CME Inside: School Breakfast in America's Big Cities

VOLUME 11, ISSUE 2 • 2012

Perspectives

A VIEW OF FAMILY MEDICINE IN NEW JERSEY

NJ Selected by CMS Innovation Center for its Comprehensive Primary Care Initiative

Details inside

Journal of the New Jersey Academy of Family Physicians
NJAFP

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Integrity ▪ Transparency ▪ Stability

Loyalty to policyholders, not shareholders.

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As the only direct writer of medical malpractice insurance in New Jersey, NJ PURE eliminates the traditional use of agents or brokers to market its policies. The average commission is 10% for each policy, year after year, costing insurance companies millions of dollars annually. By eliminating the middle man we've been able to keep our rates down and provide a direct relationship between you and us.

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214 Carnegie Center, Suite 101 ▪ Princeton, NJ 08540 ▪ Contact Joanna Elias, Esq., 609-520-8271, Assistant Director of Marketing

IN THIS ISSUE

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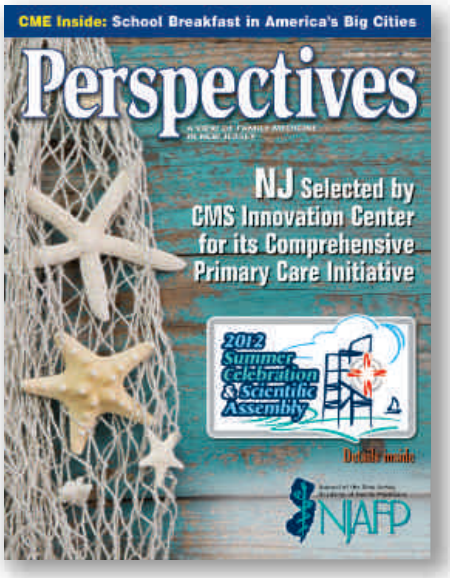

On The Cover

There is strong evidence that children learn more effectively, have less behavioral problems, and live healthier life styles when they start their day with a good breakfast. Read Clinical View on page 8 to learn about the latest FRAC report findings.

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

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NJAFP New Jersey Academy of Family Physicians

Information Explosion

Kevin Kelly is the Editor-At-Large for *Wired*, a cutting-edge, print and on-line magazine which covers how new and developing technology impacts the economy, politics and culture. According to Kelly, "Information is accumulating faster than any material or artifact in this world, faster than any by-product of our activities. The rate of growth in information may even be faster than any biological growth at the same scale."[1] In the entire history of medicine, there has never been a time when advances in knowledge and technology have had such an extreme impact on the delivery of health care. Within the biomedical literature there are more than 18 million catalogued articles. 800,000 biomedical articles were added to literature in 2008, and in 2012 that number is expected to surpass one million.[2]

Science and technology developments, advanced through the field of informatics, the evolution of Web 2.0, and the diffusion of the Internet have acted as forces for change in medical practice. It is estimated that a primary care doctor must be familiar with over 10,000 different diseases, 1,100 different lab tests, and over 3,000 different medications, along with the 400,000 articles added to the literature each year. A primary care physician must know millions of facts which are constantly changing.[3]

While there are differing opinions over the rate of the increase in medical knowledge, it is a fact that a physician's formal base of clinical knowledge becomes less useful over time and must be constantly replaced or augmented with new information. One physician, who was preparing to take his specialty boards, discovered that his entire residency program in psychoanalysis (the focus of the curriculum) had been reduced to seven pages in the most current medical textbook. The other 900 pages were devoted to biological psychiatry, all new since the physician graduated from his residency program.[4]

With these facts in mind, how are you planning to stay current with the latest advances in medicine and keep your medical knowledge up-to-date? One way is to plan to attend this year's Summer Celebration and Scientific Assembly in Atlantic City. I can promise you CME that will be rewarding and interesting. In addition, you will have the opportunity to catch up with colleagues to discuss new ideas and best practices. After all, some of the best learning happens in the hallways.

For more information on the 2012 Summer Celebration and Scientific Assembly, go to www.njafp.org/SCSA.

Happy Reading,

Theresa

Theresa J. Barrett, MS
Managing Editor

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PRESIDENT'S VIEW

The Importance of Messaging

Robert Eidus, MD, MBA

Robert Eidus, MD, MBA is the President of the New Jersey Academy of Family Physicians. He is in private practice at Cranford Family Practice/Vanguard Medical Group in Cranford, NJ.

Recently there were two separate activities which resulted, I believe, in important and compelling messages for family physicians to communicate to other people or organizations. The first came from the AAFP Task Force on Primary Care Valuation and the second came from the NJAFP board.

The AAFP, in response to the issue of whether or not to get out of the RUC, created the Task Force on Primary Care Valuation. The Task Force sent a letter to Marilyn Taverner, Acting Administrator of CMS. Among other things in the letter, the AAFP set out a working definition of what constitutes primary care. The working definition had 5 elements:

- **First contact care** - the caregiver who is first seen for a condition or ailment
- **Continuity of care** - the predominant caregiver for a patient over time
- **Comprehensive care** - providing preventive services, management of acute illnesses, managing chronic illnesses, broad scope of services within the practice setting
- **Coordinated care** - Patients seeing multiple caregivers have their care coordinated by one health professional and his/her team
- **Bridges personal family and community** - The PCP works to harness and involve family and community, especially with respect to managing chronic illness

Why is this important? Any payment reform for primary care is predicated on knowing who the primary care practitioners are. One of the problems with raising the Evaluation & Management (E&M) codes across the board is that a lot of specialists also use E&M codes (e.g. cardiology, gastroenterology, urology). Therefore, if there is a "budget" for improving primary care reimbursement it is diluted by having E&M code increases going to proceduralists as well. In addition, many specialties such as Ob/Gyn state that they are primary care practitioners.

Rather than getting into a turf battle as to which degree constitutes primary care, we should be looking at behaviors (we should acknowledge that family physicians practicing as hospitalists or in urgent care settings would also not qualify as primary care practitioners under this definition which is behaviorally oriented rather than training and certification oriented).

