Prescribed credits by the American Academy of Family Physicians. Term of approval is for one year from beginning distribution date of 1/1/12. This issue (Volume 11, Issue 1, 2012) is approved for 1 Prescribed credit. Credit may be claimed for one year from the date of this issue.

AAFP Prescribed credit is accepted by the American Medical Association as equivalent to AMA PRA category 1 credit toward the AMA Physician's Recognition Award. When applying for the AMA PRA, Prescribed credit earned must be reported as Prescribed credit, not as category 1.

Members - To obtain credit:

1. Complete and return this quiz to the NJAFP
2. Report your credit directly to the AAFP

Nonmembers – To obtain credit:

1. Complete and return this quiz to the NJAFP with a check for $15 made payable to the NJAFP and a self-addressed, stamped envelope to NJAFP CME, 224 West State Street, Trenton, NJ 08608. A certificate of completion will be sent to you.

Members are responsible for reporting their credit to the AAFP. To report credit, go to www.aafp.org/myacademy/ or call 800-274-2237.

Name: _____

AAFP Membership Number: _____

Street Address: _____

City/State/Zip: _____

Email Address: _____

Phone: _____ Fax: _____

Update on the 2012 Immunization Schedule

1. One change to the 2012 ACIP adult immunization schedule is the addition of information on specific vaccine recommendations for travelers. **T or F**

2. Routine vaccination with human papillomavirus is not currently indicated for males. **T or F**

3. Diabetics over 60 years of age should receive a Hepatitis B vaccine as soon after diagnosis as possible. **T or F**

4. The CDC does not recommend hepatitis B virus (HBV) vaccine be administered to infants soon after birth or before hospital discharge. **T or F**

5. While the FDA has approved the zoster vaccine for adults > 50 years, ACIP still recommends vaccination begin at 60 years of age. **T or F**

6. Between 2,000 and 4,000 deaths each year can be attributed to hepatitis B virus. **T or F**

7. Children who were infected with HBV prior to routine immunization have a higher risk of death from cirrhosis or hepatocellular carcinoma later in life. **T or F**

8. New Jersey exceeds the national average of newborns who receive the birth dose of HBV vaccine. **T or F**

ANSWERS ON PAGE 6

NJAFP
New Jersey Academy of Family Physicians

Call for Posters

Family Medicine Research Poster Contest

NJAFP is issuing its Call for Posters for the 2012 Scientific Assembly. This event will provide an opportunity to exhibit a research project to approximately 200 family physicians attending the Scientific Assembly. The research must be of interest and educational value to the specialty of Family Medicine, have IRB approval, and must be authored by an NJAFP physician member, a New Jersey Family Medicine resident, or a New Jersey medical student. Awards will be given to completed research in the Physician, Resident, and Student categories.

ELIGIBILITY: Original clinical or educational research in progress or completed in the past 2-3 years that has been conducted or performed by an NJAFP physician member, a New Jersey Family Medicine resident, or a medical student attending one of New Jersey's allopathic medical schools, may qualify for submission to this program. We define "student" and "resident" as the status of the investigator when most of the work was done. Please do not submit work that has been published prior to the submission deadline. Membership in NJAFP for the primary or secondary author is a prerequisite for submission.

For more information visit the NJAFP website at www.njafp.org and click on the link for the 2012 Summer Celebration and Scientific Assembly.

With Sympathy

The NJAFP extends sympathy to NJAFP President Robert Eidus, MD and his wife Lauren Shub on the passing of Lauren's mother at the end of February.

Members in the News...

Jeffrey Levine, MD *(Hillsborough)*, was interviewed by the Newark *Star Ledger* regarding his UMDNJ President's Lecture Series: "New Jersey's Obesity Epidemic: the Role of the Health Care Professional." To read the interview visit http://blog.nj.com/njv_editorial_page/2012/01/obesity_a_qa_with_nj_doctor_je.html

Special Congratulations...

Denise V. Rodgers, MD *(Newark),* UMDNJ Executive Vice President for Academic and Clinical Affairs, has been named to the position of Interim President of UMDNJ, effective January 1, 2012.

Lauren Carruth-Mehnert, MD *(Hammonton),* and all the family physicians from AtlantiCare Special Care Center (SCC) who were awarded the Premier Cares Award. The Cares Award recognizes exemplary efforts by not-for-profit community organizations to improve the health of communities in need. AtlantiCare Special Care Center provides intensive management services to the region's most complex, high-needs patients in a completely different and unique way. To read more about SCC and the Cares Award visit https://premierinc.com/about/news/12-feb/cares020112.jsp.

Do You Need to Complete a SAM for 2012?

Don't Miss NJAFP'S SAM Study Hall

NJAFP offers an ABFM Self-Assessment Module (SAM) Study Hall in conjunction with the 2012 Summer Celebration and Scientific Assembly. The SAM will be held Sunday, June 17, from 1:00pm - 6:00pm.

This year's topic is Asthma. Gary Levine, MD and Jonathon Firnhaber, MD will facilitate the study group.

You will go through the SAM with your study group, guided by your instructor. During the SAM you will explore the questions and engage in clinical discussion. At the end of the 5-hour session, your answers to the sixty-question knowledge assessment (Part A) will automatically be sent to the ABFM on your behalf. After you complete the clinical simulation portion of the module (Part B), you can claim up to 12 AAFP Prescribed CME credits (also equivalent to AMA Category I credits). You are guaranteed a passing grade when you take the SAM as part of the Study Hall.

NOTE: The SAM Study Hall requires separate registration and fee. Registration for the SAM will open at the same time the 2012 Scientific Assembly registration.

2012 Scientific Assembly News

It seems we just finished up our 2011 Scientific Assembly, and here we are planning for 2012. This year we are blending some of the old favorites with some of the new CME activities.

