INSIDE: Research Opportunities for NJ Family Physicians

CMS’ Comprehensive Primary Care Initiative comes to New Jersey

Medicare Incentives and Penalties

CME Inside: 2013 Immunization Schedules

The State of Tobacco Control
“NJ PURE has a Championship Team.”

BILL PARCELLS
Future Hall of Fame Coach

Bill Parcells understands what it takes to win. After all, he has had his share of success facing the highest levels of competition during his career. That’s why it’s no surprise Coach Parcells has selected NJ PURE as the only medical professional liability insurance carrier he endorses. Born and raised in New Jersey, like NJ PURE, he believes that integrity, transparency and stability are the ingredients it takes to make a champion. “With a track record of hard work and dedication to physicians, NJ PURE’s rise to the top of the insurance field is no surprise to me,” says Bill Parcells.

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It’s an App Filled World

I was looking through a paper catalogue and I actually touched the picture of something I wanted more information on, and…OMG…nothing happened. After I got over the embarrassment of what I had just done (you can still be embarrassed even if you are the only one who knows), I started to think about the shift in mind-set that is occurring. A year ago…heck, six months ago, I would have never touched a piece of paper and expected any other result than ink on my finger. However, today iPads, tablets and smart phones are everywhere, with a variety of apps that can help you manage everything from your grocery list to patient care.

Here are some very cool apps that I have recently become aware of.

If you have a minute or two (yes, I know, who has a spare minute these days) check these out.

 Animoto:  http://animoto.com
In three simple steps you upload photos from your computer, Facebook, Instagram, Picasa, Flickr or wherever your pictures might be, you select a video style, choose some music, maybe add a few words of your own…and voilà…you share the awesomeness that is an Animoto video. Though I’ve never used it myself, I’ve seen this demonstrated and it is pretty cool. This is not a free service, but the pricing plans are fairly simple.

 Evernote:  http://evernote.com
I love Evernote. It syncs with all your devices so your notes are always up-to-date. For example, let’s say I am sitting at my computer and I remember I forgot to add milk to my grocery list. I open the app on my computer, find my grocery list note, add milk and done. Later that night at the grocery store, I open Evernote on my phone and there is my grocery list, complete with the reminder to buy milk. You can search in your notes, take photo reminders and much more. A definite must - if you are someone who lives by lists.

 Gimp:  http://www.gimp.org
Gimp is just one of many online photo editing tools. It is a free download that lets you perform such tasks as photo retouching, image composition and image authoring. The site contains tutorials and how-to’s to help you become an expert photo editor.

 Tagxedo:  http://www.tagxedo.com
This app is just plain fun. Tagxedo allows you to turn any words into visual word clouds. The size of the words vary based on how often they appear in the text. The graphic for this article was created with Tagxedo. Your creations can be printed, uploaded to a website, or shared.

While these are all very cool apps, we are planning a special session at our upcoming Scientific Assembly and Summer Celebration that is totally focused on medical apps to help you in practice. This is just one of the many new educational offerings we are planning for this year’s conference. Check out New Jersey View (p.18) or the NJAFP website (www.njafp.org/SCSA) for details of the program, or look for the registration brochure coming to your mailbox soon.

Happy Reading,

Theresa J. Barrett, MS
Managing Editor
As I collected my thoughts for this article, many ideas surfaced. I realized that I have passed the halfway mark of my presidency year. I wouldn’t be surprised to learn that others in this position were shocked when they realized how quickly time passes. You take over the position. It takes a little time to get acclimated. You start to work on the issues that are a priority. Maybe you put out a fire or two. And while you’re doing this, you’re also practicing medicine and operating in a world of impending crisis. We survived Hurricane Sandy and the secondary snowstorm. We didn’t fal off the fiscal cliff and once again avoided Medicare pay cuts. These event-filled few months, coupled with personal issues, have made me a bit more philosophical in my approach to life. Big events make headlines, but it’s the little things that make a difference. This is true of my personal life as well as my professional life, and it’s why I became a family doctor.

This year my mom has had some issues with chronic illness and has been in and out of the hospital and rehab. I have been there every step of the way. Although I am a healthcare provider, I still find that I am frustrated with the care she has received. It’s not as if she requires a special procedure or piece of equipment, or even some expensive medication that she cannot afford – it is because she is struggling with life’s basic necessities.

Despite medical breakthroughs and advances in patient care, health care is still about providing quality of life; it is about the basic necessities. It has to do with getting the proper commode and ensuring that staff helps mom to the toilet, assists with personal hygiene and changes the sheets. Food too is important. I know she’s eating, but I must monitor her diet to ensure she is receiving proper nutrition to address her dietary needs and prevent complications from arising.

You may be asking yourself what this has to do with the current state of health care and the issues faced by family physicians. Both family physicians and healthcare facilities strive to compassionately and effectively respond to the basic needs presented by patients while expertly addressing their medical conditions. Good health care is health care that is patient-focused. Healthcare institutions must do this. Family doctors are taught to do this. Addressing the little things is essential. Shortages of professionals, insurance requirements and other issues make it more and more challenging to spend time on the little things that are so important.

Despite the challenges, family medicine continues to be the most rewarding of the medical specialties. Family medicine is all about the physician/patient relationship. We get to know our patients. We treat the patient within the context of their life situation, not just their medical diagnosis. Family physicians, more than any other specialty, influence their patients’ quality of life. Each of us has patient stories from our personal and professional lives that paint this picture in bold relief. If space allowed I would tell three or four more. These stories truly reflect who we are and the value we add to our patients’ lives.

Yet, while the family physicians continue to focus on prevention, cultivate trusting relationships with their patients, provide comprehensive care and serve as the patient’s advocate, the environment in which we operate has changed. As we look to the future, physicians are speculating about how the Affordable Care Act, Patient-Centered Medical Home (PCMH) and pilot programs, Accountable Care Organizations (ACOs) and shared risk models, electronic medical records (EMRs) and meaningful use and e-prescribing and so many other developments and changes will impact the overall delivery of health care. As we wait for the big picture to develop, New Jersey’s family physicians must be equipped and prepared to embrace these changes. As Ray notes in his article, our ability as an organization to deliver value to our members is a moving target that seems to move more quickly each day, but I and all of my colleagues in leadership are committed to providing and in fact improving on that value proposition.

In my address to the NJAFP House of Delegates last June, I emphasized my intentions as president to work to ensure that NJAFP serves its membership effectively and proactively. To that end, the NJAFP hosted a leadership retreat in January. Roland Goertz, AAFP’s outgoing Board Chair, attended this meeting and gave a very informative leadership presentation, which was well received by participants. The NJAFP also continues to collaborate with medical education and residency training programs in New Jersey in an effort to train and retain more family physicians. In April, NJAFP will hold a residency summit to delve into this issue in greater detail.

As an Academy, we realize that the practice of medicine has changed with regard to the workforce and business models. Family physicians work in diverse practice situations, including solo and group offices, employed physicians, academic physicians, physicians working for hospital systems, and single specialty and multi-specialty groups. NJAFP is committed to assisting all physicians in whatever setting they choose to practice.

There are many issues that must be addressed and I would like to issue you all a challenge. I think you will agree that without appropriate representation NJAFP will have difficulty influencing policy and moving the organization in the direction that it needs to go. The NJAFP Annual Scientific Assembly includes the meeting of the House of Delegates, NJAFP’s annual business meeting. It is a time when the NJAFP elects leaders and sets policies that can influence the practice of family medicine on the state and national level. I encourage all NJAFP members to become involved in that meeting. You may sign on officially as a delegate for your county or simply attend and provide your input. If you already attend the Assembly, take an extra half day and attend the House on Friday morning. If you can’t make it to the Assembly, consider being present for the House of Delegates. If you are unable to attend, invite a colleague in your community to get involved and contribute.

We must work together to ensure that the practice of family medicine thrives in New Jersey.
A Question of Value

Ray Saputelli, MBA, CAE is the Executive Vice President of the New Jersey Academy of Family Physicians (NJAFP) and the Executive Director of the NJAFP Foundation.

Each year at this time at least one member calls me and asks “why should I pay my dues?” The question is, of course, one of perceived value. Each of you likely makes a relative value calculation of the NJAFP’s ability to provide value for the dues you pay annually. Some of you may calculate that value based on NJAFP activities and programs by which you benefit individually, while others may place higher value on the work we do in support of the entire discipline. Still others may simply believe that membership in your professional society and the larger community of family medicine is “appropriate” and support of that community is a reasonable value proposition on its own terms. I have long believed, and frankly still maintain that the simplest answer to the question of value is still the most relevant: there is no organization other than the NJAFP that exists exclusively to represent family physicians in New Jersey. None. Nada. Zilch.

There is no organization other than the NJAFP that exists exclusively to represent family physicians in New Jersey. None. Nada. Zilch.

Physicians in New Jersey. None. Nada. Zilch. Some organizations may include family physicians in their mission, some may even limit their mission to primary care providers, but not one other group has the luxury of basing each decision on its singular ability to improve the practice environment for family physicians in New Jersey and thereby improve the health of the patients those family physicians serve. Still, even with such a simple mission, I recognize that not all members will always agree with, or perhaps understand the means by which we pursue those ends.

I recently had the opportunity to answer a question about the NJAFP’s reaction to the Patient Protection and Affordable Care Act (ACA) – first, as it was debated and passed by Congress, and then as it was primarily upheld by the Supreme Court – as an example of how we at the NJAFP work to deliver value for all of our members. I began that answer with the acknowledgement that family physicians are the backbone of our nation’s primary care infrastructure, which has unfortunately been crumbling under the weight of a misaligned, inefficient, fractured healthcare delivery and payment system for many years. The pressures faced by family physicians extend well beyond the ACA, and have existed for years before Congress enacted the law, and while some of those pressures may be relieved, some may be exacerbated. Part of the problem is that much of what is to come is still not clear to everyone.

The most important role that the NJAFP plays in our member’s professional lives with regard to ACA is to serve as both a conduit for information, and a resource for education. For example, as a result of ACA, the Center for Medicare and Medicaid Innovation (CMMI) developed the Comprehensive Primary Care (CPC) Initiative. The entire state of New Jersey was selected as one of the seven initial regions to roll out the program, which has the potential to redefine the delivery and valuation of primary care services delivered around the triple aim of lower cost, higher quality, and better patient outcomes. For the last five years NJAFP has developed the capacity to assist family physicians and other primary care clinicians to transform their practices into Patient Centered Medical Homes. We have leveraged that experience as a contracted service provider working closely with the practices selected to participate in meeting the requirements of the CPC Initiative.

The ACA will present different challenges to different segments of our membership. Physicians practicing in larger group practices, integrated delivery systems, hospital-owned practices, and other similar settings will require an entirely different set of services than those family physicians in smaller, independent practices, but our responsibility as their advocate doesn’t change. While we work to assist our members in understanding what ACA means to them and their patients, we still fight the pre-ACA battle of moving from a procedurally-based system to one that is more value-based, and so the traditional battles around the Sustainable Growth Rate (SGR) still – unfortunately – exist.

That said, we are continually retooing and refocusing our efforts to provide service as a clearinghouse for information, and as a trusted resource for education that must meet the ever increasing burden of limited available time faced by our members. Our clinical education now focuses on team-based care and elements of the PCMH. Our practice enhancement work focuses on the implementation of high-leverage processes in the clinical setting to improve...
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Opportunities for New Jersey Primary Care Practices to Embrace Primary Care Research

Are you interested in helping to generate meaningful new knowledge that is applicable to your context and practice? In a recent report by Voorhees, et al., less than 5% of board certified family physicians spend any time doing research. Yet, our nation desperately needs more relevant research conducted in primary care settings in order to improve quality of care, advance population health, and bend the cost curve. Luckily, ample resources and opportunities exist for family physicians across the United States to participate and support primary care research, and facilitate practice improvement in primary care settings.