The NJAFP also created a focused message of what we want from stakeholders in New Jersey. This is – in business parlance - an elevator pitch, a succinct message which can be clearly stated in less than a minute. Our elevator pitch has three points:

- That there be a statewide PCMH multi-payer initiative
- That there be simplification and improved uniformity of administrative rules with respect to health insurance and payment
- That state supported medical schools in New Jersey be held accountable for the percentage of students entering primary care as defined by actively engaged in primary care practice five years after graduation from medical school

The first bullet addressed the issue of payment reform. The second addressed ways to save the state money and also reduce unnecessary expenses engendered by family physicians. The third message laid down the gauntlet that state supported medical schools cannot hide behind the excuse that they cannot control what specialties their students decide to enter. Nor can they hide behind the excuse that all students going into internal medicine residencies count as primary care when we know that less than 10% will actually be doing primary care when the definition of primary care from the AAFP is applied.

State supported medical schools cannot hide behind the excuse that they cannot control what specialties their students decide to enter.

We all have "at bats" with patients, employers, legislators, regulators, and healthcare executives in our day-to-day activities. A concise and consistent message to these stakeholders as to what constitutes primary care and what family physicians would like to see happen in New Jersey will go a long way to moving the bar in a positive direction. Please take a few minutes to reflect on these important messages and consider how you can incorporate these into our daily discussions. ▲

RENAISSANCE

Raymond J. Saputelli, MBA, CAE

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

Before I write the next paragraph, it is important to note that I am hopeful that we are on the verge of a primary care renaissance in New Jersey.

This week I spent several days on Capitol Hill with a group of dedicated NJAFP leaders at the annual AAFP Family Medicine Congressional Conference. As is the case for many associations and professional societies, a sure sign of spring is the "legislative fly-in." In this regular ritual members converge on the 64-square-miles bound on all sides by reality that we call Washington, DC. This ritual is ostensibly to influence policy, but truly it is more in the hope that relationships with lawmakers and their staffers will grow over time and will have a long-term positive impact on our advocacy efforts. Our march on Washington had three familiar themes: payment, and specifically a permanent SGR fix; workforce, including asks in the area of Title VII funding and support for the National Health Service Corps; and GME funding. Because these have been AAFP advocacy efforts for several years, and because our annual efforts have successfully fostered the types of relationships with many of the New Jersey Congressional delegation that an organization like ours hopes to achieve in this process, we were met with friendly faces and the kind of body language that says "I know, and I am sympathetic to your problems." That sympathy grew when we discussed the broken primary care infrastructure in our state. We even saw genuine surprise when we highlighted data in our recent publication "Getting on the Right Track" (available at www.njafp.org/right-track) which details the serious and growing primary care crisis that has caused the AAFP to recognize New Jersey as a "Distressed Practice Environment."

Unfortunately, that was the extent of our success given the current environment in DC. Frankly, I was discouraged by the fact that our visits really became dominated by our elected officials and their staffers telling us all they could have done for us if "the other side" would just be more collaborative. This was more than typical election-year posturing. There was no sense from either side that they recognized their own contribution to gridlock. Statements like "we really want to fix the SGR, not just for you but because WE are tired of dealing with it every year" were the norm, but disturbingly followed by "if only they would..." in every case. Couple this with the uncertainty of the pending Supreme Court decision on the Patient Protection and Affordable Care Act, and, as one leader said, it would appear that the duck is already lame – at least in regard to our issues. Clearly for those family docs in New Jersey that are just hanging on in an effort to care for their patients the cavalry will not be arriving along the 95-corridor from our Nation's Capital any time soon.

I would imagine that about now you may be wondering where that renaissance is coming from. Why am I truly enthusiastic about the future of family medicine – and not just the long term future, but the near term as well? Why do I believe that those family docs who routinely tell me that they need help today are poised to actually get it? Believe it or not, my answer is largely because of what I wrote in the previous paragraph.

In New Jersey, we have been in crisis for so long that we are finally beginning to see the results of tireless efforts to find our own solutions rather than wait for help from DC.

We have become a nation that really only solves problems when the crisis is upon us (or to paraphrase Winston Churchill, we get it right after we've exhausted all the alternatives). In New Jersey, we have been in crisis for so long that we are finally beginning to see the results of tireless efforts to find our own solutions rather than wait for help from DC. Already one commercial payer in the state is committed to reinvesting in primary care through care coordination fees, and several others have indicated they will follow. Our efforts to set a reasonable floor for fee-for-service rates in addition to those care coordination fees are also beginning to take root. We have also been wildly successful in developing a core infrastructure of practices committed to transforming the

Continued on next page

RENAISSANCE *continued*

delivery of healthcare in a patient-centered, team-based approach such that we were able to attract the CMS Center for Innovation to select New Jersey as one of the states in which they will pilot the Comprehensive Primary Care Initiative (CPCI). This pilot will pay care coordination fees of as much as $20 PMPM for Medicare patients covered by participating plans. We have developed tools for physicians and practices to look for suitable methods of gaining leverage while maintaining their desired level of autonomy (www.njafp.org/integration) that will lead to even more members finding ways to increase revenues to a sustainable and satisfactory level.

At our upcoming annual meeting (and if you are reading this while the ink is still wet you have time to get there) you will find several opportunities to learn more about these initiatives and others that have the potential to truly help. At our pre-conference workshop, "Tools for Survival, Part III" we will discuss how to leverage programs like Meaningful Use and CPCI, as well as innovative compensation models and practice structures to increase leverage. At our Town Hall on Thursday evening we will have an open forum discussion with representatives from CMS (invited) about how practices can enroll in the Comprehensive Primary Care Initiative – which may be the most exciting development in primary care in a decade. Our Keynote speaker on Saturday is Paul Grundy, MD, known to many as the Godfather of the Patient Centered Medical Home. Paul will discuss how the PCMH movement is finding a foothold among employers who can truly drive payer behavior change regardless of what happens at the federal level. On Friday at our House of Delegates we will have the opportunity to dialogue with Sandra Nichols, MD, Chief Medical Officer for the Northeast Region at United Healthcare, along with Mr. Christy Bell, COO of Horizon Blue Cross and Blue Shield of New Jersey. This open dialogue would not have occurred even 3 years ago, and similar dialogue has already led to both companies taking more responsibility to improve our fractured primary care infrastructure. This is all in addition to the high quality clinical CME that you have come to expect from NJAFP.