Old Favorites

We are headed back to the Sheraton Atlantic City this year. The entire staff at the Sheraton is looking forward to welcoming us back and has promised to help make our annual conference its usual success. The 2012 Scientific Assembly will be held from June 15th to the 17th. Information is now available on the NJAFP website: www.njafp.org.

This year we are featuring a diabetes track on Saturday, June 16. We will start the track with quality improvements projects in diabetes management from NJMS. The rest of the track will focus on emerging therapies, and a series of conversations between family physicians and specialists on the challenges and best practices in working with your patients with diabetes to improve outcomes. We will also be reprising a series of 90-minute sessions focused on a specific clinical topic. Each 90-minute session will feature three 20-minute presentations and a 30-minute workshop, for example; a panel discussion, a case study, or a Q&A session. Look for more details in the registration brochure or on the NJAFP website: www.njafp.org.

Tools for Survival: Part 3

Here is your opportunity to get information and to share best practices around the hottest topics affecting primary care in New Jersey. Details about the workshop can be found on the NJAFP website. This event requires a separate registration.

House of Delegates

The Academy can be most effective in meeting your needs when you are involved in the decision making. Here is the opportunity to bring the issues that are important to you to the forefront and have a hand in crafting solutions. However, the only way you can make an impact is to plan to attend the House of Delegates on Friday, June 15. You can have a big impact by writing a resolution, serving as a delegate or just attending and offering your insights. Whatever you decide to do, make sure your voice is heard!

If you wish to serve as a delegate, contact EVP Ray Saputelli at ray@njafp.org or at 609-394-1711. ▲

WRITING A RESOLUTION

During the House of Delegates members present resolutions which help to provide guidance to NJAFP Leadership. Resolutions passed in the House of Delegates are further considered for presentation to the AAFP Congress of Delegates for national adoption. In the past New Jersey has put forth numerous resolutions which were adopted and are now part of national AAFP policy.

Resolutions are formal requests to establish or reaffirm Academy policies, implement programs or address issues of interest to family physicians and Family Medicine. There are also special resolutions of commendation acknowledging noteworthy service, or to memorialize deceased officers or delegates.

Writing a resolution is easy to master. For a complete guide to writing resolutions for submission to the House of Delegates, log in on the home page at www.njafp.org and click on the SCSA logo under Featured Event on the home page. Click on House of Delegates (Members Only) on the left side of the screen, and click on the document "Call for Resolutions 2012." For a faxed copy of this document, please call the NJAFP office at 609-394-1711.

Resolutions may be sent by regular mail to: NJAFP, Speaker of the House, 224 West State St., Trenton, NJ 08608. Resolutions may also be faxed to the NJAFP office at 609-394-7712, or emailed to Ray@njafp.org. Please put "Resolution" in the subject line.

DATES TO REMEMBER

Deadline for submission of nomination materials is on or before April 30, 2012.

Elections will be held at the House of Delegates meeting, which convenes at 8:00AM, on Friday, June 15, 2012 at the Sheraton Atlantic City, Atlantic City, NJ. The meeting is open to all members.

Deadline for submitting resolutions is on or before April 30, 2012.

Emergency resolutions submitted after the April 11th deadline will be considered received at the House of Delegates and presented to the delegates at the discretion of the Speaker.

Other dates to remember

April 30, 2012: Nominations for New Jersey Family Physician of the Year due.

May 4, 2012: Early bird registration for the 2012 Summer Celebration and Scientific Assembly ends.

Call for Nominations

Nelson Chiu, NJAFP Student Trustee speaking at the 2011 House of Delegates.

THE NJAFP NOMINATING COMMITTEE is accepting nominations for the Board of Trustees for 2012-2013 Academy year. Nominations are sought for the following positions:

- **Board Trustee:** three positions
- **Resident Trustee:** one position
- **Student Trustee:** two positions
- **AAFP Delegate:** one position
- **AAFP Alternate Delegate:** one position.

The following officers will be elected by the House of Delegates: President Elect, Vice President, Treasurer and Secretary. Interested candidates should review the nomination criteria by logging in on the home page at *www.njafp.org* and then clicking on the SCSA logo under Featured Event on the home page. Click on **"Call for Resolutions and Nominations"** on the left side of the screen, and scroll down to **"Run for a Board Position."**

Trustees' duties include attending approximately five meetings each year (with additional preparation time of approximately 2-4 hours prior to each meeting) and possibly serving on other committees at the discretion of the President. Members in good standing of the NJAFP may be considered on the slate of nominations, however, individuals who have not served on a committee or on the Board in previous years may be asked to interview with the Nominating Committee.

For details of the requirements for nomination, please call the NJAFP office at **609-394-1711**. Specific duties and responsibilities for each position are available by logging in on the home page at *www.njafp.org* and then clicking on the SCSA logo under Featured Event on the home page. Click on **"House of Delegates"** (Members Only) on the left side of the screen, and then click on the document **"Board of Trustee Position Descriptions."**

CALL FOR *FAMILY PHYSICIAN OF THE YEAR 2012*

The **Family Physician of the Year Award** provides a means for recognition of individuals who embody the principles of the family physician of excellence. It is the Academy's most prestigious award. The Selection Committee is making its first call for nominees for this award for 2012. Please consider family physicians you know who would represent New Jersey as the "best of the best."

County chapters, other groups or individuals have the opportunity to submit nominations. The physician selected will be recognized in the public relations efforts of the NJAFP, and will be forwarded as the New Jersey nominee for the prestigious AAFP Family Physician of the Year Award.

2011 Family Physician of the Year, Susie Kaye, MD *(2nd from left) from Overlook Hospital in Summit, NJ is surrounded by family and friends as they celebrate her award at the 2011 President's Gala at Bally's in Atlantic City.*

GUIDELINES FOR SELECTION

- Provides his/her community with compassionate, comprehensive and caring medical service on a continuing basis.
- Is directly and effectively involved in community affairs and activities that enhance the quality of life in his/her home area.
- Provides a credible role model, emulating the family physician as a healer and human begin to his/her community, and as a professional in the service and art of medicine to colleagues, other health professionals, and especially to young physicians in training and to medical students.
- Specific to New Jersey:
  - Has been in Family Medicine in NJ at least ten consecutive years.
  - Must be Board Certified in Family Medicine
  - Must be a member in good standing in his/her community.