In New Jersey, primary care practices can integrate medicine and research easily by joining the New Jersey Primary Care Research Network (NJPCRN). The NJPCRN is one of the largest and most successful practice-based research networks (PBRNs) in the United States, including over 300 primary care physicians caring for more than 750,000 patients across approximately 120 primary care practices. Participating practices are located in all of New Jersey's 21 counties in a variety of urban, suburban and rural settings, including several federally qualified health centers. The mission of the Network is to improve the quality of health care through the generation of research findings that can inform and influence primary care practice and public policy. Since its establishment in 2001, the NJPCRN has been:

1) Serving as the “laboratory” for a series of National Institutes of Health (NIH) and foundation-funded observational and intervention studies
2) Tracking important health trends and patterns of care in New Jersey primary care practices
3) Disseminating key research findings and data reports to primary care clinicians to help improve their practices
4) Providing brief reports to policy makers in New Jersey to inform public debates about how to improve primary care quality
5) Educating the public about primary care in New Jersey

The NJPCRN promotes research opportunities applicable to physician and practice members that are likely to make a positive impact on how medicine is practiced and patient care is provided. Such studies have made important contributions to the fields of primary care practice improvement, health information technology usage, chronic illness care, preventive services delivery and cancer prevention and control. Examples of these studies include:

1) Using Learning Teams for Reflection and Adaptation (ULTRA) - using practice teams to improve adherence to clinical guidelines
2) Supporting Colorectal Cancer Outcomes through Participatory Enhancements (SCOPE) - using practice teams and learning collaboratives to improve colorectal cancer screening rates
3) Assessing Barriers to Glycemic Management: Intensification for Insulin Use Among Patients with Uncontrolled Diabetes
4) Barriers to Breast and Cervical Cancer Screening in Obese Women
5) Cardiovascular Disease Care and EMR Use in Community-Based Primary Care Practices
6) Organizational Self-Assessment to Improve Diabetes Care in Primary Care Practices
7) Randomized Control Trial of Controlled Breathing Effects on Ambulatory Blood Pressure
8) Assessing Processes of Transformation into Patient-Centered Medical Homes

Join us in embracing research as a core value of family medicine. Members receive incentives for participating in studies, and the added benefits of collaborating with like-minded clinicians, practice members, and academic researchers who understand the demands of primary care, and discovering new ways to implement practice improvement that benefits the health of patients in New Jersey.

For more information or to become a member of the NJPCRN, please contact Gabrielle J. Davis, MSHS, Manager, at davissg@umdnj.edu or 732-235-7380.

References

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Physician Payment Sunshine Act:  
**Finalized Rule Released, CMS Limits Reporting Requirements for CME**

The Centers for Medicare & Medicaid Services (CMS), in the finalized regulations to implement the Physician Payment Sunshine Act (Section 6002 of the Affordable Care Act), has exempted payments or other transfers of value provided as compensation for speaking at a continuing education program. However, certain conditions must be met, which are consistent with the ACCME’s accreditation standards and standards for commercial support. These are standards that NJAFP consistently follows as part of their CME process.

According to the final rule, payments or other transfers of value provided as compensation for speaking at a continuing education program are not required to be reported, if all of the following conditions are met:

1. The event at which the covered recipient is speaking meets the accreditation or certification requirements and standards for continuing education of one of the following:
   - The Accreditation Council for Continuing Medical Education (ACCME)
   - The American Academy of Family Physicians (AAFP)
   - The American Dental Association’s (ADA) Continuing Education Recognition Program
   - The American Medical Association (AMA)
   - The American Osteopathic Association (AOA)

2. The applicable manufacturer does not pay the covered recipient speaker directly.

3. The applicable manufacturer does not select the covered recipient speaker or provide the third party (such as a continuing education vendor) with a distinct, identifiable set of individuals to be considered as speakers for the continuing education program.

If you have any questions, please contact Ray Saputelli, MBA, CAE at ray@njafp.org or in the Academy office at 609-394-1711.

*More information on the Sunshine Act is available at:
http://www.policymed.com/2013/02/physician-payment-sunshine-act-final-rule-released-cms-limits-reporting-requirements-for-.html*

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**New Jersey Medicaid Reminder**

The Centers for Medicare & Medicaid Services (CMS) mandate for ICD-10 Diagnosis and Surgical 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 the date of service beginning October 1, 2014. New Jersey Medicaid will open their testing window for all providers as of January 1, 2014 and remain open for the full period until the compliance date of October 1, 2014. For all updates concerning these new codes and the federally mandated compliance date, please visit our Medicaid website at www.njmmis.com/headlines and look for “Web Announcement: ICD-10 is coming, will you be compliant?”
What Have You Done For Me Lately?

NJAFP staff and members of the Board have been working diligently to keep family medicine and primary care in the forefront of the healthcare scene in New Jersey. NJAFP has been represented in the following NJ Spotlight articles:

- **November 16, 2012**
  Decision to Expand Medicare Coverage in NJ Christie’s Call

- **November 26, 2012**
  Bill Would Let NJ Nurses Prescribe on Their Own, Without Consulting Physicians

- **November 27, 2012**
  NJ Doctors Turn to Medical Schools to Help Close the Family-Practice Gap

- **December 12, 2012**
  The Fiscal Cliff, A Lose-Lose for NJ’s Healthcare Facilities

- **January 4, 2013**
  Higher Payments May Prompt More NJ Doctors to Accept Medicaid Patients

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**Save the Date**

**Wonca 2013 Prague**

**20th World Conference**

**Family Medicine**

**Care for Generations**

**June 25-29, 2013**

**Prague, Czech Republic**

Approved for 20.25 AAFP Prescribed Credits

[www.wonca2013.com](http://www.wonca2013.com)

The 20th WONCA World Conference will be held June 25-29, 2013 in Prague, Czech Republic. The overall theme of the conference is “Family Medicine - Care for Generations,” which will address all dimensions of the discipline including clinical, professional, health policy, education, research, and quality issues.
Immunization Schedule Updates

Adult Immunization Schedules

While immunizations are recommended throughout life to avert vaccine-preventable diseases and their complications, adult vaccination coverage remains low for most routinely recommended vaccines and well below the targets for Healthy People 2020. Although progress has been made, approximately 42,000 adults die each year from vaccine-preventable diseases. Vaccine coverage in adults must increase substantially in order to reduce the occurrence of vaccine-preventable diseases in adults.

The updated Standards for Adult Immunization Practices encourage healthcare providers to make sure that adult vaccination services are readily available; patients’ vaccination status is routinely assessed; patients are educated about vaccines; and personnel are trained to administer and document vaccinations in order to improve immunization rates. However, there was little improvement in noninfluenza adult vaccine coverage from 2010 to 2011 except for a modest increase in Tdap (tetanus, diphtheria, and acellular pertussis) vaccination overall and HPV (human papillomavirus) vaccination among women. Many adults have not received one or more recommended vaccines. According to the Centers for Disease Control and Prevention (CDC), “Vaccination coverage levels among adults are unacceptably low. Substantial improvement in adult vaccination is needed to reduce the health consequences of vaccine-preventable diseases among adults.”

Healthy People 2020

The objectives for Healthy People 2020 recognize that we are a mobile society and that diseases do not stop at geopolitical borders. Being aware of vaccine-preventable diseases and completing prevention and treatment courses are necessary components for reducing the transmission of infectious disease. Influenza, tuberculosis, and viral hepatitis are among the leading causes of illness and death in the United States and account for substantial spending on the related consequences of infection. Vaccination is one of the most cost-effective clinical preventive services and a core component of any preventive services package.

Following is a sample of Healthy People 2020 immunization goals for adults. For the complete summary go to [http://www.healthypeople.gov/2020/topicsobjectives2020](http://www.healthypeople.gov/2020/topicsobjectives2020)

<table>
<thead>
<tr>
<th>Goal</th>
<th>Baseline</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce meningococcal disease</td>
<td>0.34 per 100,000 population reported in 2004–08</td>
<td>0.3 cases per 100,000 pop.</td>
</tr>
<tr>
<td>Reduce new invasive pneumococcal infections among adults aged 65 years and older</td>
<td>40.4 new cases per 100,000 adults were diagnosed in 2008</td>
<td>31 new cases per 100,000 adults</td>
</tr>
<tr>
<td>Increase the percentage of noninstitutionalized adults aged 18 to 64 years who are vaccinated annually against seasonal influenza</td>
<td>27% received influenza vaccine for the 2008–09 influenza season</td>
<td>80%</td>
</tr>
<tr>
<td>Increase the percentage of noninstitutionalized high-risk adults aged 18 to 64 years who are vaccinated annually against seasonal influenza</td>
<td>42% received influenza vaccine for the 2008–09 influenza season</td>
<td>90%</td>
</tr>
<tr>
<td>Increase the percentage of noninstitutionalized adults aged 65 years and older who are vaccinated annually against seasonal influenza</td>
<td>66% received influenza vaccine for the 2008–09 influenza season</td>
<td>90%</td>
</tr>
<tr>
<td>Increase the percentage of healthcare personnel who are vaccinated annually against seasonal influenza</td>
<td>53% received influenza vaccine for the 2008–09 influenza season</td>
<td>90%</td>
</tr>
<tr>
<td>Increase the percentage of pregnant women who are vaccinated against seasonal influenza</td>
<td>11% received influenza vaccine for the 2008–09 influenza season</td>
<td>80%</td>
</tr>
<tr>
<td>Increase the percentage of adults who are vaccinated against pneumococcal disease</td>
<td>61% of persons aged 65 years and older in 2009 had ever received a pneumococcal vaccination</td>
<td>90%</td>
</tr>
<tr>
<td>Increase the percentage of adults who are vaccinated against zoster (shingles)</td>
<td>10% of adults aged 60 years and older in 2009 had received zoster (shingles) vaccine</td>
<td>30%</td>
</tr>
<tr>
<td>Reduce new hepatitis C infections</td>
<td>0.3 new symptomatic hepatitis C cases per 100,000 population were reported in the past 12 months in 2007</td>
<td>0.2 new cases per 100,000</td>
</tr>
<tr>
<td>Increase the proportion of persons aware they have a hepatitis C infection</td>
<td>49% of National Health and Nutrition Examination Survey respondents who tested positive for chronic hepatitis C reported that they were aware of their hepatitis C infection status prior to the laboratory confirmation in 2002–07</td>
<td>60%</td>
</tr>
<tr>
<td>Reduce tuberculosis (TB)</td>
<td>4.9 confirmed new cases of tuberculosis per 100,000 population were reported to CDC by local health departments in all 50 States and the District of Columbia in 2005</td>
<td>1.0 new case per 100,000 population</td>
</tr>
</tbody>
</table>
PCV13 and PPSV23

Information on the use of 13-valent pneumococcal conjugate vaccine (PCV13) and the timing of administration of PCV13 relative to the 23-valent pneumococcal polysaccharide vaccine (PPSV23) in adults has been included in the immunization schedule. Adults aged 19 years and older with immunocompromising conditions (including chronic renal failure and nephrotic syndrome), functional or anatomic asplenia, cerebrospinal fluid leaks, or cochlear implants, who have not previously received PCV13 or PPSV23 receive a dose of PCV13 first, followed by a dose of PPSV23 at least 8 weeks later. Subsequent doses of PPSV23 should follow current PPSV23 recommendations for adults at high risk. Adults aged 19 years and older with immunocompromising conditions, functional or anatomic asplenia, CSF leaks or cochlear implants, who previously have received 1 or more doses of PPSV23 should be given a PCV13 dose 1 or more years after the last PPSV23 dose was received. For those who require additional doses of PPSV23, the first dose should be given no sooner than 8 weeks after PCV13 and at least 5 years after the most recent dose of PPSV23. The schedule also clarifies which adults need 1 or 2 doses of PPSV23 before age 65 years. Other changes to the PPSV23 footnote include adding information regarding recommendations for vaccination when vaccination status is unknown.

Tetanus, diphtheria, and acellular pertussis (Tdap)

Recommendations for immunizations have been expanded to include routine vaccination of adults aged 65 years and older and for pregnant women to receive Tdap vaccine with each pregnancy.

Influenza

Manufacturers of the live, attenuated influenza vaccine (LAIV) have obtained Food and Drug Administration (FDA) approval for a quadrivalent influenza vaccine containing one influenza A (H3N2), one influenza A (H1N1) and two influenza B vaccine virus strains, one from each lineage of circulating influenza B viruses. In approximately half of the recent influenza seasons, the trivalent influenza vaccine has included an influenza B vaccine virus from the lineage different from the predominant circulating influenza B strains. Including both lineages of influenza B virus is intended to increase the likelihood that the vaccine provides crossreactive antibodies against a higher proportion of circulating influenza B viruses.