I do believe that we are at the early stages of a primary care renaissance in New Jersey. A glimpse into what it might look like and how you can be a part of it begins on June 14 in Atlantic City. I hope to see many of you there. ▲

Perspectives:
A View of Family Medicine in New Jersey
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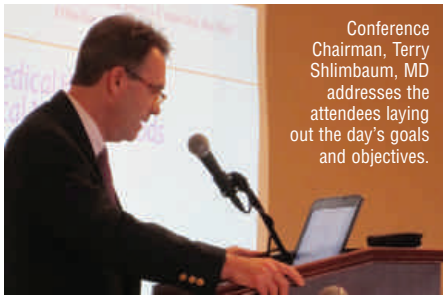
NJAFP Hosts Healthcare Think Tank

The Healthcare Quality work group, facilitated by Mary Campagnolo, MD (L) discussed how to improve the quality of healthcare delivery in New Jersey.

On April 27, 2012, physicians, nurses, healthcare coalitions, academicians, health insurers, purchasers of health care, healthcare facilities, government leaders and policy makers convened in Trenton to brainstorm solutions to New Jersey's fragmented and dysfunctional healthcare system. Organized by NJAFP, **Collaborating for the Healthcare of New Jersey-Connecting the Silos - *A One-Day Think Tank***, attracted a broad spectrum of New Jersey healthcare leaders and included almost 100 participants. The "invitation only" event was supported by the American Academy of Pediatrics – NJ Chapter, New Jersey Business and Industry Association, Medical Society of New Jersey, New Jersey Association of Osteopathic Physicians and Surgeons, Horizon Healthcare Innovations, and Rutgers Center for State Health Policy.

David Nace, MD, Chair of the Patient-Centered Primary Care Collaborative opened the conference with the keynote address focusing on how a patient-focused approach to health care could be achieved through the concept of a Patient Centered Medical Home. Laura K. Landy, President of the Fannie E. Rippel Foundation, discussed the current status of New Jersey health care and the need to improve the quality and efficiency of healthcare delivery in New Jersey. Following her presentation, a panel made up of healthcare providers, insurers and employers outlined what they are doing to ensure innovative healthcare delivery in New Jersey.



Conference Chairman, Terry Shlimbaum, MD addresses the attendees laying out the day's goals and objectives.

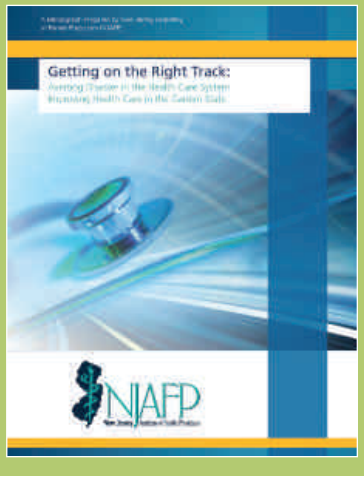
In the afternoon, conference participants were assigned to subject matter-specific work groups organized around the topics of healthcare access, healthcare cost and affordability, healthcare quality, healthcare workforce and health information technology. Work groups discussed: the current status of the state's healthcare system, the components of an ideal healthcare system, barriers to creating an ideal system and strategies for overcoming the barriers.

Thanks to a grant from the Robert Wood Johnson Foundation, key recommendations from the conference were documented and will be shared in a White Paper in the months ahead.

According to Conference Chair, Terry Shlimbaum, MD, the One-Day Think Tank "was important to lay the foundation for continued dialogue toward the improvement of our healthcare delivery system in New Jersey. This is the first step. Given the varied backgrounds and accomplishments of participants, we are pleased to have successfully identified a focus."

NJAFP Releases "Getting On The Right Track: Averting Disaster in the Healthcare System"

NJAFP has released a monograph which details many of the issues at the core of New Jersey's fractured and fragmented healthcare system, and offers potential solutions. In issuing the paper, NJAFP President Robert Eidus, MD notes: "New Jersey is the poster-child for inefficient, costly, fragmented care. This document explains why we are in this mess and how we might get out of it before New Jersey becomes a full-fledged primary care desert, unable to provide citizens with basic care at sustainable costs." The monograph and associated references can be downloaded from the NJAFP website at www.njafp.org.



What Have You Done For Me Lately?

In February 2012, the **NJAFP** met with the New Jersey Department of Banking and Insurance to discuss the implementation of the Department's health identification card regulations and health insurer compliance with these regulations. The Department provided information on the manner in which the plans are complying. NJAFP's focus has been on the ease in which physicians and their staff can easily identify on the patient's card whether the plan is fully insured (regulated by NJDOBI) or self-funded (regulated by ERISA and not the State). This information is key to knowing what set of rules the insurer is operating under for healthcare coverage determinations for patients and/or contractual issues with physicians.

In February 2012, the **NJAFP** met with the Governor's Chief Health Policy Officer to discuss the NJ Board of Chiropractic Examiners' proposed regulations revising the scope of practice of chiropractors. NJAFP had successfully fought legislation that permitted chiropractors to provide pre-participation physicals for students. The Chiropractic Board blatantly ignored the legislative prohibition and granted the authority to perform pre-participation physicals to chiropractors in their proposed regulations. NJAFP, along with several other physician-specialty societies, submitted written public comments in opposition to this proposal to the Chiropractic Board with support from the Governor's Office.

In March 2012, **NJAFP staff** and NJAFP Board Member, **Dr. Robert Gorman**, met with the New Jersey Association of Health Plans to revisit some old issues and discuss the new generation of managed care hassle factors identified by NJAFP members. NJAFP will continue working with the health plans individually and through the association to address these issues.