TO NOMINATE A FAMILY PHYSICIAN

Members wishing to place a candidate in nomination should submit the following materials to:

NJAFP Selection Committee,
224 West State St. Trenton, NJ 08608

1. Name, address and phone numbers of the nominee.
2. Name, address and phone numbers of the nominating individual.
3. Letter of nomination *(no more than two pages).*
4. A current CV
5. Three letters of support *(two from colleagues, one from person in his/her community).*
6. Other supportive material as appropriate *(not over 15 pages).*

NOMINATIONS MUST BE RECEIVED NO LATER THAN

APRIL 30, 2012

NJAFP
New Jersey Academy of Family Physicians

The New Jersey Prescription Drug Monitoring Program

Finally implemented and ready for Physician Registration

Claudine Leone, Esq.

Claudine Leone, Esq. is the Director of Governmental Affairs for the NJAFP.

Between November 3 and December 7, 2011, a single patient obtained a four-month supply of oxycodone and methadone by presenting prescriptions, now believed to be forged, to three New Jersey pharmacies on a total of 14 occasions. The patient circumvented the safeguards that pharmacies and insurance carriers use to spot such abuse by spreading out his visits between the pharmacies, and by paying with cash in some instances and by insurance in others.

As a result, in one month the individual obtained a total of 2,520 doses of highly addictive, narcotic medications classified as Controlled Dangerous Substances.

The apparently abusive pattern of purchasing drugs was revealed this month by the New Jersey Attorney General – and the discovery was made as a result of the New Jersey Prescription Monitoring Program (NJPMP).

NJPMP is a powerful new tool in the State's fight against the abuse and diversion of prescription drugs, as well as the often-heavy insurance costs of fraudulently-obtained prescription medication.

The NJPMP, established by State legislation and maintained by the Division of Consumer Affairs, has been collecting detailed data from 2,000 pharmacies statewide since September 1, 2011. Pharmacies provide data every 15 days on all prescription sales of drugs classified as Controlled Dangerous Substances (CDS) and Human Growth Hormone (HGH).

The result is a searchable database that includes detailed information on the sale of these high-risk drugs when they are dispensed in outpatient settings in New Jersey, or by out-of-state pharmacies dispensing into New Jersey. The information on each transaction includes, among other things: the patient's name and date of birth; the dates at which the prescription was written and the drug was dispensed; the name, quantity, and strength of the medication; the method of payment for the medication; and the identities of the prescriber and pharmacy. The database now includes information on approximately 4 million prescriptions dispensed in New Jersey since September 1.

The New Jersey Prescription Monitoring Program is one of several new tools in a statewide effort to halt the abuse and diversion of prescription drugs and help promote fiscal integrity in the healthcare sector. The database will help the Division of Consumer Affairs and other law enforcement agencies identify and investigate individuals and businesses suspected of fraudulently diverting controlled drugs for abuse.

Patient information in the database is kept confidential in compliance with Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Privacy and Security Rules. Under HIPAA and the State law that establishes the NJPMP, the Division of Consumer Affairs on January 4, 2012, began allowing State-licensed prescribers and pharmacists to obtain free accounts to access and search the database through a secure website. You

The launch of the NJPMP is one component of the Division of Consumer Affairs' comprehensive effort to halt the diversion and abuse of prescription drugs, which includes:

- Enhanced enforcement initiatives, including a reorganization of and additional staffing for the Division's Enforcement Bureau, which investigates prescription drug diversion cases on behalf of the State Board of Medical Examiners, Board of Pharmacy, and New Jersey's other healthcare-related professional licensing boards.
- Effecting a reduction in supply, by encouraging practitioners to prescribe only the amount of medication needed for treatment; working with pharmacies to develop a set of statewide best practices for drug security; and encouraging parents and grandparents to maintain their medication securely within the home, and to dispose of their unwanted medications safely and responsibly through Project Medicine Drop (see www.NJConsumerAffairs.gov/meddrop for details), a pilot program providing New Jerseyans medication disposal opportunities 24 hours a day, 365 days a year.
- Educating constituencies, including an outreach campaign for prescribers, pharmacists, parents, and teenagers, about the dangers of prescription drug abuse and ways to prevent abuse.
- Enabling recovery for persons struggling with addiction by advancing measures that will facilitate abusers' access to treatment and the treatment community's access to patient-specific prescription information.

For much more information on the New Jersey Division of Consumer Affairs' initiative to halt the diversion and abuse of prescription drugs, view the Division's NJPMP website at www.NJConsumer Affairs.gov/pmp, and the Division's Project Medicine Drop website at www.NJConsumerAffairs.gov/meddrop.

can register at www.NJRxReport.com *(see box for more details).*

Registered practitioners must certify they are seeking data only for the purpose of providing health care to current patients. Any practitioners who access or share NJPMP data for any other purpose are subject to civil penalties of up to $10,000 for each offense, and disciplinary action by the practitioner's professional licensing board.

The January 2012 launch was the first phase of a three-phase process during which the NJPMP will be further enhanced and expanded, culminating in approximately May 2012.

As they enhance the collection and use of this information by the state, the New Jersey Attorney General was clear to note that the state will remain mindful of the legitimate uses for medication and ensure practitioners are empowered to meet their patients' healthcare needs. The state is also aware that certain medical practices prescribe larger amounts of CDS medications than others during the normal course of providing patient care and the state will approach analysis of the NJPMP data with this knowledge.