Live, attenuated influenza vaccine is expected to be the only quadrivalent formulation available and manufacture of the trivalent formulation will cease beginning with the 2013–14 season. It is possible, however that quadrivalent inactivated influenza vaccine formulations might be available for the 2013–14 season as well. Because a mix of quadrivalent and trivalent vaccines might be available, the abbreviation for inactivated influenza vaccine has been changed from trivalent inactivated influenza vaccine (TIV) to inactivated influenza vaccine (IV). The abbreviation for LAIV remains unchanged.

Zoster

The footnote on zoster was changed to clarify that ACIP recommends vaccination of persons beginning at age 60 years both for persons with and without underlying health conditions for whom the vaccine is not contraindicated.

See pages 10-11 for the full Adult Immunization Schedule

Childhood Immunization Schedules

(Summarized from the 2013 ACIP Recommended Vaccine Schedule for Children and Adolescents. Please refer to the complete immunization schedule for full information.)

The Advisory Committee on Immunization Practices (ACIP) has released the 2013 immunization schedule for children and adolescents and a catch-up schedule. Healthcare providers are advised to use the recommended schedule and the catch-up schedule in combination and not as stand-alone documents.

The 2013 version of the schedule includes new references and links to additional information, including one for travel vaccine requirements and recommendations. There are also new references provided for vaccination of persons with primary and secondary immunodeficiencies.

Other changes to note are:

- “Recommended immunization schedule for persons aged 0 through 6 years” and “Recommended immunization schedule for persons aged 7 through 18 years” have been combined into one recommendation schedule, “Recommended immunization schedule for persons aged 0 through 18 years.”
- Abbreviations for influenza vaccine were updated with the anticipation of quadrivalent vaccine for the 2013–14 influenza season. Influenza vaccine footnotes were updated to provide dosing guidance for children aged 6 months through 8 years for the 2012–13 and 2013–14 influenza seasons.
- The footnotes for meningococcal conjugate vaccine (MCV4) and tetanus and diphtheria toxoids and acellular pertussis (Tdap) vaccine were updated to reflect recent recommendations.

See pages 12-15 for the full Child/Adolescent Immunization Schedules and Catch-up Schedule.

The CDC website also has great resources to help parents understand their child’s vaccination schedule, including an interactive tool where parents can build individual immunization schedules for each of their children. Visit http://www.cdc.gov/vaccines/schedules/easy-to-read/child.html#print for more information.

References

Recommended Adult Immunization Schedule—United States - 2013

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

<table>
<thead>
<tr>
<th>VACCINE</th>
<th>AGE GROUP</th>
<th>19-21 years</th>
<th>22-26 years</th>
<th>27-49 years</th>
<th>50-59 years</th>
<th>60-64 years</th>
<th>≥ 65 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Influenza 1,2</td>
<td>1 dose annually</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Tetanus, diphtheria, pertussis (Td/Tdap) 1,2</td>
<td>Substitute 1 time dose of Tdap forTd booster; then boost with Td every 10 yrs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Varicella 1,7</td>
<td>2 doses</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Human papillomavirus (HPV) Female 5,8</td>
<td>3 doses</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Human papillomavirus (HPV) Male 5,8</td>
<td>3 doses</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Zoster 1</td>
<td>1 dose</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measles, mumps, rubella (MMR) 1,7</td>
<td>1 or 2 doses</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumococcal polysaccharide (PPSV23) 9,10</td>
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<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Pneumococcal 13-valent conjugate (PCV13) 11,12</td>
<td>1 dose</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>Meningococcal 4</td>
<td>1 dose</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis A 13</td>
<td>2 doses</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Hepatitis B 14</td>
<td>3 doses</td>
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<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

*Covered by the Vaccine Injury Compensation Program

Report all clinically significant post-vaccination 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 1-800-822-7962. Information on how to file a Vaccine Injury Compensation Program claim is available at www.hrsa.gov/vaccinecompensation or by telephone 1-800-338-2145. To file a claim for vaccine injury contact the U.S. Court of Federal Claims, 717 Madison Place, NW, Washington, DC 20001; telephone 202-397-1400.

Addendum information for this schedule of immunization includes additional information on vaccine use with its current and historical uses. The recommendations in this schedule are approved by the Centers for Disease Control and Prevention (CDC). The American Academy of Family Physicians (AAFP), the American College of Physicians (ACP), the American Academy of Obstetricians and Gynecologists (ACOG), American College of Physicians (ACP), American College of Obstetricians and Gynecologists (ACOG), and American Academy of Nurse Midwives (ACNM).

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

10 Perspectives Volume 12, Issue 1 • 2013
Footnotes — Recommended Immunization Schedule for Adults Aged 19 Years and Older—United States, 2013

1. Additional information
   • Additional guidelines for adults and for children and adolescents through age 18 years are available at http://www.cdc.gov/vaccines/schedules/.
   • Information on recommendations for particular chronic or medical conditions and other general immunization information can be found at the Centers for Disease Control and Prevention (CDC) website at http://www.cdc.gov/vaccines/.

2. Inactivated vaccines
   • All adults should receive tetanus-diphtheria-acellular pertussis (Tdap) as a single dose at any time after age 7 years. Adults who have not previously received Tdap vaccines should receive a single dose of Tdap at any time after age 7 years.

3. 2- or 3-dose series
   • Most adults should receive 2 doses of pneumococcal conjugate vaccine (PCV23) at the same visit.

4. Varicella vaccination
   • Varicella vaccine is recommended for all adults (19 years or older) who have not been previously vaccinated. Varicella vaccine is also recommended for adults younger than 19 years.

5. Human papillomavirus (HPV) vaccination
   • All adults should receive a dose of human papillomavirus (HPV) vaccine, regardless of sex, as a single dose at any time after age 19 years.

6. Influenza vaccination
   • Inactivated influenza vaccine is recommended for all adults (19 years or older) who have not previously received a vaccine.

7. Health care, including influenza vaccination
   • Adults should receive a single dose of tetanus-diphtheria-acellular pertussis (Tdap) as a single dose at any time after age 7 years.

8. Hepatitis B vaccination
   • All adults should receive a dose of hepatitis B vaccine, regardless of age, as a single dose at any time after age 19 years.

9. Travel-related immunizations
   • All adults should receive a single dose of hepatitis A vaccine (Havrix or hepatitis A virus [HAV] vaccine, or hepatitis B vaccine, if not previously vaccinated.

10. Postpartum
    • All adults should receive a single dose of hepatitis B vaccine (Havrix or hepatitis A virus [HAV] vaccine, or hepatitis B vaccine, if not previously vaccinated.

11. Tuberculosis vaccination
    • All adults should receive a single dose of BCG (Bacille Calmette-Guérin) vaccine, regardless of age, as a single dose at any time after age 19 years.

12. Tetanus vaccination
    • Adults should receive a single dose of tetanus-diphtheria-acellular pertussis (Tdap) as a single dose at any time after age 7 years.

13. Varicella vaccination
    • Varicella vaccine is recommended for all adults (19 years or older) who have not been previously vaccinated. Varicella vaccine is also recommended for adults younger than 19 years.

14. Inactivated influenza vaccine
    • Inactivated influenza vaccine is recommended for all adults (19 years or older) who have not previously received a vaccine.

15. Varicella vaccine
    • Varicella vaccine is recommended for all adults (19 years or older) who have not been previously vaccinated. Varicella vaccine is also recommended for adults younger than 19 years.

16. Hepatitis B vaccine
    • All adults should receive a single dose of hepatitis B vaccine (Havrix or hepatitis A virus [HAV] vaccine, or hepatitis B vaccine, if not previously vaccinated.

17. Tuberculosis vaccine
    • All adults should receive a single dose of BCG (Bacille Calmette-Guérin) vaccine, regardless of age, as a single dose at any time after age 19 years.

18. Tetanus vaccine
    • Adults should receive a single dose of tetanus-diphtheria-acellular pertussis (Tdap) as a single dose at any time after age 7 years.

19. Inactivated influenza vaccine
    • Inactivated influenza vaccine is recommended for all adults (19 years or older) who have not previously received a vaccine.

20. Varicella vaccine
    • Varicella vaccine is recommended for all adults (19 years or older) who have not been previously vaccinated. Varicella vaccine is also recommended for adults younger than 19 years.

21. Inactivated influenza vaccine
    • Inactivated influenza vaccine is recommended for all adults (19 years or older) who have not previously received a vaccine.

22. Varicella vaccine
    • Varicella vaccine is recommended for all adults (19 years or older) who have not been previously vaccinated. Varicella vaccine is also recommended for adults younger than 19 years.

23. Inactivated influenza vaccine
    • Inactivated influenza vaccine is recommended for all adults (19 years or older) who have not previously received a vaccine.

24. Varicella vaccine
    • Varicella vaccine is recommended for all adults (19 years or older) who have not been previously vaccinated. Varicella vaccine is also recommended for adults younger than 19 years.

25. Inactivated influenza vaccine
    • Inactivated influenza vaccine is recommended for all adults (19 years or older) who have not previously received a vaccine.

26. Varicella vaccine
    • Varicella vaccine is recommended for all adults (19 years or older) who have not been previously vaccinated. Varicella vaccine is also recommended for adults younger than 19 years.

27. Inactivated influenza vaccine
    • Inactivated influenza vaccine is recommended for all adults (19 years or older) who have not previously received a vaccine.

28. Varicella vaccine
    • Varicella vaccine is recommended for all adults (19 years or older) who have not been previously vaccinated. Varicella vaccine is also recommended for adults younger than 19 years.
**Figure 1. Recommended immunization schedule for persons aged 0 through 18 years – 2013.**  
(For those who fall behind or start late, see the Catch-Up Schedule [Figure 2].)

**NOTE:** The above recommendations must be read along with the footnotes of this schedule.

### Footnotes — Recommended immunization schedule for persons aged 0 through 18 years—United States, 2013

1. Hepatitis B (HepB) vaccine. (Minimum age: birth)
   - Routine vaccination:
     - 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 HepB (anti-HBs) at 1 to 2 months of age.
     - If a mother's HBsAg status is unknown, administer HepB vaccine to all infants according to the recommendations for hepatitis B vaccination in the vaccine schedule.
     - Infants born to mothers with unknown HBsAg status should be referred to a pediatrician or other clinician who can test for hepatitis B infection within 12 hours of birth. Determine the mother's HBsAg status as soon as possible and, if positive, administer HepB vaccine to all infants under 28 days of age (before age 1 week).

2. Polio vaccine. (Minimum age: 6 months)
   - Routine vaccination:
     - At 2 and 4 months of age.

3. Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine. (Minimum age: 6 months)
   - Routine vaccination:
     - At 2 and 4 months of age.

4. Haemophilus influenzae type b (Hib) conjugate vaccine. (Minimum age: 6 months)
   - Routine vaccination:
     - At 2 and 4 months of age.

5. Influenza vaccine. (Minimum age: 6 months)
   - Routine vaccination:
     - At 6 months of age.

6. Pneumococcal conjugate vaccine (PCV13).
   - Routine vaccination:
     - At 2 and 4 months of age.

### Schedule

<table>
<thead>
<tr>
<th>Vaccines</th>
<th>Birth</th>
<th>1-11 mos</th>
<th>12-23 mos</th>
<th>2-4 yrs</th>
<th>5-18 yrs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis B (HepB)</td>
<td> </td>
<td> </td>
<td> </td>
<td> </td>
<td> </td>
</tr>
<tr>
<td>Polio (IPV)</td>
<td> </td>
<td> </td>
<td> </td>
<td> </td>
<td> </td>
</tr>
<tr>
<td>Polio (OPV, Oral vaccine)</td>
<td> </td>
<td> </td>
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<td> </td>
<td> </td>
</tr>
<tr>
<td>Haemophilus influenzae type b (Hib) conjugate</td>
<td> </td>
<td> </td>
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<td> </td>
<td> </td>
</tr>
<tr>
<td>Pneumococcal conjugate vaccine</td>
<td> </td>
<td> </td>
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<td> </td>
</tr>
<tr>
<td>Rotavirus (RVV)</td>
<td> </td>
<td> </td>
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<td> </td>
<td> </td>
</tr>
<tr>
<td>Influenza</td>
<td> </td>
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</tr>
</tbody>
</table>

### Catch-Up Schedule

**NOTE:** The above recommendations must be read along with the footnotes of this schedule.

1. Hepatitis B (HepB) vaccine. (Minimum age: birth)
   - Routine vaccination:
     - 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 HepB (anti-HBs) at 1 to 2 months of age.
     - If a mother's HBsAg status is unknown, administer HepB vaccine to all infants according to the recommendations for hepatitis B vaccination in the vaccine schedule.
     - Infants born to mothers with unknown HBsAg status should be referred to a pediatrician or other clinician who can test for hepatitis B infection within 12 hours of birth. Determine the mother's HBsAg status as soon as possible and, if positive, administer HepB vaccine to all infants under 28 days of age (before age 1 week).