In April 2012, **NJAFP** submitted written public comments to the New Jersey Department of Banking and Insurance on their proposed regulations dealing with provider contracting and provider networks. These regulations are the Department's second attempt to address many of the health plan contracting and network issues that NJAFP has raised, including the practice of one-sided unilateral changes to contracts and the proper management of provider networks. The public comments and the proposed regulations are currently being reviewed by the Department.

Breakfast Really is the Most Important Meal

Newark Public Schools should be proud. Newark and Detroit were the only two large public school systems, out of 26 recently surveyed, that provided school breakfast to 70 percent of the low-income students who receive school lunch.

As a physician and former licensed nutritionist, I believe this is big news for children in New Jersey. I work with many obese children and their families, including many who are food insecure. From this experience, I've learned that reducing hunger and improving nutrition aren't separate goals. They both can be achieved by improving participation in the federal nutrition programs. By providing needed food and resources, these programs help to reduce food insecurity and its negative health consequences.

Research shows us that eating breakfast has important benefits, both in terms of overall health and in terms of school success. Students who eat breakfast at school show improved attendance, behavior, and academic performance as well as decreased tardiness. They also have better health and nutrition. Children who eat breakfast have lower BMI's, smaller waist circumferences, and less likelihood of being chronically obese in the short term and long term than those who skip breakfast.

Unfortunately, too many children start the day with an empty belly. Nationally, one in four children live in food insecure households. Standing between these children and the risk of hunger are what I believe are two of the most important health programs of the federal government: the School Breakfast and the National School Lunch Programs.

In 2010-2011, the National School Lunch Program helped give a free or reduced price healthy lunch to over 20 million low-income children on an average day. School breakfast, however, reached only 48 percent of those very children. Why the disparity? Some schools don't offer breakfast, or make participation difficult or uncomfortable for children (e.g. if school buses arrive too late). Parents may be unaware of the breakfast program, or have trouble getting their children to school early enough due to work and commuting schedules.

Creative strategies on the part of most large school districts, including Newark, are improving school breakfast rates. Universal breakfast (providing breakfast at no charge to all students) has proven to be an effective strategy, in part because it reduces stigma that can be a barrier to low-income student participation. Another strategy, serving breakfast in the classroom, dramatically increases participation by making it convenient and accessible to all. It helps families whose early morning schedules make it difficult to fit in

breakfast—either at home or in the cafeteria before school starts—due to long commutes and nontraditional work hours.

And these creative strategies are working – and that's why the fact that Newark is reaching so many low-income children with breakfast is one that matters a great deal to the state and to the nation. We know that far too many children struggle with hunger and poor nutrition, yet we also know there is a solution to that challenge. I applaud the work of the Newark Public Schools, and I urge more states and schools to follow its lead. Our entire society will benefit from giving each of our school children a good nutritional start to their day.

Marcy Oppenheimer, MD
Family Medicine Resident, PGY III
Georgetown/Providence Hospital, Family Medicine Residency Program

Early Results Show Patient-Centered Medical Homes Drive Quality and Cost Improvements

Horizon Blue Cross Blue Shield of New Jersey has announced landmark results for New Jersey's only comprehensive, state-wide Patient-Centered Medical Home (PCMH) Program. Horizon Healthcare Innovations (HHI), the company's subsidiary, developed the PCMH Program in collaboration with leading primary care doctors and the New Jersey Academy of Family Physicians to increase accountability and coordination to improve patient care and contain costs. The early results show the PCMH model is effective.

The results below compare 2011 preliminary quality and cost trends between 24,000 Horizon BCBSNJ members participating in the medical home program and members not in the program. The findings show that patients within the medical home program are benefiting and the costs are lower.

Quality Measures

- 8% higher rate in improved diabetes control (HbA1c)
- 6% higher rate in breast cancer screening
- 6% higher rate in cervical cancer screening

Cost and Utilization Indicators

- 10% lower cost of care (per member per month)
- 26% lower rate in emergency room visits
- 25% lower rate in hospital readmissions
- 21% lower rate in hospital inpatient admissions
- 5% higher rate in the use of generic prescriptions

HHI has been expanded to cover more than 80,000 members and is developing other accountable care delivery models that will be announced in coming months. The PCMH Program will expand throughout 2012. The program now includes 152 physicians at 22 practices within ten counties.

According to NJAFP President Robert Eidus, MD, "Horizon Healthcare Innovations and the New Jersey Academy of Family Physicians have been leaders and catalysts in New Jersey to promote this model and to assist family doctors and other primary care physicians in the transformation of their practices. The NJAFP believes that new models of care that revolve around the patient are critical to solving the access, quality and cost issues that face us all in New Jersey."

Moving On:

Letter to the Editor

HAVING BEEN AROUND in Family Medicine long enough to think I have seen it all, I am also old enough to know "it ain't over til it's over." Change is inevitable and our reluctance, as intelligent, motivated and self-reflective physicians, to accept change without a fight is just as predictable. After all, we were taught to ask why and why not through all our training.

The last several months and frankly the last two years, have restored my faith that change can be good, and restored my belief that being focused on the patient is paramount. That our unwavering commitment as advocates for improved access and quality of care for patients has finally been recognized. With the movement toward Patient Centered Medical Home (PCMH), we as family physicians are finally being recognized as a critical piece of the chaotic, erratic and broken puzzle called the U.S. healthcare system. A system focused on inconsistent and inappropriate markers of success.

The "new" focus will be on "patient centeredness." This focus should renew the relationships with patients that are needed for fixing the delivery of health care. It will build collaborative relationships with nurses, medical assistants, nutritionists and receptionists. It will place emphasis on looking for opportunities for savings and safety. It will force all to work for the common goal, and foster partnerships between payers, purveyors, and providers.

I want to be a family physician that moves toward "turning NJ healthcare right side up" and I want to lead others in the same direction. I want to be an agent of change, and I want to move on and use the lessons learned from NJ healthcare history to provide a provocative stimulus to continue our dialogue with insurers and let us help them to understand what needs to be done; fix what is broken, and strengthen what is working.