Ultimately the state is viewing this database as an important tool for physicians and other healthcare practitioners to have a complete picture of their patient's use of prescription medications that are classified as Controlled Dangerous Substances and Human Growth Hormones. With access to this information, physicians and pharmacists will be able to identify an individual with a possible substance abuse problem and refer them to appropriate treatment.

NJAFP members are encouraged to register with the NJPMP and provide feedback to NJAFP on their experience with the program. For more information about the program, please visit http://www.nj.gov/oag/ca/pmp/index.htm. ▲

How Do I Register?

Access to the New Jersey Prescription Monitoring Program (NJPMP) database at www.NJRxReport.com is granted to prescribers and pharmacists who are licensed by the State of New Jersey and in good standing with their respective licensing boards.

To obtain access, prescribers and pharmacists must first register with Optimum Technology, the vendor contracted by the State to manage the PMP, by following these steps:

1. Go to www.NJRxReport.com, a secure website maintained by Optimum Technology.
2. Click on the "Not a member? Register" link.
3. Follow the instructions, which include selecting your specific profession, and entering required information such as your State license number and other identifying information.
   – The site will then direct you to a link for the "Request for Access" form.
4. You must print out and complete the "Request for Access" form. Sign the printed version, have it notarized, and mail the notarized original to Optimum Technology at the address provided on the form.
5. After the form has been submitted and your information processed, you will receive an email from Optimum Technology with instructions on how to access the PMP.
6. If you have questions about the website, please contact Optimum's help desk at (866) 683-2476 or njrxreport@otech.com.

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The Road to Meaningful Use – A Practice, Dedicated Doctors, & NJ-HITEC

Denise Anderson, PhD

Denise Anderson, PhD is Director for Strategic Initiatives for NJ-HITEC.

- ✔ **You have done your research.**
- ✔ **You have selected the appropriate Electronic Health Record (EHR) system for your practice.**
- ✔ **You have invested staff time and your time to ensure that you are using the system properly.**

However, you are *still* not ready at attest… what is going wrong?

Although attestation is as easy as hitting the "enter" button on your computer, the path to attestation can be very bumpy, challenging, and frustrating. The resources and knowledge of the New Jersey Health Information Technology Extension Center (NJ-HITEC) has proved valuable to many physicians who are in the process of attesting for Meaningful Use. NJ-HITEC is the federally-designated Regional Extension Center (REC) for the Garden State, which was established by the New Jersey Institute of Technology through a grant from the Office of the National Coordinator (ONC), Department of Health and Human Services to assist primary care providers in the selection and implementation of an EHR system.

NJ-HITEC Meaningful Use Manager, Balavignesh Thirumalainambi, outlines three scenarios to assist physicians in ensuring they are on the correct path to attestation by meeting the core requirements for Stage I Meaningful Use (MU). NJ-HITEC's MU expert explains, "In the first situation, a practice is using an EHR system that is not certified by the ONC. In the second scenario, the EHR system is only partially certified. Finally, in the third case, the practice is using a certified EHR system, but is having trouble meeting the specific requirements outlined by the Centers for Medicare and Medicaid Services (CMS)."

Here are NJ-HITEC's suggested solutions to assist providers:

- The first item of business is to determine if the provider's EHR system is ONC certified. This issue is resolved by cross-referencing the provider's EHR system to the ONC's Certified HIT Product List (CHPL), which can be found at http://onc-chpl.force.com/ehrcert.
- If the system is not certified, the practice should verify if the vendor is not certified or if the system just needs an upgrade to meet the criteria. When working with practices, the NJ-HITEC team has helped practices outline a timeline to resolve issues. Also, if the practice is working on an EHR system that is partially certified, the NJ-HITEC team has also assisted in determining the gaps in certification and assists in finding a product or upgrade that addresses the disparity in the system.
- If the EHR system meets all certification criteria but the provider is still unable to meet the Stage I Meaningful Use criteria, the NJ-HITEC team has performed a Meaningful Use Gap Analysis. Thirumalainambi notes, "A key point to understand is that providers do not need to count their patients for the 90-day period. The system should do that for them and generate a Meaningful Use report by default."
- Once the issues in the scenarios are resolved, the provider can review the Meaningful Use report for a status of how they are progressing in meeting the Meaningful Use core requirements. "Most of the systems provide Meaningful Use reports that give the correct numbers; the required numerators and denominators. If the provider is falling behind on any of the core requirements, we advise the provider on the steps to take to rectify the situation. Most of the time it's a workflow issue."

NJ-HITEC has the tools and resources to assist physicians work through any issue that may arise. Rao Vinnakota, MD, a pediatrician, and Radha Vinnakota, MD, an Ear, Nose, Throat (ENT), both believed it was time to upgrade. Working with their vendor, Berkshire Medical Technologies, as well as the NJ-HITEC team, both physicians have been successful in the implementation and utilization of their EHR system. The 66-year-old pediatrician states, "From day one the NJ-HITEC team was very enthusiastic in working with us. Bala and Giri Vurinka (NJ-HITEC Health IT Consultant) realized we were reasonably experienced in using the system. However, Bala provided us a roadmap to follow to be sure we were compliant with the federal guidelines. If we had any questions, we contacted the team and they answered our questions promptly and, when necessary, came to our office to assist us." Sometimes a practice just needs to develop a roadmap to be successful or sometimes a practice may need assistance just to get started. The implementation of an EHR system can be challenging, but a simple change in workflow design can alleviate some of the frustration.

A provider must meet the following requirements within the 90-day period to be eligible to attest to Stage I Meaningful Use:

- 15 Core Objectives
- Five out of 10 Menu Objectives (one of the five must be a Public Health Objective)
- Six Clinical Quality Measures (CQMs) out of a list of 44 items (the CQM is also one of the 15 Core Objectives)

There are a number of misconceptions regarding the criteria. Thirumalainambi explains one of the most significant misunderstandings, "Providers are under the impression that they have to meet all the requirements for the entire 90-day period. That is not case. They have to meet the thresholds of all of the criteria within the 90-day period as well as meet all the requirements on the 90th day."