2. Polio vaccine. (Minimum age: 6 months)
   - Routine vaccination:
     - At 2 and 4 months of age.

3. Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine. (Minimum age: 6 months)
   - Routine vaccination:
     - At 2 and 4 months of age.

4. Haemophilus influenzae type b (Hib) conjugate vaccine. (Minimum age: 6 months)
   - Routine vaccination:
     - At 2 and 4 months of age.

5. Influenza vaccine. (Minimum age: 6 months)
   - Routine vaccination:
     - At 6 months of age.

6. Pneumococcal conjugate vaccine (PCV13).
   - Routine vaccination:
     - At 2 and 4 months of age.

### Schedule

<table>
<thead>
<tr>
<th>Vaccines</th>
<th>Birth</th>
<th>1-11 mos</th>
<th>12-23 mos</th>
<th>2-4 yrs</th>
<th>5-18 yrs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis B (HepB)</td>
<td> </td>
<td> </td>
<td> </td>
<td> </td>
<td> </td>
</tr>
<tr>
<td>Polio (IPV)</td>
<td> </td>
<td> </td>
<td> </td>
<td> </td>
<td> </td>
</tr>
<tr>
<td>Polio (OPV, Oral vaccine)</td>
<td> </td>
<td> </td>
<td> </td>
<td> </td>
<td> </td>
</tr>
<tr>
<td>Haemophilus influenzae type b (Hib) conjugate</td>
<td> </td>
<td> </td>
<td> </td>
<td> </td>
<td> </td>
</tr>
<tr>
<td>Pneumococcal conjugate vaccine</td>
<td> </td>
<td> </td>
<td> </td>
<td> </td>
<td> </td>
</tr>
<tr>
<td>Rotavirus (RVV)</td>
<td> </td>
<td> </td>
<td> </td>
<td> </td>
<td> </td>
</tr>
<tr>
<td>Influenza</td>
<td> </td>
<td> </td>
<td> </td>
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<td> </td>
</tr>
</tbody>
</table>

### Catch-Up Schedule

**NOTE:** The above recommendations must be read along with the footnotes of this schedule.

1. Hepatitis B (HepB) vaccine. (Minimum age: birth)
   - Routine vaccination:
     - 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 HepB (anti-HBs) at 1 to 2 months of age.
     - If a mother's HBsAg status is unknown, administer HepB vaccine to all infants according to the recommendations for hepatitis B vaccination in the vaccine schedule.
     - Infants born to mothers with unknown HBsAg status should be referred to a pediatrician or other clinician who can test for hepatitis B infection within 12 hours of birth. Determine the mother's HBsAg status as soon as possible and, if positive, administer HepB vaccine to all infants under 28 days of age (before age 1 week).

2. Polio vaccine. (Minimum age: 6 months)
   - Routine vaccination:
     - At 2 and 4 months of age.

3. Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine. (Minimum age: 6 months)
   - Routine vaccination:
     - At 2 and 4 months of age.

4. Haemophilus influenzae type b (Hib) conjugate vaccine. (Minimum age: 6 months)
   - Routine vaccination:
     - At 2 and 4 months of age.

5. Influenza vaccine. (Minimum age: 6 months)
   - Routine vaccination:
     - At 6 months of age.

6. Pneumococcal conjugate vaccine (PCV13).
   - Routine vaccination:
     - At 2 and 4 months of age.

### Schedule

<table>
<thead>
<tr>
<th>Vaccines</th>
<th>Birth</th>
<th>1-11 mos</th>
<th>12-23 mos</th>
<th>2-4 yrs</th>
<th>5-18 yrs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis B (HepB)</td>
<td> </td>
<td> </td>
<td> </td>
<td> </td>
<td> </td>
</tr>
<tr>
<td>Polio (IPV)</td>
<td> </td>
<td> </td>
<td> </td>
<td> </td>
<td> </td>
</tr>
<tr>
<td>Polio (OPV, Oral vaccine)</td>
<td> </td>
<td> </td>
<td> </td>
<td> </td>
<td> </td>
</tr>
<tr>
<td>Haemophilus influenzae type b (Hib) conjugate</td>
<td> </td>
<td> </td>
<td> </td>
<td> </td>
<td> </td>
</tr>
<tr>
<td>Pneumococcal conjugate vaccine</td>
<td> </td>
<td> </td>
<td> </td>
<td> </td>
<td> </td>
</tr>
<tr>
<td>Rotavirus (RVV)</td>
<td> </td>
<td> </td>
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<td> </td>
<td> </td>
</tr>
<tr>
<td>Influenza</td>
<td> </td>
<td> </td>
<td> </td>
<td> </td>
<td> </td>
</tr>
</tbody>
</table>

### Catch-Up Schedule

**NOTE:** The above recommendations must be read along with the footnotes of this schedule.

1. Hepatitis B (HepB) vaccine. (Minimum age: birth)
   - Routine vaccination:
     - 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 HepB (anti-HBs) at 1 to 2 months of age.
     - If a mother's HBsAg status is unknown, administer HepB vaccine to all infants according to the recommendations for hepatitis B vaccination in the vaccine schedule.
     - Infants born to mothers with unknown HBsAg status should be referred to a pediatrician or other clinician who can test for hepatitis B infection within 12 hours of birth. Determine the mother's HBsAg status as soon as possible and, if positive, administer HepB vaccine to all infants under 28 days of age (before age 1 week).

2. Polio vaccine. (Minimum age: 6 months)
   - Routine vaccination:
     - At 2 and 4 months of age.

3. Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine. (Minimum age: 6 months)
   - Routine vaccination:
     - At 2 and 4 months of age.

4. Haemophilus influenzae type b (Hib) conjugate vaccine. (Minimum age: 6 months)
   - Routine vaccination:
     - At 2 and 4 months of age.

5. Influenza vaccine. (Minimum age: 6 months)
   - Routine vaccination:
     - At 6 months of age.

6. Pneumococcal conjugate vaccine (PCV13).
   - Routine vaccination:
     - At 2 and 4 months of age.
For further guidance on the use of the vaccines mentioned below, see http://www.cdc.gov/vaccines/pubs/acip-list.htm.

- For other catch-up issues, see Figure 2.
- For vaccination of persons with high-risk conditions:
  - HIV-infected persons should be vaccinated as long as their immune system function is adequate and their CD4+ T-cell count is 200 cells per microliter or higher.
  - Persons with chronic liver disease should be vaccinated if they have no sign of active disease.
  - Persons with chronic renal disease should be vaccinated if they are not on dialysis.
  - Persons with chronic respiratory disease should be vaccinated if they have no active respiratory infection.
  - Persons with cancer should be vaccinated if they are not receiving chemotherapy.
  - Persons with systemic lupus erythematosus should be vaccinated if they are not receiving immunosuppressive therapy.

6a. Pneumococcal conjugate vaccine (PCV) (Minimum age: 6 weeks)

Routined vaccination:
- Administer series of PCV13 vaccine at 2, 4, 6, 12 months of age.
- For children aged 12 months and older who are not yet vaccinated, give 2 doses of PCV at least 8 weeks apart:
  - First dose if the child has not previously received any dose of PCV13 vaccine.
  - Second dose if the child has previously received any dose of PCV13 vaccine.

Catch-up vaccination:
- Administer 1 dose of PCV13 to all healthy children aged 12 through 59 months who are not previously vaccinated for age.

7. Influenza vaccine

Influenza vaccine (Minimum age: 6 months)

Routine vaccination:
- Administer annual influenza vaccine at ages 6 months through 8 years.
- Administer annual influenza vaccine at ages 9 years and older.

Catch-up vaccination:
- Administer annual influenza vaccine at ages 6 months through 8 years.
- Administer annual influenza vaccine at ages 9 years and older.

8. Meningococcal conjugate vaccine (MenACWY)

Routine vaccination:
- Administer MenACWY vaccine to all children at ages 11 through 12 years.
- Administer MenACWY vaccine to all children at ages 11 through 12 years.
- Administer MenACWY vaccine to children aged 13 through 16 years.

Catch-up vaccination:
- Administer MenACWY vaccine to children aged 13 through 16 years.

9. Measles, mumps, and rubella (MMR) vaccine

Minimum age: 12 months

Routine vaccination:
- Administer the first dose of MMR vaccine at age 12 through 15 months, and the second dose at age 4 through 6 years.
- The second dose may be administered before age 4 years, provided at least 4 weeks have passed since the first dose.

Catch-up vaccination:
- Administer 2 doses of MMR vaccine to children aged 12 months and older who are not yet vaccinated for age.

Additional information:
- For contraindications and precautions to use of a vaccine and for additional information regarding the vaccine, vaccination providers should check the relevant AIPPA statement available online at http://www.cdc.gov/vaccines/pubs/aippa-statements.htm.
- For the purposes of calculating intervals between doses, 4 weeks = 28 days. Interval is for months or years unless otherwise specified.
- Information on travel vaccine requirements and recommendations is available at http://www.cdc.gov/travel/vaccines.html.

FIGURE 2. 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 • 2013

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 Figure 1 and the footnotes that follow.

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Minimum Age for Dose 1</th>
<th>Minimum Interval Between Doses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis B</td>
<td>Birth</td>
<td>4 weeks and at least 16 weeks after first dose; minimum age for the final dose is 24 weeks</td>
</tr>
<tr>
<td>Rotavirus A</td>
<td>6 months</td>
<td>4 weeks</td>
</tr>
<tr>
<td>Hib (pneumococcal conjugate vaccine)</td>
<td>6 weeks</td>
<td>4 weeks</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>6 weeks</td>
<td>4 weeks</td>
</tr>
<tr>
<td>Poliovirus</td>
<td>6 weeks</td>
<td>4 weeks</td>
</tr>
<tr>
<td>Measles, mumps, rubella</td>
<td>12 months</td>
<td>4 weeks</td>
</tr>
<tr>
<td>Varicella</td>
<td>12 months</td>
<td>4 weeks</td>
</tr>
<tr>
<td>Hepatitis A</td>
<td>12 months</td>
<td>6 months</td>
</tr>
</tbody>
</table>

**Persons aged 4 months through 6 years**

1. Hepatitis B (Hepatitis B vaccine; Minimum age: birth)

   **Routine vaccination:**
   - Administer monovalent Hepatitis B vaccine to all newborns before hospital discharge.
   - For infants born to hepatitis B surface antigen-positive mothers, administer Hepatitis B vaccine and 0.3 mL of hepatitis B immune globulin (HBIG) within 12 hours of birth. Infants should be tested for HBsAg and anti-HBc. Infants who are HBsAg-positive will need 3 doses of Hepatitis B vaccine and HBIG (administered 0-1-6 months). Infants who remain HBsAg-negative should receive 3 doses of Hepatitis B vaccine and HBIG (administered 0-1-6 months). Infants who remain HBsAg-negative should receive 3 doses of Hepatitis B vaccine at 2, 4, and 6 months of age. Infants who are anti-HBc-positive will need 2 doses of Hepatitis B vaccine and HBIG (administered 0-6 months). Infants who are anti-HBc-negative should receive 3 doses of Hepatitis B vaccine at 2, 4, and 6 months of age.

2. Rotavirus (Rotavirus vaccine; Minimum age: 4 weeks for both RV1 [Bepsac] and RV2 [Bilota]).

   **Routine vaccination:**
   - Administer a total of 4 doses of RV vaccine to all infants between 6 weeks and 14 months of age. Infants should be tested for anti-B subunit. Infants with anti-B subunit should receive 2 additional doses of RV vaccine (administered at 4-6 months of age, 6-8 months of age, 6-8 months of age, and 6-8 months of age). Infants who remain anti-B subunit-negative should receive 3 additional doses of RV vaccine (administered at 4-6 months of age, 6-8 months of age, and 6-8 months of age). Infants who are anti-B subunit-positive should receive 1 additional dose of RV vaccine (administered at 4-6 months of age). Infants who are anti-B subunit-negative should receive 2 additional doses of RV vaccine (administered at 4-6 months of age and 6-8 months of age). Infants who are anti-B subunit-positive should receive 1 additional dose of RV vaccine (administered at 4-6 months of age).

3. Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine (Minimum age: 6 weeks)

   **Routine vaccination:**
   - Administer a total of 4 doses of DTaP vaccine to all infants between 6 weeks and 14 months of age. Infants should be tested for anti-B subunit. Infants with anti-B subunit should receive 2 additional doses of DTaP vaccine (administered at 6-8 months of age and 12-15 months of age). Infants who remain anti-B subunit-negative should receive 3 additional doses of DTaP vaccine (administered at 6-8 months of age, 12-15 months of age, and 18-21 months of age). Infants who are anti-B subunit-positive should receive 1 additional dose of DTaP vaccine (administered at 6-8 months of age). Infants who are anti-B subunit-negative should receive 2 additional doses of DTaP vaccine (administered at 6-8 months of age and 12-15 months of age). Infants who are anti-B subunit-positive should receive 1 additional dose of DTaP vaccine (administered at 6-8 months of age). Infants who are anti-B subunit-negative should receive 3 additional doses of DTaP vaccine (administered at 6-8 months of age, 12-15 months of age, and 18-21 months of age). Infants who are anti-B subunit-positive should receive 2 additional doses of DTaP vaccine (administered at 6-8 months of age and 12-15 months of age).

4. Tetanus and diphtheria toxoids and acellular pertussis (Tdap vaccine; Minimum age: 16 years for Bectisac, 11 years for Adacel).

   **Routine vaccination:**
   - Administer 1 dose of Tdap vaccine to all adolescents aged 16 through 18 years.

**Persons aged 7 through 18 years**

1. Varicella (Varicella vaccine; Minimum age: 12 months)

   **Routine vaccination:**
   - Administer a total of 2 doses of varicella vaccine to all infants between 12 months and 16 months of age. Infants should be tested for anti-B subunit. Infants with anti-B subunit should receive 1 additional dose of varicella vaccine (administered at 12-15 months of age). Infants who remain anti-B subunit-negative should receive 2 additional doses of varicella vaccine (administered at 12-15 months of age and 18-21 months of age). Infants who are anti-B subunit-positive should receive 1 additional dose of varicella vaccine (administered at 12-15 months of age).

**Footnotes**

- The above recommendations must be read along with the footnotes of this schedule.

- For further guidance on the use of the vaccines mentioned below, see: [http://www.cdc.gov/vaccines/pubs/acip-list.htm](http://www.cdc.gov/vaccines/pubs/acip-list.htm)
Further guidance on the use of the vaccines mentioned below, see: http://www.cdc.gov/vaccines/pubs/acip-recs.htm.

- Administer one dose of Tdap vaccine to pregnant adolescents during each pregnancy (preferred during 27 through 36 weeks’ gestation) regardless of duration of years since prior Tdap vaccination.

Catch-up vaccination:
- Perinatal aged 7 through 10 years who are not fully immunized with the childhood DTaP vaccine series, should receive one dose of catch-up Tdap vaccine in the catch-up series of additional doses required on the following schedule: for these children, an adolescent Tdap vaccine should not be given.

- Perinatal aged 11 through 18 years who are not fully immunized should receive one dose followed by a booster dose 8 years thereafter. A total of 2 doses should be administered, one dose at age 11 or 12 years, and the second dose at age 16 or 17 years.

- Administer one dose of Tdap vaccine to children aged 10 through 18 years, as part of the catch-up schedule. This dose can count as the adolescent Tdap dose, and can then later be used for a booster dose at age 11–12 years.

- For further catch-up, see Figure 2.

5. Meningococcal vaccine (Types A, C, W-135 and Y):

- Meningococcal polysaccharide vaccine (MCV). Minimum age: 9 years

Routine vaccination:
- Administer a 3-dose series of MCV (Pomona Bacterin, Connaught) to all children at age 11 or 12 years, and at 15 years of age. The 3rd dose should be administered at age 11 or 12 years and at 15 years of age. The third dose should be administered at age 11 or 12 years and at 15 years of age.

- Hib. (PRP-1) should be offered to the child dose at age 12 months through 6 years, who have received at least 1 dose of Hib.

Catch-up vaccination:
- For those 1 year of age 12 months, administer booster (at final dose) at 18 months after 1.
- At least 6 weeks of Pneumococcal 13-valent conjugate vaccine (PCV13) or a 23-valent pneumococcal polysaccharide vaccine (PPV23) had produced previously or an additional 2 doses of PCV13 or PCV6 at least 5 weeks after the first dose (or 1 dose of PCV13) at age 2 years or older.
- At least 6 months of age 12 months, administer the third dose of PCV13 to children aged 2 years or older.

6. Pneumococcal conjugate vaccine (PCV13). Minimum age: 9 years

Routine vaccination:
- Administer a series of PCV13 vaccine at age 2, 4, 6, 9 months with a booster dose at age 12 through 15 months.

- For children, 14 through 18 years who have received an age-appropriate series of PCV13 vaccine.

Catch-up vaccination:
- For children, 14 through 18 years who have received an age-appropriate series of PCV13 vaccine.

7. Human papillomavirus vaccine (HPV). Minimum age: 9 years

Routine vaccination:
- Administer a 3-dose series of HPV vaccine at age 11 or 12 years to all girls, age 11 through 12 years, and girls age 13 through 18 years.

8. Bacterial meningococcal invasive disease vaccine (MCV4). Minimum age: 2 years

Routine vaccination:
- Administer MCV4 to all children at age 2 years or older.

9. Haemophilus influenzae type b (Hib) conjugate vaccine (Hib).

Routine vaccination:
- Administer the first dose of Hib vaccine at age 12 through 15 months and the second dose at age 4 through 6 months.

10. Varicella (VZV) vaccine. (Minimum age: 12 months)

Routine vaccination:
- Administer varicella vaccine at age 12 through 15 months and the second dose at age 4 through 6 months.

Catch-up vaccination:
- Administer varicella vaccine at age 12 through 15 months and the second dose at age 4 through 6 months.
- Those who have received 1 dose of VZV vaccine at age 11 through 13 months and 1 dose of VZV vaccine at age 4 through 6 months and are at least 18 years of age, may initiate full vaccination with 1 dose of VZV vaccine.

11. Hepatitis A vaccine (HepA). (Minimum age: 12 months)

Routine vaccination:
- Administer 2 doses of HepA vaccine at age 12 through 23 months, administer the 2nd dose by 6/10 years.

Catch-up vaccination:
- Administer 2 doses of HepA vaccine at age 12 through 23 months to persons who have never received any doses of HepA vaccine.

Special population:
- Administer 2 doses of HepA vaccine at age 12 through 23 months to persons who have never received any doses of HepA vaccine.

12. Human papillomavirus variants (HPV) (HPV31, 33 and 45) (Cervarix) (Minimum age: 9 years)

Routine vaccination:
- Administer a 3-dose series of HPV vaccine in a single dose at 1, 2, and 6 months to all adolescents aged 11–12 years.

Special population:
- Administer a 3-dose series of HPV vaccine in a single dose at 1, 2, and 6 months to all adolescents aged 11–12 years.

8. Influenza vaccine. (Minimum age: 6 months for inactivated influenza vaccine and 2 years for live, attenuated influenza vaccine (LAIV))

Routine vaccination:
- Administer 2 doses of influenza vaccine each year at age 2 to 4 years, with a booster dose at age 5 years. The first dose in the series should be administered no later than the end of October and the 2nd dose before the end of December.

Catch-up vaccination:
- For children aged 5 through 8 years, minimum age and maximum age are recommended if the person is at risk for medical complications associated with influenza (i.e., based on a patient’s medical history or during an annual exam).

9. Influenza vaccine. (Minimum age: 6 months for inactivated influenza vaccine and 2 years for live, attenuated influenza vaccine (LAIV))

Routine vaccination:
- Administer 2 doses of influenza vaccine each year at age 2 to 4 years, with a booster dose at age 5 years. The first dose in the series should be administered no later than the end of October and the 2nd dose before the end of December.

Factors to consider:
- If more than 1 dose of influenza vaccine is administered in a series of 2 doses, at least 2 doses should be administered, regardless of the child’s age.

Additional information:
- For contraindications and precautions to use of vaccine and for additional information regarding that vaccine, vaccine suppliers, and recommendations for the use of the vaccines, visit the CDC Web site for the “Vaccines for Children” publication.

For further information and recommendations on the use of the vaccines, please visit the CDC Web site for the “Vaccines for Children” publication.
Mary Kearns-Kaplan, MLS, MSW is the Adult Outreach Services Coordinator at the New Jersey State Library Talking Book & Braille Center. http://www.njstbbc.org

One of the best kept secrets in New Jersey is the New Jersey State Library Talking Book & Braille Center (TBBC). TBBC provides no-cost, home-delivered, audiobook and Braille services to eligible New Jersey residents who are print-impaired. New Jersey residents of all ages, who cannot read standard print or cannot hold a book in their hands, or turn the pages of a book because of a physical impairment, as well as those who have a reading disability or vision impairment may be eligible for TBBC’s services.

If we look at vision loss alone, the National Eye Institute reports a 27% increase in vision impairments between 2000 and 2010.\(^1\) Projections predict a 71% increase by 2030.\(^1\) Studies of those with impaired vision report social isolation, depression, and loss of daily living activities affiliated with the loss of vision.\(^2,3,4\)

TBBC’s services can provide much-needed enrichment of a person’s daily life and promote literacy. As a regional library of the National Library Service for the Blind and Physically Handicapped in the U.S. Library of Congress, TBBC provides to registered members:

• Accessible, easy-to-use audiobook players
• Audiobooks and audio magazines on digital cartridges and access to downloadable audiobooks, audio magazines and Braille
• Braille Books
• News Reading Services

All of these services are provided at no cost. In addition, all services are delivered to the home. Also, all materials ship back and forth postage-free as Free Matter for the Blind or Handicapped.

An individual must apply for TBBC’s services and have his/her application certified. The eligibility criteria are:

• **Visual Handicap:** Lacks visual acuity to read standard printed materials without special aids or devices other than regular glasses
• **Blindness:** Visual acuity of 20/200 or less in the better eye without correcting glasses or the widest diameter of visual field subtending an angular distance no greater than 20 degrees
• **Deaf-Blind:** Severe auditory impairment in combination with legal blindness
• **Physical Handicap:** Unable to hold a book or turn pages as a result of physical limitations. Examples include: without arms or the use of arms; impaired or weakened muscle and nerve control; limitations resulting from strokes, cerebral palsy, multiple sclerosis, muscular dystrophy, polio, arthritis, or similar conditions
• **Reading Disability:** Organic dysfunction of sufficient severity to prevent reading printed materials in a normal manner

Physicians can certify an application for any individual. Other health-care professionals, such as nurses, social workers, physical therapists, and teachers, can certify individuals for physical and vision impairments, but a reading disability requires certification by only a physician.

In addition to serving individuals in their home, TBBC serves any facility that serves eligible individuals. Your practice can have an institutional account with TBBC to demonstrate the player with your patients. Individual and institutional applications can be downloaded from the following TBBC website: http://njsltbbc.org/application

TBBC is committed to serving the print impaired. We are reaching out to the medical community to increase the awareness of our services. Offering this valuable service to your patients may enrich their lives, promote literacy and ameliorate some of the emotional consequences that result from being unable to read printed materials. If you have any questions, please send Mary Kearns-Kaplan an email at mkaplan@njstatelib.org or call her at 800-792-8322, extension 834.

References

An Update on the Comprehensive Primary Care Initiative

Cari Miller, MSM is Director of Private Sector Advocacy and Project Operations for the NJAFP.

In September of 2011, the Centers for Medicare & Medicaid Services (CMS) released its request for applications for the Comprehensive Primary Care (CPC) Initiative. This program from the CMS Innovation Center is directed at assisting primary care practices in the delivery of higher quality, better coordinated, and more patient-centered care. Made possible by the Affordable Care Act, this collaboration is modeled after the innovative practices developed by large employers and others in the private sector.