During the last year, as part of a group of physicians working with Horizon, I truly believe that their leadership heard the message of what needs to be fixed, and what will be the cost of these changes. There was not total agreement on every issue, but there was professionalism and understanding of all our differences and a willingness to work toward real solutions.

The recent completed Horizon Pilot on PCMH is a step in the right direction to compensate primary care physicians more appropriately for delivering enhanced population management to the insured, placing the right care in the right place at the right time. It also gives the NJ population an opportunity to look toward savings in healthcare costs by reducing redundancy, waste and unnecessary care by using care coordination and technology. It is a step in the right direction.

We now need to be part of the collaborative team that works toward the common goal of providing better care more efficiently and accepts no less than what is good for patients. We also, however, need to move on from the days of distrust, resentment and finger pointing toward our new insurer partners. We need to embrace their skills as they embrace ours. We need to forget the grudge…and move on.

Kenneth W. Faistl, MD, FAAFP
Colt's Neck, NJ

CME Test Answers: 1. T; 2. F; 3. T; 4. T; 5. F; 6. F; 7. T; 8. T; 9. F; 10. T; — 11. T; 12. F; 13. T; 14. T; 15. F

CLINICAL VIEW

CME

School Breakfast in America's Big Cities

Madeleine Levin, MPH

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Summary/Abstract

Background

Through robust breakfast programs, schools play an important role in ensuring the food security of children, while also supporting improved attendance, greater academic success, improved health, and reduced obesity. Unfortunately, too many school breakfast programs have low participation rates because they typically require children to eat in the cafeteria before school starts. As a result, some children miss this important meal because they feel singled out and self-conscious of being labeled as "low income," while others miss it because of timing issues. When the bus is late or the morning routine falls behind schedule, the opportunity for breakfast is missed.

This article is an abridged version of the Food Research and Action Center's (FRAC) report, *School Breakfast in America's Big Cities,*[1] which analyzed school breakfast participation in 26 large urban districts, one of which was Newark, NJ. These urban districts serve many low-income children and are able to benefit from economies of scale to increased breakfast participation. The concentration of poverty in many cities means that these districts have an especially important mission to ensure that children have access to adequate nutrition in order to learn, grow, and thrive.

Methodology

In the summer of 2011, FRAC sent a survey regarding school year 2010-2011 school breakfast participation and practices to 35 large urban school districts. FRAC selected the districts based on size and geographic representation, seeking to look at not just the nation's largest districts but at the largest school districts in a substantial number of states. School food service staff in 26 districts responded between August and November 2011.

Results

FRAC's research shows that breakfast in the classroom is one of the most successful ways to improve participation rates. The analysis of participation in 26 large urban school districts' breakfast programs finds that districts offering breakfast in the classroom have the highest participation rates. The top four school districts—the District of Columbia, Detroit, Houston and Newark (NJ)—serve breakfast to 65 percent or more of the low-income students that received school lunch each day, and all four feature programs in which all students are offered breakfast at no charge, with most eating in the classroom at the beginning of the school day. Of the top ten school districts with the highest breakfast participation rates, all offer breakfast free to all students throughout their district, and all but one has large-scale in-classroom breakfast programs.

Introduction

School breakfast improves children's diets, increases school achievement, promotes positive student behavior, reduces obesity and food insecurity, and builds lifelong healthy eating habits.[2] School breakfast provides an especially needed support to millions of struggling families, but with fewer than half of low-income children getting breakfast,[3] too many children are missing out. These children who do not eat breakfast start the school day unable to concentrate and not ready to learn.[4]

In 2010 approximately 16.2 million American children – 21.6 percent of all children - lived in food insecure households.[5] Food insecurity, as defined by the U.S. Department of Agriculture, means the household's "access to adequate food is limited by a lack of money and other resources."[6] Although experts agree that breakfast is the most important meal of the day, for children living in these struggling households a filling, nutritious meal every morning is often beyond their parents' ability to provide.

For millions of other children, the barriers to eating breakfast at home are a matter of time, transportation, or physiology, not money. As the demands on working parents have grown, and parents face longer commutes to distant jobs or jobs with non-traditional work hours, or children face long bus rides, sitting down to a healthy breakfast has become a rare event for many families. Along with the early morning rush, many children do not have an appetite when they first start the day, so skipping breakfast becomes an unhealthy routine for many.

From every perspective — nutrition, health, education, and productivity — cities should be doing much more to get children to breakfast and breakfast to children, and receive federal dollars to do so. This article describes the gaps in many cities' current efforts, and the strategies they can use to reach more children.

Proven Benefits

Eating School Breakfast Decreases the Risk of Food Insecurity

There is strong evidence that school breakfast offered to all students for free* helps eliminate disparities between food secure and food insecure children.[7] Research has also shown that access to school

* Offering breakfast to all students for free is sometimes referred to as "universal breakfast" or "universal-free breakfast." The program helps remove the stigma for low-income children of participation in school breakfast and thereby increases participation among students generally, but particularly low-income students.

breakfast decreases the risk of marginal food insecurity and breakfast skipping, especially for low-income children.[8,9] Students with improved nutrient intake as a result of school breakfast report decreases in symptoms of hunger.[10]

Eating School Breakfast Improves School Performance

As schools work to raise their students' academic performance and test scores, making sure every child has eaten a nourishing breakfast is an important but often overlooked tool. Researchers report that children who skip breakfast have more difficulty distinguishing among similar images, show increased errors, and have slower memory recall.[11] Studies also show that children who live in families that experience hunger have lower math scores, are more likely to repeat a grade, and receive more special education services.[12,13]

Eating a healthy breakfast helps to lay the groundwork children need to learn. Eating breakfast improves math grades, vocabulary skills and memory.[14] Children who eat breakfast at school – closer to class and test-taking time – perform better on standardized tests than those who skip breakfast or eat breakfast hours earlier at home.[15]