Fully reporting demographics and recording vital signs are two of the most common pitfalls that providers encounter when trying to meet Stage I MU Meaningful Use requirements. There are a couple of issues regarding demographics. First, the regulation requires the provider to record five different data points – date of birth, gender, race, ethnicity, and preferred language. If a provider fails to record one of these data points, the patient record will not be counted in the demographic reporting measure. Second, if the data is being recorded properly but not properly entered in the EHR system, the system will not recognize the data when the Meaningful Use report is run.

Another example of workflow deficiency occurs in recording vital signs. "All providers record vital signs but their reporting measures will not increase until height, weight, and blood pressure are collectively reported at least once during the same patient visit," states Thirumalainambi. "We recommend that providers select one qualified staff member to record all three data points so they can ensure the requirement is met."

If you haven't joined the healthcare IT evolution, what are you waiting for? ▲

Update on Meaningful Use

NJ-HITEC continually keeps its members up-to-date on the latest healthcare IT news. At present, NJ-HITEC has assisted more than 400 providers attest for Medicare incentives.

- The ONC has pushed Meaningful Use Stage 2 to 2014.
- New Jersey Medicaid has initiated a new program, providing support to Specialists if they meet certain criteria. Specialists who would have had more than 30% (Pediatricians are required to have 20%) of their patients dedicated to Medicaid and Medicaid HMOs during any 90 days in 2010 (http://nj.gov/njhit/physicians/amielgible/calculating/) can receive around $30,000 by April 2012, if they become Meaningful Users. Please visit http://nj.gov/njhit/physicians/amielgible/ for more information.
- NJ-HITEC will support this New Jersey Medicaid EHR Incentive Program.

Note: *It's not too late. Medicare providers can still begin in 2012 and receive the maximum incentives. The 90 days of Meaningful Use can be anytime in 2012 to receive the full incentive payment within the next five years.*

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AMERICAN ACADEMY OF FAMILY PHYSICIANS

ASK AND ACT
A TOBACCO CESSATION PROGRAM

On Being an Ambassador of Family Medicine

Sara Leonard, MD

Sara Leonard, MD is a PGY-2 at UMDNJ-RWJ at CentraState in Freehold, NJ and serves as a Resident Trustee on the NJAFP Board.

The other day, one of the more seasoned nurses at the hospital asked me what type of medicine I am planning to specialize in after residency. While it seems like an obtuse question to ask a family medicine resident at a hospital with an unopposed family medicine residency program; the fact is that I've lost count of the number of times I've been asked that very same question by people who I would have generally expected to already know the answer. What I've gleaned from these questions is that it should not be taken for granted that the general public understands what family medicine means. As a result, I've evolved into an unofficial ambassador of sorts. I find myself explaining on an almost daily basis that family medicine is a specialty, clarifying the difference between a family doctor and a GP, and talking about our unique patient-centered approach and varied scope of practice.

I've found that a surprising number of people mistakenly believe family doctors are, for the most part, an extinct breed.

I've found through these conversations that a surprising number of people mistakenly believe family doctors are, for the most part, an extinct breed. In fact, most of the responses I hear are similar to the one from a patient I met while serving as medicine on-call, who exclaimed with delight, "I love family doctors; I didn't think they existed anymore!" Not only are we still around, but there are thirteen residency programs in the state of New Jersey training and graduating new family doctors every year. I wish that we could hire an advertising executive or public relations firm and put up billboards or print catchy ads the caliber of a Nike or Pepsi spot to help address this issue. Maybe that will happen someday. But, until then, each of us is the billboard, the publicist, and the ambassador. We are all challenged with taking advantage of incidental opportunities to put in a good word for our specialty and increase public awareness of what we do – especially what we do differently.

I had one of those incidental opportunities several months ago with an inpatient I will call Mr. Paris, who promptly told me upon our first meeting that all medical decisions and changes in treatment would need to be made by his pulmonologist or cardiologist. Within a couple of days I found Mr. Paris and his wife to be exasperated by the conflicting information they were receiving from pulmonary, cardio, and renal consultants. It was at that point that I explained that it is my job as a family physician to help guide him through these complex health issues, to help him understand the findings and opinions of various consultants while keeping the whole person, not just individual organ systems or diseases, at the center of everything we do. I saw something

change in this cantankerous man's expression as we went on with our discussion. And as I left, I hoped that what I said had registered with him and that he was able to see my potential role within his assembly of very competent and respected specialists.

I believe that defining our role within a sea of specialists and sub-specialists is not just important in cases like that of Mr. Paris, but it is also of paramount importance in a specialist dominated state like New Jersey. In fact, it is for that very reason that this is the state where perhaps we are needed the most. I think it's important for the new generation of family doctors to keep that in mind. Family medicine does have a place in New Jersey's future and we do have the power to affect that future. I saw evidence of this when I, a second year resident, and my intern, acting as ambassadors and proud poster-children of family medicine, with very little effort, transformed a man with multiple serious medical conditions from someone who thought he had no real use for a primary care physician, into someone who wouldn't make an important decision without discussing it with the two of us first. Certainly Mr. Paris knew that we didn't have the specific training and experience of his specialists, but he also knew that we would help him navigate the complex healthcare environment and advocate for him like no one else.