On Wednesday, August 22, 2012, CMS announced the seven regions and the practices that would be participating in the CPC Initiative. At that time, 73 practices were selected for participation in New Jersey; currently there are 70 New Jersey practices active in the CPC Initiative. These practices are represented geographically throughout the state. The following link contains a list of those practices: https://data.cms.gov/Government/CPC-Initiative-Participating-Primary-Care-Practice/i5v-srz

Overall, 500 primary care practices were selected throughout the seven regions to participate in the CPC Initiative. Practices were selected through a competitive application process based on the use of health information technology; ability to demonstrate recognition of advanced primary care delivery by accreditation bodies, such as NCQA patient-centered medical home (PCMH) recognition; service to patients covered by participating payers in the market; participation in practice transformation and improvement activities, and diversity of geography, practice size and ownership structure.

CMS recognizes that the primary care practice is a key point of contact for patients’ healthcare needs. In recent years, new ways have emerged to strengthen primary care by improving care coordination, making it easier for clinicians to work together, and helping clinicians spend more time with their patients. Around the country, healthcare providers and health plans have taken the lead in investing in primary care. For example:

- By focusing on care coordination and primary care, the Community Care of North Carolina program was able to decrease preventable hospitalizations for asthma by 40% and lower visits to the emergency department by 16%.
- Group Health Cooperative of Puget Sound reduced emergent and urgent care visits by 29% and hospital admissions by 6%.
- Geisinger Health Plan’s program reduced admission rates by 18% and hospital readmissions by 36% per year.
- Comprehensive Health Services, whose business is providing workforce health care, found that increasing the use of primary care doctors translated into a 17% reduction in costs for established patients in the course of one year.

The CPC Initiative intends to build on these and other efforts and test a new payment model. During the first two years of the CPC Initiative, CMS is paying primary care providers for improved and comprehensive care management, and after two years will offer these practices the opportunity to share in any savings generated.

Specifically, CMS is paying participating practices a risk-adjusted, monthly care management fee for their Medicare Fee-for-Service beneficiaries. For the first two years of the initiative, the per-beneficiary, per-month (PBPM) amount will average approximately $20; for years 3 and 4, the PBPM will be reduced to an average of $15. In addition a shared savings model is also a component of the program. Many studies suggest that it costs less to provide health care to patients who receive care from primary care practices that offer comprehensive services compared to those that don’t provide such services. After two years, all practices participating in this initiative will have the opportunity to share in a portion of the total Medicare savings in their market.

CMS is collaborating with other payers in the local markets who have committed to similar payment reform to recognize and engage the necessary work and transformation needed in today’s primary care practice. In New Jersey, in addition to CMS, there are six additional plans participating. Each plan contracts directly with individual practices and has tailored a payment model similar to CMS (note: specific PBPM vary by health plan).

NJAFP’s Role

NJAFP is serving as lead faculty for the New Jersey initiative, in collaboration with TransforMed. The NJAFP team is providing assistance, tools and education to practices participating in the initiative to foster practice transformation and achievement of goals and milestones developed for the project by CMS. Specifically, NJAFP is working with practices to develop and implement plans that assist in supporting access and continuity, planned care, patient risk stratification, patient engagement and self-management, care coordination and more. The NJAFP team looks forward to providing updates, lessons learned and sharing best practices through future articles.

NJAFP applauds CMS for selecting New Jersey as one of the seven initial CPCI sites, and we thank the following plans for their participation: Horizon Blue Cross/Blue Shield of New Jersey, Horizon New Jersey Health, AmeriHealth, AmeriGroup, Teamsters Multi-Employer Taft Hartley Funds, and UnitedHealthcare.
If you miss this year’s Scientific Assembly, you are going to miss a lot…

Here are just a few of the clinical highlights planned for this year:
- Windows of Susceptibility: The Environment and its Suspected Influence on Breast Cancer
- Drug Recognition – Cop’s Stuff for Family Physicians
- Rash Decisions – Dermatological Issues in Children, Adolescents and Adults
- Dead on Arrival: Heart Disease in Women

And of course, all your old favorites will be back…
- Resident Knowledge Bowl
- President’s Gala
- An Exhibit Floor with old friends and new
- Treasure Chests

Plus a Sunday morning meditation class and other surprises.

On-line registration will open on March 15. In the meantime, visit the NJAFP website http://www.njafp.org/SCSA to stay updated on what we are planning.

NEW THIS YEAR…
Our event has gone mobile! To download the Guidebook application to your iPhone, iPad, Android device, Blackberry, or any other web-enabled device, go to http://www.guidebook.com/getit, scan the QR code below with your phone’s QR scanner, or search for Guidebook in the Apple, Google, or Amazon app stores.

Scan this QR code to download the Guidebook application. Use this app in June to download the 2013 SCSA Conference Program.

Around the State…

John F. Tabachnick, MD (Westfield) has been appointed new clinical chair of family medicine at Summit Medical Group. Summit Medical Group (SMG) is the largest privately held multispecialty medical practice in New Jersey.

Robert Eidus, MD, MBA (Cranford) was featured in the winter 2013 issue of Robert Wood Johnson Medicine. In the article, Dr. Eidus spoke about the efforts being made to reinvent family medicine.

In the News…

Richard Corson, MD (Hillsborough) was featured in an AAFP News Now article on the aftermath of Hurricane Sandy. To read the article go to http://www.aafp.org/online/en/home/publications/news/news-now/practice-professional-issues/20130111hurricanesandy.html

The NJAFP was featured in an AAFP News Now article on transforming and transcending distressed practice environments and the chapter’s Comprehensive Primary Care Initiative.

Rich Corson, MD (Hillsborough) and members of NJAFP staff were quoted throughout the article. http://www.aafp.org/online/en/home/publications/news/news-now/chapter-of-the-month/20121231newjerseyafp.html

With Sympathy…

The NJAFP extends its heartfelt sympathies to the friends and family of Edward Schauer, MD who passed away peacefully on Saturday, January 26, 2013 at the age of 87.

Dr. Schauer practiced medicine for over 50 years with the Schauer Family Medical Group. He was a devoted member of many medical organizations. He served the NJAFP as President in 1967–68 and as Director (1975–1978) and Vice President (1978–1979) for the American Academy of Family Physicians.

Dr. Schauer was instrumental in forming the Department of Family Practice at Jersey Shore University Medical Center, where he served as Director and Chief of Staff (1981–1984).

Ed was a past Grand Knight of the Knights of Columbus for St. Catherine of Siena Parish in Farmingdale, and was active on the Farmingdale Town Council. Dr. Schauer served as Mayor for several years and was a past Grand Marshal of the Memorial Day Parade.

In lieu of flowers, donations may be made to the Jersey Shore University Medical Center (JSUMC) Emergency Room, 1945 Hwy. 33, Neptune, NJ 07753; the Meridian Sub-Acute Rehabilitation at Wall, 1725 Meridian Trail, Wall, NJ 07719; or a charity of your choice.

Remembering Ed

“Benjamin Franklin once said ‘Dost thou love life? Then do not squander time, for that is the stuff life is made of.’ Ed certainly maximized his time to benefit us all!”

“Ed was loved and respected by many. He made a strong impression on me when I was a new doctor…”

“Like all of you I am saddened by the passing of Ed. For most of us he was the face of our HOD and represented medicine and especially family medicine with vigor and pride.”

“Ed was one of the first people that I met when I came into the NJAFP in the 1970s. He was the model of a physician who was willing to get engaged in medical leadership and also engaged in the political process.”
**Ready to Serve:**

**2013-2014 Call for Nominees for the Board of Trustees**

**YOUR INVOLVEMENT** is key to the success of the NJAFP. Consider running for the Board of Trustees. There are eight board positions open for the 2013–2014 year:

- **Three Board of Trustee positions:** three-year term: 2013 through 2016
- **One Resident Trustee:** two-year term: 2013-2015
- **Two Student Trustees:** one- to two-year term (depending on graduation date): 2013–2015
- **One AAFP Delegate:** two-year term: 2013-2015
- **One AAFP Alternate Delegate:** two-year term: 2013-2015

Members in good standing of the NJAFP may be considered for the slate of nominees upon submission of the following documents and the approval of the Nominating Committee:

- A letter of interest indicating the position for which you plan to run;
- Current CV;
- Two letters of recommendation/nomination from members of the Academy;
- Declaration of any conflict of interest (form available through NJAFP Office).

For additional information, go to [http://www.njafp.org/SCSA](http://www.njafp.org/SCSA) or contact Ray Saputelli at ray@njafp.org or 609-394-1711.

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**Resolved...**

**Whereas,** I understand the importance of adding my voice to other NJAFP members to improve family medicine in New Jersey, and,

**Whereas,** Resolutions are an important part of expressing my opinion, and,

**Whereas,** Resolutions are also the best way to influence Academy policy, and,

**Whereas,** Resolutions are a way to bring issues to the attention of the AAFP, therefore be it

Resolved, I will write a resolution to be debated at the NJAFP House of Delegates which will convene on Friday, June 21, 2013 at 8:00am at Bally’s Atlantic City. And be it further

Resolved, I will submit my resolution to the NJAFP office by the deadline of May, 13, 2013. And be it further

Resolved, I will beg, cajole, and implore every NJAFP member that I meet to do the same and invite them to join me at the House of Delegates on Friday, June 21, 2013 at Bally’s Atlantic City.

It is easy to write a resolution. Don’t be discouraged by the formality of it. Help is available. Just contact the NJAFP office for assistance. Resolutions are due in the NJAFP office by May 13, 2013. Go to [www.njafp.org/SCSA](http://www.njafp.org/SCSA) for more details.

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**Dates to Remember**

**April 30, 2013** – Deadline for nominations for Family Physician of the Year

**April 30, 2013** – Deadline for nominations for the NJAFP Board of Trustees

**May 13, 2013** – Deadline to submit a Resolution for consideration by the House of Delegates

**June 21, 2013** – House of Delegates convenes at 8:00am at Bally’s Atlantic City

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**Call for Family Physician of the Year**

Do you know a family physician who embodies the principles of the family physician of excellence? If so, the Selection Committee for the Family Physician of the Year Award has issued a call for nominees for this award for 2013.

Please consider family physicians you know who would represent New Jersey as the “best of the best.” 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. For more information, visit [www.njafp.org/SCSA](http://www.njafp.org/SCSA)
2013 CALL FOR...

NEW JERSEY FAMILY PHYSICIAN OF THE YEAR

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 2013. 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.

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 being 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.

Nominations must be received NO LATER than

APRIL 30, 2013

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).
MEDICARE INCENTIVES AND PENALTIES
ARE YOU PREPARING FOR THE CHANGES?

Claudine M. Leone, Esq.

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

The American Academy of Family Physicians (AAFP) recently published a very helpful guidance document entitled, “Medicare Initiatives and You: Bonuses and Penalties,” which I have included in part in this issue of Perspectives Government Affairs View. AAFP succinctly outlined what you need to be aware of and prepare for in terms of bonus payments and penalties for Medicare Incentive programs. For the full PDF with helpful tables and charts go to: www.aafp.org/bonuspenalty

What’s This All About?

There are many new Medicare initiatives that present a unique opportunity for you to demonstrate the quality of care you provide and to increase your net revenue, offering bonus payments that reward value in primary care rather than volume. If you have not already done so, implementing the Medicare initiatives in 2013, instead of waiting until 2014, could potentially save you more than $19,000 per physician in your practice.*

*Calculation based on a three-physician practice with $1.425 million total annual revenue and a 20% Medicare payer mix.

Meaningful Use of the Electronic Health Record

The Medicare Electronic Health Record (EHR) Incentive Program provides bonus payments to eligible professionals who demonstrate meaningful use (MU) of certified EHR technology. The cumulative payment amount depends on the year in which a professional begins participating in the program. Physicians whose participation starts in 2013 may receive up to $39,000 in cumulative payments; physicians who start in 2014 may receive up to $24,000. Penalties for those who do not demonstrate MU of EHR are set to begin in 2015.

More information on the EHR Incentive Program can be found at http://www.cms.hhs.gov/Recovery/11_HealthIT.asp on the Centers for Medicare & Medicaid (CMS) website.

Electronic Prescribing

The Electronic Prescribing (eRx) Incentive Program offers a bonus of 0.5% for eligible professionals who successfully use electronic prescrip- tions for their Medicare Part B services by the end of 2013. Eligible professionals who have not successfully used electronic prescriptions for their Medicare Part B services will be penalized in 2013 and 2014. To avoid this penalty, you must have met the program’s requirements by June 30 of the prior year (e.g., to avoid a penalty in 2014, requirements must be met by June 30, 2013).