Eating School Breakfast Reduces Behavioral Problems

As any parent knows, a hungry child is much more likely to be irritable and poorly behaved. Research has confirmed this connection. For example, teenagers experiencing hunger are more likely to be suspended from school, have difficulty getting along with other children, and tend to have few friends.[16] In addition, hungry children are more likely to be absent and tardy.[17] Encouraging participation in the School Breakfast Program is a good way to improve school attendance and discipline. Studies have shown that students who participate in school breakfast have decreased behavioral and psychological problems, and fewer discipline referrals.[18,19]

Eating School Breakfast Improves Children's Diets

Many children in the United States grow up surrounded by low-quality, "fast food," and many have developed unhealthy eating habits. In contrast, breakfasts served as part of the School Breakfast Program are required to provide twenty percent of the key nutrients children need every day, and contain no more than 30 percent of calories from fat and 10 percent of calories from saturated fat.[20]

Studies show that children with access to school breakfast eat a better overall diet, less fat, and more magnesium, vitamin C and folate.[21,22] USDA research shows that children who participate in school breakfast eat more fruits, drink more milk, and consume a wider variety of foods than those who do not eat school breakfast or who have breakfast at home.[23]

Eating School Breakfast Can Help Reduce Obesity

Current research indicates that one-third of America's children are overweight or obese.[24] Most troubling, this translates into increased risks of premature death and an overall lower quality of life. Obesity is associated with greater risk of diabetes, heart disease, stroke, asthma, osteoarthritis, cancer and even psychological disorders.[25]

Children and adolescents who eat breakfast are significantly less likely to be overweight, while skipping breakfast is associated with a higher risk of obesity.[26,27,28] Research suggests that people who do not eat breakfast get hungrier later in the day and tend to overeat as a result — consuming more calories each day than they would if they had eaten breakfast in the morning.[29,30] School breakfast helps ensure that children will not be tempted to overeat at other meals, or snack before lunch.[31]

Methodology

FRAC has issued this report annually since 2007. In the summer of 2011, FRAC sent a survey regarding school year 2010-2011 school breakfast participation and practices to 35 large urban school districts. (The survey is available by request.) FRAC selected the districts based on size and geographic representation, seeking to look at not just the nation's largest districts but at the largest school districts in a substantial number of states. School food service staff in 26 districts responded between August and November 2011. FRAC staff also conducted phone interviews with districts with high, or recently increased participation in the breakfast program to highlight best practices for the report.

FRAC calculates the number of low-income students – i.e. those eligible for free or reduced-price school meals – eating breakfast and lunch each day (average daily participation, or ADP) in each city by dividing the number of free and reduced-price breakfasts and lunches (respectively) served over the course of the school year by the number of days on which breakfast and lunch was served, as reported in the survey by each district.

Findings

Enrollment and Student Eligibility Rates

The 26 districts that participated in this study ranged in size from 26,000 students to more than 1 million students during the 2010–2011 school year (enrollment figures for each school district are available in the full report). Enrollment trends within school districts can impact participation, but even districts with declining enrollment are achieving increases in breakfast participation. Also, due to the recession, most districts, even those with falling overall enrollment, had increased numbers of students qualifying for free and reduced-price meals.

The districts responding to this survey reported the percent of their student enrollment determined to be eligible for free and reduced-price meals through the National School Lunch and Breakfast Programs. These eligibility figures provide a snapshot of the relative level of poverty and nutritional need in each school district. The percentages varied from a low of 44 percent combined free and reduced-price eligible students in Seattle, Washington to a high of 94 percent in Memphis, Tennessee (eligibility rates for each school district are available in the full report).

Breakfast Participation

Cities that increased daily low-income student breakfast participation in school year 2010-2011 compared to 2009-2010 included Houston by an impressive 29,957 students (45 percent increase), Denver by 2,409 (21 percent increase), Orange County (Orlando, FL) by 4,848 students (18 percent increase), District of Columbia by 1,818 students (18 percent increase), Memphis by 3,019 students (9 percent increase), and Philadelphia by 4,141 students (8 percent increase).

Effectiveness in Reaching Low-Income Students with School Breakfast

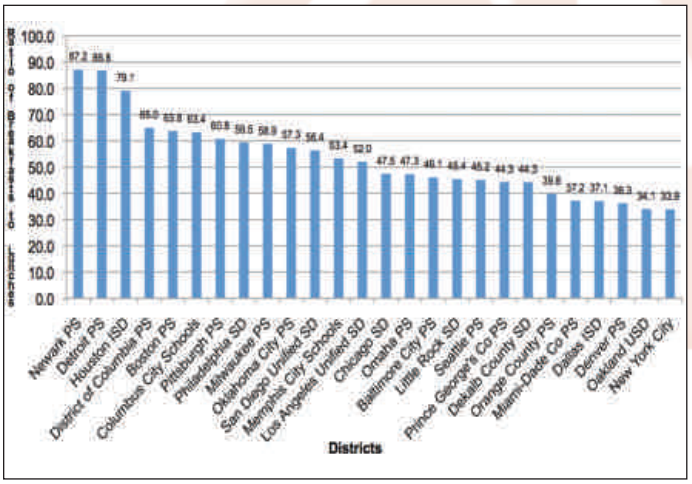
FRAC uses free and reduced-price participation in the school lunch program as a benchmark against which to measure low-income student participation in school breakfast. Because there is broad participation in the lunch program by low-income students in districts around the country, it is a fair measurement of how many students could and should be benefiting from school breakfast each day. Nationally, in school year 2010–2011, 48.2 low-income children ate free or

reduced-price breakfast for every 100 low-income children who ate free or reduced-price lunch on an average day. The ratio is about 60:100 in the best performing states – 63.5:100 in New Mexico, 61.4:100 in South Carolina, and 60:100 in Vermont.[32]

FRAC sets a goal for large urban districts to serve breakfast to at least 70 out of 100 low-income students who eat school lunch. This is a challenging, yet achievable goal, because large districts can benefit from economies of scale, and the concentration of free and reduced-price eligible students translates into larger federal reimbursements for the meals served. Most importantly, the concentrations of poor children in these urban areas present districts with the imperative to ensure that children have access to adequate nutrition in order to learn, grow, and thrive.