Changing healthcare policy, fighting for better legislation, and taking on insurance companies are all daunting, but necessary tasks in ensuring a brighter future for family doctors in New Jersey. Telling a patient who thanks me for taking the time to make sure she understands her condition, "I'm a family doctor – that's what we do," is far less daunting. It may not seem like much, but patient by patient, I know it will make a difference. I would like to urge all of my fellow residents to take advantage of those incidental opportunities to increase awareness and promote family medicine through your daily work. Just because someone sees a family doctor or receives care at a family health center doesn't mean that they really understand what makes our specialty so special. Our patients have a lot of power. They talk about their experiences with relatives, friends, and neighbors. Many have the power to choose their insurance company, or the insurance carrier for a small business. Most will be given a book with eligible providers and have the power to choose a name under the Family Medicine heading. And, there may even be one or two who stand up at a town meeting to address a campaigning politician and say, "I read an article stating that family doctors in New Jersey are in a distressed state, what are you going to do to help them?" In fact, that seems a lot like something Mr. Paris would do. ▲

Tar Wars® UPDATE

"Giving up smoking is the easiest thing in the world. I know because I've done it thousands of times." *– Mark Twain*

Mark Twain's humor aside… giving up cigarettes is hard, and the best way to never have to suffer the thought of giving them up is to never pick up a cigarette in the first place. You know this, because you struggle with getting your patients to quit every day.

But what if there was something you could do to make sure that the patient never ends up in your office for help quitting cigarettes or dealing with the consequences of smoking? Well, there is. It will only require about two hours of your time and the potential benefits will impact hundreds of kids in New Jersey. The program is called Tar Wars.

Tar Wars is fun, interactive and thought provoking for 4th and 5th graders. The presentation is free to the school and we often find teachers or school nurses are willing to schedule the program with health or science classes.

Tar Wars presentation materials, including the presenter's guide, can be downloaded from www.tarwars.org. Other tools included in the presentation kit consist of visual-aids and examples of manipulative advertising—which kids find very amusing once they learn how tobacco companies are manipulating them into thinking smoking is "cool."

Culminating the Tar Wars experience is the Tar Wars Poster Contest. The poster contest allows students to creatively express the messages they took away from the Tar Wars program and reinforces the idea of how positive and healthy choices can lead to bright futures.

Poster contest information, guidelines and deadlines are also available on the Tar Wars website. For posters to be considered in the NJAFP poster contest, they must be postmarked by May 10, 2012. The winner of the NJAFP state contest will become the New Jersey submission for the National Poster Contest held each year in Washington, DC.

Please contact State Tar Wars Coordinator, Candida Taylor, at 609-394-1711 or email at Candida@njafp.org. She can answer any questions you may have or help you schedule a presentation. ▲

Meghan Johnson stands proudly beside her 2011 New Jersey State winning poster at the National Conference in Washington, DC

AAFP Sends Coalition Letter to FDA on the Non-Face-to-Face Sale of Tobacco Products

In a coalition letter sent January 19, the AAFP and other national medical organizations provided comments to the Food and Drug Administration about how non-face-to-face sale and distribution practices for cigarettes and smokeless tobacco will change due to the *Prevent All Cigarette Trafficking Act* (PACT Act), which impacts the advertising, promotion and marketing of tobacco products sold or distributed through non-face-to-face transactions. According to Tobacco Free Kids[1] the act will ensure that federal, state and local tobacco taxes on cigarettes and smokeless tobacco sold via mail order or on the Internet are collected. The hope is that by reducing the availability of tax-less, low-cost cigarettes the act will reduce smoking, especially among children.

To read the full letter signed by the AAFP, visit http://www.aafp.org/ online/etc/medialib/aafp_org/documents/policy/fed/statements/tobacco011912.Par.0001.File.tmp/Nonfacetofface011912.pdf

1. Campaign for Tobacco Free Kids. 2010. THE PACT ACT: Preventing Illegal Internet Sales of Cigarettes & Smokeless Tobacco. Accessed February 2012 at http://www.tobaccofreekids.org/research/factsheets/pdf/0361.pdf

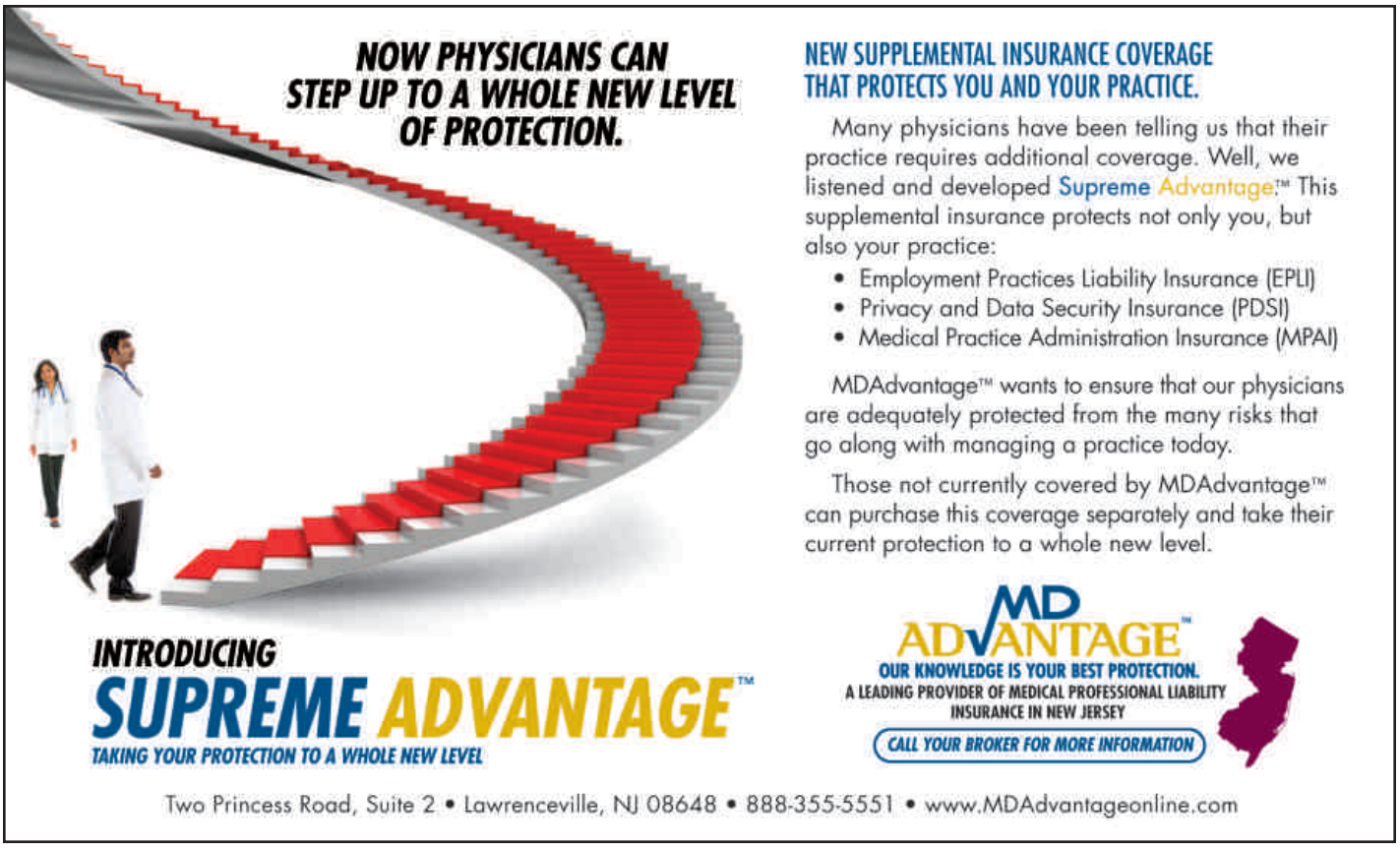
CHANGES AHEAD *Executive Vice President's View continued from page 5*