More information on the eRx Incentive Program can be found at http://www.cms.hhs.gov/ERxIncentive on the CMS website.

Physician Quality Reporting System

The Physician Quality Reporting System (PQRS) includes a bonus payment for eligible professionals who report data on quality measures for covered services provided to Medicare Part B Fee-for-Service beneficiaries. Individual eligible professionals may choose from multiple reporting options for either individual or group measures. Group practice reporting options are also available. PQRS reporting deadlines are based on the method of reporting. If you qualify for PQRS bonuses in 2013 and 2014, you will avoid penalties in 2015 and 2016, respectively. An additional bonus of 0.5% is available for eligible professionals who work with a qualified Maintenance of Certification (MOC) entity and complete certain other requirements from 2012 through 2014.

More information on the Physician Quality Reporting System program can be found at http://www.cms.gov/PQRI/01_Overview.asp on the CMS website.

Value-Based Payment Modifier Program

Beginning in 2015, payment rates under the Medicare Physician Fee Schedule for groups of 100 or more eligible professionals will be subject to a value-based payment modifier (VBPM). By 2017, this modifier will be implemented for all physicians. Physicians who do not demonstrate higher quality and lower costs will receive lower payments. The VBPM is based on performance two years prior (e.g., application of the VBPM in 2015 will be based on performance in 2013). Eligible professionals may avoid penalties by successfully participating in the PQRS.

More information on Value-Based Payment Modifier Program can be found at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/index.html on the CMS website.

ICD-10

On October 1, 2014, the ICD-10 is scheduled to become the HIPAA-mandated code set for reporting diagnoses and conditions. To receive payment from Medicare, Medicaid, and all private payers, you must code all claims using ICD-10 for dates of service on or after October 1, 2014. Failure to do so may result in claim denials. The conversion from ICD-9 codes to ICD-10 codes will be significant for you and your staff. You can ensure a smooth transition and avoid an interruption in payment by educating yourself and your staff about the new code set and planning early for conversion.

More information on ICD-10 transition specific to providers can be found at http://www.cms.gov/Medicare/Coding/ICD10/ProviderResources.html on the CMS website.

The Bottom Line

The more you do now, the better off you’ll be. Remember, early implementation of MU of EHR, eRx, and PQRS enables you to capture bonus payments and avoid penalties. ▲

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On January 17, 2013, the Office for Civil Rights of the U.S. Department of Health & Human Services (OCR) issued its long-awaited final rule ("Rule") modifying the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy, security, enforcement, and breach notification rules pursuant to the Health Information Technology for Economic and Clinical Health (HITECH) Act. The Rule becomes effective on March 26, 2013, and compliance will be required by September 23, 2013.

Summary of Major Provisions
The Rule is comprised of the following four final rules:

1. Final modifications to the HIPAA Privacy, Security, and Enforcement Rules mandated by the Health Information Technology for Economic and Clinical Health (HITECH) Act, and certain other modifications to improve the Rules, which were issued as a proposed rule on July 14, 2010. These modifications:
   - Make business associates of covered entities directly liable for compliance with certain of the HIPAA Privacy and Security Rules’ requirements;
   - Strengthen the limitations on the use and disclosure of protected health information for marketing and fundraising purposes, and prohibit the sale of protected health information without individual authorization;
   - Expand individuals’ rights to receive electronic copies of their health information and to restrict disclosures to a health plan concerning treatment for which the individual has paid out of pocket in full;
   - Require modifications to, and redistribution of, a covered entity’s notice of privacy practices;
   - Modify the individual authorization and other requirements to facilitate research and disclosure of child immunization proof to schools, and to enable access to decedent information by family members or others;
   - Adopt the additional HITECH Act enhancements to the Enforcement Rule not previously adopted in the October 30, 2009, interim final rule (referenced immediately below), such as the provisions addressing enforcement of noncompliance with the HIPAA Rules due to willful neglect.

2. A final rule adopting changes to the HIPAA Enforcement Rule to incorporate the increased and tiered civil money penalty structure provided by the HITECH Act, originally published as an interim final rule on October 30, 2009.

3. A final rule on Breach Notification for Unsecured Protected Health Information under the HITECH Act, which replaces the breach notification rule’s “harm” threshold with a more objective standard and supplants an interim final rule published on August 24, 2009.

4. A final rule modifying the HIPAA Privacy Rule as required by the Genetic Information Nondiscrimination Act (GINA) to prohibit most health plans from using or disclosing genetic information for underwriting purposes, which was published as a proposed rule on October 7, 2009.

Any questions about the final Rule should be directed to Susan B. Orr, Esq. at Tsoules, Sweeney, Martin & Orr, LLC at 610-423-4200 or sorr@tshealthlaw.com
The Centers for Medicare & Medicaid Services (CMS) jump-started the Health Information Technology (HIT) evolution through its Electronic Health Record (EHR) Incentive Programs. Furthermore, for those who believe that HIT is a passing fad, the statistics state the opposite – HIT is here to stay. According to a study published in the 2013 January/February issue of the *Annals of Family Medicine*, EHR adoption by family physicians has doubled since 2005, with researchers estimating that the adoption rate will exceed 80% by the end of 2013. (*Healthcare IT News*, January 15, 2013.) Moreover, CMS has already distributed billions of dollars in federal incentives and that amount grows daily.

The term *Meaningful Use* has become synonymous with EHR technology, and achieving *Meaningful Use* of an EHR system is one of the building blocks available to assist physician practices to become eligible for potential participation in various programs that utilize HIT. One such program, recently launched, is the Comprehensive Primary Care (CPC) Initiative. The CMS CPC Initiative is a multi-payer program fostering collaboration between public and private healthcare payers to strengthen primary care.

In August 2012, CMS announced the practices chosen to participate in this initiative. These practices represent over 2,100 providers serving an estimated 313,000 Medicare beneficiaries across the country and include the following markets: the states of Arkansas, Colorado and Oregon, New York’s Capital District-Hudson Valley Region, Ohio and Kentucky’s Cincinnati-Dayton Region, Oklahoma’s Greater Tulsa Region, and the state of New Jersey.

In New Jersey, CMS selected 70 primary care practices, which include approximately 270 providers. This initiative will benefit potentially more than 41,000 Medicare beneficiaries. Along with the Medicare population, additional New Jersey residents will benefit; these include residents who are covered by Amerigroup, AmeriHealth New Jersey, Horizon Blue Cross Blue Shield of New Jersey, Teamsters Multi-EmployerTaft Hartley Funds and United Healthcare. The organizations collaborating to assist the practices through this process are TransforMED, New Jersey Academy of Family Physicians (NJAFP), and the New Jersey Health Information Technology Extension Center (NJ-HITEC).

TransforMED is assisting in overall project coordination, NJAFP is providing the practices with support and assistance needed for practice transformation, and NJ-HITEC is providing education and training in HIT. NJ-HITEC *Meaningful Use* Director, Bala Thirumalainambi, explains, “NJ-HITEC’s role in this project is to function as “expert faculty” to the New Jersey CPCI partners for HIT. This initiative is testing the idea that by supporting primary care, we have the opportunity for better health, better care, and decreased healthcare system costs. NJ-HITEC is proud to be part of this initiative and contribute to the efforts of healthcare reform.”

North Jersey Services Provider Coordinator, Dena Ragusa, the lead on this initiative for NJ-HITEC, adds, “There are nine milestones which primary care practices have to meet for CPCI. The fifth milestone – *Use Data to Guide Improvement to Care at the Provider/Care Team Level* – relates to the clinical quality measures that a provider’s EHR system should be reporting to achieve *Meaningful Use.*” Ragusa further explains, “NJ-HITEC has developed a tool that will assist the providers in understanding how to utilize their EHR system to meet the CPCI milestones. The tool emphasizes how *Meaningful Use* measures are incorporated in the CPCI milestones and how a provider can use a certified EHR system to meet those milestones. By comparing these measures, we are able to guide providers on other possible system functionality that may be necessary for this initiative. The tool is rolling out in New Jersey and Arkansas first and then we anticipate this tool to be used nationally.”

NJ-HITEC will also be providing webinars on topics such as *Meaningful Use* Stage 2 and Stage 1 Updates; Clinical Quality Reporting; Public Health Agencies (Registries); Utilizing EHRs for Data Collection and Data Reporting and more.

NJ-HITEC Executive Director, Bill O’Byrne states, “We have established ourselves as *Meaningful Use* subject matter experts as well as national leaders in HIT. We earned this reputation because of our knowledge and dedication to assist physicians to achieve *Meaningful Use* Stage 1, Year 1. We welcome the opportunity to share our expertise with the PCPs selected as well as NJAFP and TransforMED.”
The Opportunities Are There, We Just Don’t Know It

As an NJAFP Resident Trustee, I have participated in many discussions on the topic of resident retention in New Jersey following graduation. I, like everyone, had my theories about why more New Jersey-trained family doctors haven’t stayed in the state and what should be done about it. However, it wasn’t until I began looking for a job myself that I saw the situation in a whole new light.

Initially, I was struck by the contrast between how I was being actively pursued for positions in other states, yet it required significant effort on my part to find opportunities in New Jersey. And, those opportunities seemed scarce at best. Certainly, I knew there had to be more positions or the fact that New Jersey is a net exporter of graduating residents would not be an issue worth discussing at board meetings and strategic planning sessions. I pondered this while my email inbox filled with an average of 18 job opportunities daily - opportunities in other states. And between dodging cell phone calls, colorful brochures in my mailbox, and messages from recruiters at my workplace, I wanted to scream to New Jersey employers to get in the game. Because based on what I had been experiencing, it’s no wonder they are losing talent to other states.

The way I learned about the majority of New Jersey-based positions was either through another resident who was pulled aside by a potential employer and asked to spread the word, or through a faculty member or program director in much the same way. The problem with this word-of-mouth method of recruiting is that there are limitations to how many people receive the message. I don’t think it’s a coincidence that there are no positions in other states and barely seeing New Jersey in that mix at all, I can’t help but wonder about the perceived attention in future endeavors to retain graduates in the state.

I had my theories about why more New Jersey-trained family doctors haven’t stayed in the state. However, it wasn’t until I began looking for a job myself that I saw the situation in a whole new light.

Residents who leave the state after graduation sign employment contracts months earlier than their colleagues who stay. I suspect that we lose more graduates than we need to and that some more active advertising and recruiting could help to change that.

My suspicion was reinforced recently by a discussion I had with a fellow resident regarding the position I accepted in New Jersey. He stated that had he known about such an offer, he never would have signed a contract in another state. And, when I reminded him that his salary will be significantly higher than mine, he stated that it would have been worth $40,000 less to be closer to his family. I think this reinforces my belief that an electronic database of available positions is an area worthy of attention in future endeavors to retain graduates in the state.

I think it also underscores how, although we are burdened with very high student loan debt, New Jersey employers don’t necessarily need to compete at the seemingly impossible level of Midwest salaries to keep us; they just need to be highly competitive within the state itself.

Many of us find value in other aspects of a job opportunity beyond what can be put into a paycheck. I feel as if the younger generation of physicians is often wrongly accused of being financially greedy, when in fact we are simply responding to the pressure and harsh reality of needing to pay off our high student loan debt.

I am always surprised by how many physicians with whom I speak are shocked by the dollar amount of my student loans, when in fact, my debt is only average compared to that of many of my fellow residents. It should be noted that it is not uncommon for the Caribbean graduates, who make up the largest percentage of New Jersey family medicine residents, to have debt greater than $250,000 and some even greater than $300,000. Certainly, that kind of debt places us in perfect position to be seduced by generous loan forgiveness and hefty salaries in far away, middle-of-nowhere locations that also boast a low cost of living. I know, because I was close to accepting such an offer.

Early in my second year, I was wooed by a recruiter from Wisconsin. The mere thought of what she was offering calmed my growing anxiety about my student loan debt and conjured images of a new and exciting lifestyle. Thankfully, I held onto the words of my program director who advised me to figure out where I would be happy first rather than let my loans dictate where I go. I was lucky to know early on that there would be some good options for me in New Jersey, but not everyone can be as certain of their options, as I’ve learned these past months. Plus, the options today are different from those some years ago. I remember one middle-aged physician telling me that he thought it was so funny to hear me mention a job search, because when he came out of residency, they simply hung up a shingle and started practicing. Unfortunately, with high student loan debt and the current climate of insurance reimbursement, that is not a viable option for me and many of my peers. And while our generation of physicians may be accused of not wanting to put any skin in the game, the fact is that the game has changed. The benefits and rewards are not nearly as high as they used to be, and that changes what we’re willing to sacrifice to gain them.