Figure 1 and **Table 1** shows the districts by their effectiveness at reaching children with breakfast, as demonstrated by the ratio of low-income students eating school breakfast compared to lunch. Only three districts—Detroit, MI, Houston, TX and Newark, NJ—met or exceeded the goal of 70 percent low-income student breakfast participation in school year 2010-2011. Four additional districts exceeded a breakfast to lunch ratio of 60:100 low-income students. An additional six of the 26 urban districts in this study served breakfast to more than half of their low-income students that received lunch each day. Thirteen districts were below the national average (48.2:100).

Figure 1: Effectiveness in Reaching Low-Income Students with School Breakfast:



Reaching All Children Who Need School Breakfast: The Nutritional and Fiscal Benefits

Uneaten meals represent substantial harm to children's health and development. Also, missed school breakfast meals add up to tens of millions of dollars in federal child nutrition funding going unclaimed by districts every year. Each school day in school year 2010–2011, schools lost at least $1.48 in federal nutrition funding for every child who would have received a free breakfast and $1.18 for every child who would have received a reduced-price breakfast, but who was not served. An additional $0.28 in federal funds per child per meal was forfeited if those low-income children attended a "severe need" school—a school in which at least 40 percent of lunches served were free or reduced-price.

If each district in this study had provided at least 70 low-income children with breakfast (through the School Breakfast Program) for every 100 low-income children that received lunch (through the National School Lunch Program) in the 2010–2011 school year, an additional 528,916 students would have eaten a healthy school breakfast every day and the 26 districts would have received an additional $136.5 million in child nutrition funding. **Table 1** provides these data for each district, arranged from the highest to lowest amount of dollars lost. Most of the lost revenue and unserved low-income students are clustered in the largest districts, with nearly one third in New York City alone. The New York City Department of Education would have collected $50.95 million in additional federal funds, and served an additional 193,785 low-income students, if it met the 70:100 ratio. But fifteen districts failed to collect at least $1 million. In these districts, the unnecessary loss of federal breakfast dollars hurts children and schools.

Table 1: School Districts' Additional Funding and Participation if 70 Low-Income Students Were Served School Breakfast (SBP) Per 100 Served School Lunch (NSLP)

Discussion: Expanding Participation

School District	Ratio of Low-Income SBP Students to 100 Low-Income NSLP Students	Additional Low-Income Students Served if 70 SBP per 100 NSLP	Additional Annual Funding if 70 Low-Income Students Served SBP per 100 NSLP
New York City Dept. of Education, NY	33.9	193,785	$50,954,409
Los Angeles Unified School District, CA	52.0	58,210	$14,840,950
Miami-Dade Co. Public Schools, FL	37.2	55,146	$14,428,327
Chicago Public Schools, IL	47.5	54,965	$13,530,579
Dallas Independent School District, TX	37.1	35,944	$9,137,561
Orange County Public Schools, FL	39.8	24,015	$6,295,390
DeKalb County School District, GA	44.3	14,473	$3,727,338
Prince George's Co. Public Schools, MD	44.3	13,771	$3,608,440
Denver Public Schools, CO	36.3	12,784	$3,138,562
Baltimore City Public Schools, MD	46.1	10,808	$2,737,963
Philadelphia School District, PA	59.5	9,396	$2,427,536
Memphis City Schools, TN	53.4	8,078	$2,151,860
Oakland Unified School District, CA	34.1	6,649	$1,748,360
Omaha Public Schools, NE	47.3	6,493	$1,544,014
Milwaukee Public Schools, WI	58.9	5,280	$1,361,082
Seattle Public Schools, WA	45.2	3,546	$879,438
Oklahoma City Public Schools, OK	57.3	3,549	$869,003
Little Rock School District, AR	45.4	2,972	$811,216
San Diego Unified School District, CA	56.4	2,642	$667,782
Boston Public Schools, MA	63.8	2,004	$526,435
Columbus City Schools, OH	63.4	2,071	$520,912
Pittsburgh Public Schools, PA	60.8	1,405	$362,944
District of Columbia Public Schools, DC	65.0	930	$247,185
Houston Independent School District, TX	79.1	*	*
Detroit Public Schools, MI	86.8	*	*
Newark Public Schools, NJ	87.2	*	*
TOTAL		**528,916**	**$136,517,287**

All of the districts surveyed have schools with high concentrations of poverty. In such schools, there are important program options to reach many more children with breakfast. The pace at which districts are able to implement these programs depends on a range of factors: administrative support, financial resources for start-up expenses, and buy-in from the school community (parents, principals, teachers, janitors, and other school support personnel).

Offering Breakfast Free to All Children

Programs that offer meals at no charge to all students, regardless of income, (sometimes called "universal") help reach more children. The traditional means-tested school breakfast served in the cafeteria before school (in which the higher income children pay) creates a sense among the children that the program is just "for poor kids." Offering all children breakfast at no charge reduces the stigma, making school breakfast more attractive to students. It also helps schools implement programs such as breakfast in the classroom or offering breakfast from "grab and go" carts in the hallways at the start of the

school day. Of the 26 large urban school districts surveyed, only one—Seattle Public Schools —does not offer breakfast free to all students, regardless of income, at some or all of their schools.

Alternative Service Methods

Breakfast in the Classroom: Students eat breakfast in their classrooms, either at the beginning of the school day or early during the day. Often, breakfast is brought to classrooms from the cafeteria in containers or served from carts in the hallways by food service staff.

"Grab and Go": All the components of school breakfast are conveniently packaged so students can easily grab a reimbursable meal quickly from the cafeteria line or from carts elsewhere on school grounds. Depending on the school's rules, students can eat in the classroom, or somewhere else on campus.

Breakfast after First Period or "Second Chance Breakfast": Usually implemented in middle and high schools, this method allows students time after their first period to obtain breakfast from the cafeteria or carts in the hallway, or to eat in the classroom or cafeteria. Computerized systems ensure that children receive only one breakfast each day.