issues between NJ Family Physicians and UHC:

1. Lack of local presence for providers and lack of responsiveness to provider issues
2. Insufficient understanding of the fragility of primary care in New Jersey with associated stress by virtue of United/Oxford's fee schedule
3. Non alignment of provider payment with creating value and lack of support of the PCMH model

While there are certainly no guarantees of success, Dr. Eidus' letter has opened up a line of communication that has the potential to improve the conditions in our distressed primary care environment. We have engaged in several recent meetings and calls with UHC representatives where we were able to share our concerns, provide specific and quantifiable examples, and in a few cases get not only understanding, but a real response to, and action on, our issues. While payment is always a top concern, one of the most egregious and consistently noted problems with UHC in member calls and emails to the NJAFP office has been the first item – lack of local presence and responsiveness. Our members simply have no avenue with which to help themselves when they have an issue with UHC. We found this particularly problematic because lack of responsiveness in this way is most easily equated with a lack of desire to be responsive – suggesting a complete disregard for the primary care community in NJ. Shortly after communicating this lack of presence and responsiveness to UHC, the NJAFP was provided with the contact list that appears on page 5. This list will also be posted on NJAFP.org by the time this issue reaches your desks. I strongly encourage NJAFP members to use this list in an effort to resolve issues with United for which you previously had no contact information, and to let me know personally if you find that you are unable to get a timely response from any of the representatives listed. I hope to be in a position to communicate similar responsiveness on our other issues, particularly those regarding recognizing the value of primary care and the stress on our primary care infrastructure caused by the entirely inadequate fee schedules that most members have experienced with UHC and Oxford, in an upcoming article in this space.

As the speed of our race continues to increase, and the sheer number of other factors that require our individual and collective attention and monitoring grows in what seems to be exponential fashion, the NJAFP remains committed to doing all we can to help you to keep your focus. I encourage you to take advantage of the tools and resources that we provide, and to leverage your NJAFP community for assistance when you need it. We can't slow the race down, and I am not sure that we would want to if we could, given the incredible need and urgency for change, but we can help those of you who want to run the race more efficiently and effectively to do so. As always, I maintain my personal commitment to you as well. Please feel free to contact me at any time to let me know how the NJAFP can better serve you. ▲

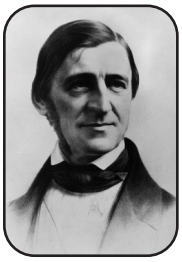


Reflections on the Decision to Give

FOUNDATION VIEW

Giving, the decision to give, is highly personal. Everyone donates their time or their talents for reasons that are truly their own. In this issue of *Perspectives* we decided to share the thoughts of others on giving in hopes of encouraging you to consider your Foundation when making a choice as to where you can go to give back.

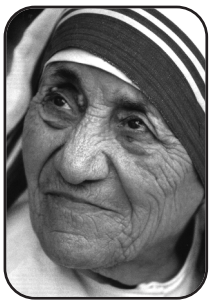
"When you give yourself, you receive more than you give." – *Antoine de Saint-Exupéry*



"You cannot do a kindness too soon because you never know how soon it will be too late." – *Ralph Waldo Emerson*

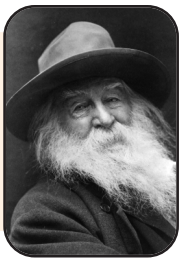
"Don't say that you want to give, but go ahead and give! You'll never catch up with a mere hope." – *Johann Wolfgang von Goethe*

"I have found that among its other benefits, giving liberates the soul of the giver." – *Maya Angelou*



"If you can't feed a hundred people, then just feed one." – *Mother Teresa*

"A gift consists not in what is done or given, but in the intention of the giver or doer." – *Seneca*



"When I give I give myself." – *Walt Whitman*

"We make a living by what we get, but we make a life by what we give." – *Winston Churchill*

Thank you for your generosity!

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CLOSING VIEW

Dr. Wiedemer is a Trustee of the NJAFP, is on staff at the Phillips-Barber Family Health Center, Lambertville, NJ, and is Associate Director of the Family Medicine Residency Program at Hunterdon Medical Center in Flemington, NJ. In addition to developing a large patient following at Phillips-Barber, he also serves on the Asthma Task Force at Hunterdon Medical Center. He resides with his family in Ringoes, NJ.