Prior to beginning my job search, I had always thought a large part of the problem with retention of graduating residents was New Jersey itself. I believed that those who were not born and raised here probably didn’t share my love for the state. I thought that perhaps they lacked appreciation for good pizza and cannoli, preferred to be closer to family, wanted a different climate, a slower pace, or just longed to be back in the area they consider home. I think that in many ways that is still true. But New Jersey almost lost me, and I’ve seen others like me leave as well. After my experiences with receiving a deluge of employment opportunities from other states and barely seeing New Jersey in that mix at all, I can’t help but wonder if employers in New Jersey are losing talent, who, like my colleague, would have stayed had they only known a suitable opportunity existed.
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Tobacco use is the single most preventable cause of death in the United States. Each year in the United States, cigarette smoking and exposure to secondhand smoke causes 443,000 – or 1 in 5 – deaths. Economic losses are also staggering. Smoking-caused diseases result in $96 billion in healthcare costs annually.

American Lung Association State of Tobacco Control Report Card:

<table>
<thead>
<tr>
<th>SUBJECT</th>
<th>GRADE</th>
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<tbody>
<tr>
<td>Tobacco Prevention</td>
<td>F</td>
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<tr>
<td>Smoke-free Air</td>
<td>A</td>
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<td>Cigarette Tax</td>
<td>B</td>
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<tr>
<td>Cessation</td>
<td>D</td>
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Tobacco Prevention – F
Thumbs down for New Jersey for providing no state funding for tobacco prevention and cessation programs despite smoking costing the state $5.6 billion in economic costs each year.

Smoke-free Air – A
Thumbs up for New Jersey’s smoking restrictions
- Government Workplaces: Prohibited
- Private Workplaces: Prohibited
- Schools: Prohibited
- Childcare Facilities: Prohibited
- Restaurants: Prohibited
- Bars: Prohibited (allowed in cigar bars/lounges)
- Casinos/Gaming Establishments: Restricted*
- Retail Stores: Prohibited
- Recreational/Cultural Facilities: Prohibited
- Penalties: Yes
- Enforcement: Yes
- Preemption: No

Cigarette Tax – B
Tax rate per pack of 20: $2.70

Cessation – D
Despite the poor grade, thumbs up for New Jersey expanding the tobacco cessation medications available to State employees.

Overview of State Cessation Coverage

STATE MEDICAID PROGRAM:
- Medications: All health plans cover nicotine replacement therapy (NRT) Patches and Bupropion (Zyban); coverage for NRT Gum, NRT Lozenges, NRT Inhalers, NRT Nasal sprays and Varenicline (Chantix) varies by plan
- Counseling: No coverage
- Barriers to Coverage: Barriers to coverage vary by health plan**

STATE EMPLOYEE HEALTH PLAN(S):
- Medications: Covers all 7 recommended cessation medications***
- Counseling: Some health plans cover phone and/or online counseling
- Barriers to Coverage: No barriers

STATE QUITLINE:
- Investment per Smoker: Data not reported; Centers for Disease Control and Prevention (CDC) recommends an investment of $10.53 per smoker

OTHER CESSATION PROVISIONS:
- Private Insurance Mandate: Yes

To review the American Lung Association’s State of Tobacco Control Grades for New Jersey visit http://www.stateoftobaccocontrol.org/state-grades/new-jersey/

The CDC Publication, The State of Tobacco Control 2012,2 provides a comprehensive view of each state’s efforts to control tobacco use. In New Jersey, 16.8% of adults (ages 18 and older) smoke. The prevalence of smoking ranges from 11.8% to 29.0%. At 16.8%, New Jersey ranks third across all states and D.C.

When it comes to smokeless tobacco, New Jersey ranks 5th across all states at 1.6%. The prevalence of smokeless tobacco use ranges from 1.4% to 9.8% across all states and D.C.

On the positive side, the percentage of adults who reported being exposed to secondhand smoke within the past 7 days was lower in New Jersey than in the nation overall. In 2009-2010, New Jersey ranked 15th among all states with overall exposure at 44.5%.

EXPOSURE TO SECONDHAND SMOKE

<table>
<thead>
<tr>
<th>Overall</th>
<th>Workplaces</th>
<th>Homes</th>
<th>Vehicles</th>
<th>Public Places</th>
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<tbody>
<tr>
<td>44.5%</td>
<td>23.2%</td>
<td>10.0%</td>
<td>11.5%</td>
<td>29.6%</td>
</tr>
</tbody>
</table>

**Barriers could include: Limits on duration, annual or lifetime limits on quit attempts, requiring prior authorization, requiring co-payments, requiring using one or more cessation treatments before using others and/or requiring the use of counseling to receive medications.

***The 7 recommended cessation medications are: NRT Gum, NRT Patch, NRT Nasal Spray, NRT Inhaler, NRT Lozenge, Varenicline (Chantix) and Bupropion (Zyban).

*Includes tobacco prevention and cessation funding provided to states from the Centers for Disease Control and Prevention and U.S. Food and Drug Administration.
CURRENT CIGARETTE AND SMOKELESS TOBACCO USE AMONG ADULTS BY DEMOGRAPHIC CHARACTERISTICS

The complete report can be accessed at http://www.cdc.gov/tobacco/data_statistics/state_data/state_highlights/2012/sections/index.htm

The complete New Jersey report can be accessed at http://www.cdc.gov/tobacco/data_statistics/state_data/state_highlights/2012/pdfs/states/new_jersey.pdf

Reference

CME TEST ANSWERS:
1) C – 42,000
2) E – all of the above
3) B – Hepatitis B
4) E – Tetanus, diphtheria, & acellular pertussis
5) E – patient is pregnant
6) True
7) True
8) True
9) False
10) False

Tobacco cessation resources available at www.askandact.org
- Quitline Referral Cards
- Posters
- PowerPoint Presentations
- Patient Education Materials
- Lapel Pins
- Pharmacologic Product Guide
- CME
- Group Visits Guide
- Coding Information

Many materials available in both English and Spanish. Shipping charges apply.
I pulled up to a cluster of low-slung apartment buildings at 6:00pm last Thursday to do a house call. The patient is a 94-year-old man, “Francis,” who lives with an aide. His daughter, “Sue,” lives in a nearby building. Sue called me to set up care for her father because she wanted to change primary providers, but she did not say why.

I got out of my RAV4, and I realized that I had the address of the building, but I did not know the apartment number. I looked up and down the cold, quiet street and pulled my coat collar closer as I dialed Sue’s cell number. Almost reflexively, as her phone rang a door opened part way down the street from where I stood, and Sue called out “We’re over here!”

I clutched the house call bag in my right hand, ended my call, touched my stethoscope in my pocket to confirm its presence and turned toward the light and warmth emanating from the open doorway.

“Hi Sue!” I called.

“Hi ya. Come on in,” she replied in what sounded like one multisyllabic word in her North Jersey accent.

I peeled off my coat in the sweltering apartment as soon as I stepped across the threshold. Francis sat on a waterproof blanket on a loveseat surrounded by pillows and afghans. He faced the oversized TV mounted on the wall, but I do not think he watched it as his cataract clouded gaze focused toward the floor.

I introduced myself to Sue’s sister, “Donna,” and the live-in aide from Russia, whose name I did not catch. I sat down beside Francis and touched his hand. “I’m Dr. Wiedemer. It’s nice to meet you.” I spoke loudly.

Francis looked up toward Sue and responded in Italian with a hoarse voice. According to Sue, he said that he wanted to sell his truck. Sue told me that her father was a carpenter for decades, and related a story of how her father had severed the tips of his fingers off with a power saw years ago, but he worked until 5:00 before going to the hospital because “his shift wasn’t over.” Apparently the hospital bandaged his fingers and sent him home. As a member of the Greatest Generation, he probably did have a Living Will and a DNR order, but Sue said she would want him to go to the hospital if he needed it.

Francis did have a Living Will and a DNR order, but Sue said she would want to talk about whether to continue to encourage her to try.

Sometimes it’s the families and caregivers that we provide the most care for. I hope Sue starts to take care of herself. I talk to Sue while he ate. I watched him finish his soup, salad, milk, some pasta and “gravy” and two cookies without dropping a speck of food on his bib.

“I don’t know how long he has to live after this one visit,” I answered.

“Do you believe his last doctor thought he was going to die? He wanted me to think about hospice!” Sue exclaimed.

“Yes, with his walker,” Sue answered as she placed his walker in front of him and spoke to him in Italian.

Francis stood up to my surprise, straightened himself over his walker and shuffled about 20 feet across the floor to the kitchen. He sat in his chair and the aide placed a bib around his neck. I talked to Sue while he ate. I watched him a speck of food on his bib.

“How are you? I mean, how are you holding up as a caregiver?” I inquired.

“I’m not,” Sue answered. “I took care of my mother for two years, she died, and then I started to care for my father, and I’ve been caring for him for the last six years. I’m tired, and I keep missing work when he has a bad day. Those seem to be more frequent. I can’t put him in a nursing home. My family would NEVER do that! But, I can’t keep doing this,” her voice trailed off as her face sunk in.

I began to see now why Sue had asked for a “new doctor.” She was torn between loyalty and obligation and her shear exhaustion.

I started to ask about his other medical problems including atrial fibrillation, diabetes, heart disease, dementia and spinal stenosis. He probably has more years behind him than before him. I don’t know how long he has to live after this one visit,” I answered.

“I don’t know. It’s up to me and my sister. I wish my mother would have out Ma Fir.

Sometimes it’s the families and caregivers that we provide the most care for. I hope Sue starts to take care of herself. I continue to encourage her to try.

“I don’t know what Sue will decide or how Francis will do. We see patients all the time, but sometimes it’s the families and caregivers that we provide the most care for. I hope Sue starts to take care of herself. I continue to encourage her to try.

As always, I look forward to your comments.

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

*Names have been changed to protect identity.
**Immunization Schedule Updates**

1. Approximately how many adults die each year from vaccine-preventable diseases?
   a) 22,000; b) 32,000; c) 42,000; d) 52,000; e) 62,000.

2. The use of 13-valent pneumococcal conjugate vaccine (PCV 13) is recommended for adults aged 19 years and older who have: a) chronic renal failure; b) cochlear implants; c) cerebrospinal fluid leaks; d) nephrotic syndrome; e) all of the above.

3. Administration of the first dose of which of the following vaccines is appropriate for newborns according to the Advisory Committee on Immunization Practice’s (ACIP) recommended immunization schedule for persons aged 0 through 18 years – 2013?
   a) Hepatitis A (HepA); b) Hepatitis B (HepB); c) Measles, Mumps, Rubella (MMR) d) Pneumococcal conjugate (PCV13); e) Varicella (VAR).

4. Based on ACIP’s recommended immunization schedules for persons aged 0 through 18 years – 2013, it is appropriate to administer the 5th dose of which vaccine in persons aged 4 to 6 years?
   a) Hepatitis A (HepA); b) Human papillomavirus (HPV4); c) Inactivated Poliovirus (IPV); d) Rotavirus (RV); e) Tetanus, diphtheria and acellular pertussis (Tdap).

5. ACIP’s recommended adult immunization schedule – 2013 states that the Measles, Mumps, Rubella (MMR) vaccine is contraindicated in which of the following cases?
   a) Patient has chronic alcoholism; b) Patient has chronic lung disease; c) Patient has chronic liver disease; d) Patient has diabetes; e) Patient is pregnant.

6. True or False: Many adults have not received one or more recommended vaccines.

7. True or False: Recommendations for immunizations have been expanded to include women who are pregnant to receive tetanus, diphtheria, and acellular pertussis (Tdap) vaccine with each pregnancy.

8. True or False: The abbreviation for inactivated influenza vaccine has been changed from trivalent inactivated influenza vaccine (TIV) to inactivated influenza vaccine (IIV).

9. True or False: According to the Centers for Disease Control and Prevention (CDC), vaccination coverage levels among adults are significantly high.

10. True or False: According to Health People 2020, 10% of persons aged 65 years and older in 2009 had ever received a pneumococcal vaccination.

**ANSWERS ON PAGE 27**
The days of going without the right medical professional liability coverage are

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