You can reach Dr. Wiedemer at editor@njafp.org.

The Pain Behind the Pain

Joseph P. Wiedemer, MD

There are some patients I struggle with more than others. "Tony" (not his real name) is one of them. Tony is 61 years old, and I have seen him for over 10 years. Physically, he is fairly healthy. He has mild obesity and his fasting glucose is usually between 115 and 120. He was a runner, but he started walking every day after he developed pain in his right knee.

When I saw him for his knee pain, he said, "You've got to do something for this knee! It hurts to walk more than a mile."

This was summertime about a year and a half ago. I asked "Did you do anything to injure it?" as I examined his large leg and manipulated the slightly swollen knee.

"No. It just started hurting!" He snapped.

I knew at the time that he ran every day, but he weighed 260 pounds and is 6'3" tall. I explained that I thought he had osteoarthritis, but checked him for Lyme, gout, and ordered an x-ray. I also recommended physical therapy, weight loss and some anti-inflammatory medications. I told him I did not think he should have an arthroscopy at that time and gave him a recent article on knee pain from the AFP.

He left my office, called an orthopedic surgeon, had an x-ray and MRI. The orthopedist offered an arthroscopy, and he scheduled it for about eight weeks later. In the meantime Tony lost weight, took the anti-inflammatory medicine and started walking instead of running. He changed his diet from pizza, wings and six beers a night to salads and one or two "light beers." Not surprisingly, he lost 20 to 25 pounds in six weeks when he saw me back.

"How's your knee?" I asked.

"You know, it's crazy. It feels better than ever! I have no pain, and I can do anything," he answered. He looked apprehensive though.

"So, what's the problem?" I asked.

"Well, I have this scope scheduled in 2 weeks, and I don't know if I should get it. My knee feels great, but I had all of the pre-op testing, and it's all set to go," he replied.

"So, what are you thinking?" I asked.

"Well, I don't want it to come back…" he paused.

"You lost weight, you're walking four miles a day, your knee is not swollen any more, and you have no pain. All of that is good," I stated.

"Yeah, I know. I just don't know…" he hesitated. I looked puzzled.

"There are just some times when I HAVE to get out. I hunt in the fall, and now that I retired last spring, I plan to do a lot of hunting. I don't need this knee pain to keep me down."

I keyed in on "HAVE to get out" because he has shared little snippets of his life that I have been able to put together throughout the years. He has shared with me that "No one knows everything that goes on in my life," but he has shared enough for me to get a picture.

Tony was born in 1950 and is the oldest of eight children in an Irish-Catholic family. His next oldest brother is 11 months younger, and Tony refers to him as an "Irish twin." His father was mostly absent during his childhood with work and drinking alcohol. His mother, per Tony, was "busy taking care of babies." Tony became a parentified child at a young age. He dropped out of college during his first year, even though he is very intelligent. He enlisted in the army in the late 1960's and went to Viet Nam into combat zones. He does not share much about his experiences there, but I think it must have been a very difficult experience, although he denies it.

Tony married when he came home from the war, and he and his wife had a son and a daughter. He worked in manufacturing for most of his career in a job that allowed him to "get home when his children got home from school." It allowed him to participate in their school and sports activities.

Recently, Tony shared with me that his son married, and Tony now has a granddaughter. He has hinted that his new daughter-in-law has "some anxiety or depression" and seems to be having difficulties "being a new mom." Tony travels to their home in South Jersey "to help with projects," but I think it may be for more of a supportive role to his son.

Tony's daughter lives with him and his wife. Tony's wife also has anxiety by the stories Tony shares with me, but he does not think she does. Their daughter seems to have severe anxiety and cannot work. Tony's father is elderly and lives in the area and requires assistance, and I think there is a strained relationship between them due to Tony's experiences in childhood.

In the past I have asked him, "Have you ever considered therapy for all of the stress you are under?"

"I've looked at the VA. They have therapists," he replied.

"So, would you go to one? It may be someone you can tell everything to," I offered.

Tony changes the subject in a way that says, "No. I'm not interested. Don't ask again."

Tony would like to travel and often comes in with information about trips he read about. He never takes them due to his family obligations and care giving. I think he would greatly benefit from seeing a therapist to explore those times when he "HAS to get out." Perhaps I am that person for him now. I may be the person he has shared the most with, even though "no one knows everything that goes on in his life."

Tony did have the arthroscopy, and he remains pain free. Sometimes it is the pain behind the knee pain that drives our patients. Tony's role as care giver to so many people in his life has left him with little more than surviving, rather than thriving. He reads about travel, but can never actually do it. He is "sandwiched" between caring for his father with whom he has resentment and his wife and children and now grandchild. All of this makes him feel that he "has to get out some times."

Tony sees me probably two to four times a year, but not often enough for me to consider it "therapy," although he may have some therapeutic benefit from talking about his life with me. We are fortunate in those times when we are the person patients can talk to. We, in our role as family physicians, continue to support and give compassionate care, even to patients with whom we struggle.

As always, I look forward to your comments. ▲

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   For teachers and school administrators alike[4]

1 United States Department of Agriculture Food and Nutrition Service: School Breakfast Program. http://www.fns.usda.gov/cnd/breakfast/. Assessed 9/17/10.
2 Gleason et al. School Breakfast Program but Not School Lunch Program Participation Is Associated with Lower Body Mass Index. J Am Diet Assoc. 2009;109:S118-28.
3 The Nutrition Consortium of New York State. Academics & Breakfast Connection Pilot: Final Report on New York's Classroom Breakfast Project. http://www.hungernys.org/programs/documents/ABCfinal.pdf. Assessed 9/16/10.
4 The New York City Department of Education: SchoolFood. http://www.opt-osfns.org/osfns/. Assessed 9/17/10.

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