Breakfast in the Classroom

Twenty-three of the 26 districts in this study had some type of alternative breakfast service method—where breakfast is served after the school day begins—in at least some of their schools during the 2010–2011 school year. Districts used a variety of methods, including "grab and go," and breakfast after first period for middle and high school students. Allowing students to eat in the classroom dramatically increases participation by making it convenient and accessible to all. For instance, Newark, Detroit, Houston and the District of Columbia reached the largest percentage of low-income students by requiring breakfast in the classroom in almost all K–8 schools.

Conclusion

School districts should do much more to reach children with school breakfast and reap the nutritional, health and educational benefits it brings. School districts that offer breakfast in the classroom free to all students have the highest participation rates. The increased participation and resulting increased federal reimbursements, coupled with the economies of scale and lower administrative costs, often help districts break even or come out ahead financially. More districts and schools, especially those with large percentages of low-income students, should move to this model and experience its positive outcomes—higher attendance, lower absenteeism, better health, reduced behavior problems, fewer visits to the school nurse, reduced obesity, and higher student achievement.

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Breakfast in the Classroom Success in Newark, NJ[33]

In 2003, after 15 years of lackluster participation in school breakfast, Tonya Riggins, the Director of Newark's Food Services, decided to take action. She wanted to serve breakfast in the classroom and found a principal willing to work with her. Implementation was very successful, and the principal believed that increased breakfast participation was an important element in supporting improved student achievement at her school. Soon, other principals were requesting help in setting up breakfast in the classroom programs at their schools, and the superintendent made it a priority. As a result, the district has served breakfast in the classroom in all 75 elementary and middle schools since the 2004-2005 school year, producing more than a 150 percent increase in participation. Instead of serving 8,500 to 9,500 students breakfast each day, Newark Public Schools served 26,000 children breakfast daily in the 2004-2005 school year. This success has continued ever since, with an average daily participation of almost 24,000 in the 2010-2011 school year.

The district's breakfast menus include both hot and cold items. Children eat during the first 10 minutes of class, while teachers take attendance and conduct other administrative tasks. In some schools, older students help distribute the breakfast to younger students by delivering bins containing the meals from the cafeteria to the classrooms. These students also return the meal count daily attendance sheets, earning service credit as classroom monitors. In other schools, a grab-and-go model is utilized where each student picks up their breakfast as they enter the building and takes it to class. Teachers have found that the program does not interfere with their instruction time, and that children are more attentive and able to focus on their work throughout the day.

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CME

A Brief Overview of Obesity and its Treatment

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"Obesity is a complex multifactorial chronic disease that develops from an interaction of genotype and the environment. Our understanding of how and why obesity develops is incomplete, but involves the integration of social, behavioral, cultural, physiological, metabolic and genetic factors."

– National Heart, Lung and Blood Institute[1]

The National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK), as well as the World Health Organization (WHO) define obesity as a chronic disease with a body mass index (BMI) of ≥30 kg/m^2. According to the most recent data from the National Center for Health Statistics, in 2009-2010, 78 million adults (defined as those over 20 years of age) were considered obese,[2] with conservative estimates among children and adolescents at 15.5% (body mass index greater than the 95th percentile for age).[3]

Obesity is a significant risk factor for cardiovascular disease, diabetes, cancer, osteoporosis and other chronic diseases, such as kidney disease, sleep apnea, and depression.[1,4] Studies have also shown that children and adolescents who are obese are more likely to develop pulmonary, cardiovascular, endocrine and psychosocial problems which persist into adulthood than do their normal weight peers.[5] Obesity is the fifth leading cause of death worldwide, causing approximately 2.8 million adult deaths each year.[6] It is the second leading cause of preventable death in the United States, presenting a major public health challenge.[1]

Aside from the associated health risks, society itself plays an important role in obesity. In a review and update on obesity, Puhl and Heuer[7] found the following: employees who are obese may be viewed as lazy, lacking in self-discipline, and less competent than their non-obese counterparts, with a negative impact on salary, promotions, and business decisions regarding those obese employees. Students who are obese may face harassment and rejection from academic colleagues, biased attitudes from professors, and wrongful dismissals from universities. In the healthcare environment studies have shown that some physicians, nurses, dietitians, and psychologists have negative attitudes toward

patients who are obese which can lead to patient reluctance in seeking medical care.

The prevention of obesity should always be a primary goal, however the treatment of those who already obese is an urgent matter.[5] Treatment is a two-step process consisting of assessment of the degree of overweight and overall health status and the management of the condition consisting of reducing body weight and treating the accompanying risk factors.[1] There are several approaches toward treating obesity. These include diet and exercise, behavior therapy, CAM therapy and pharmacotherapy. However, once an obese patient has failed on these treatments, the next step may be surgical intervention.[5,8]

The benefits of bariatric surgery have been recognized as a viable treatment option for obesity and obesity-related diseases in adults.[9-11] The choice of bariatric surgery for children and adolescents is not so straight forward. In addition to the comorbidity assessments and anthropometric measurement, other factors such as adverse medical and psychosocial outcomes, compliance and follow-up, principles of adolescent growth and development, and family structure, must be taken into consideration.[3] A review of the literature showed that the risks of treatment are acceptable when the benefit outweighs the risk of not treating the patient. Bariatric surgery in pediatric weight management should be viewed as needs based, rather than age based when the risk of chronic comorbidities outweigh the risk of surgery, no matter the patient's age.[5]

The American College of Physicians recommends surgery for those patients with a BMI of at least 40 kg/m^2 who have failed on traditional therapy and present with obesity-related, co-morbid conditions.[12] The International Diabetes Federation Taskforce on Epidemiology and Prevention of Diabetes has stated that bariatric surgery is an effective and cost-effective therapy for patients with type 2 diabetes and obesity who are not achieving recommended treatment targets with medical therapies, especially in the presence of other major co-morbidities.[13] Researchers have also found that there were fewer cardiovascular deaths and a lower incidence of cardiovascular events in obese adults who underwent bariatric surgery.[14] Buchwald, et al.[9] found that adults who underwent bariatric surgery experienced complete resolution or improvement in obstructive sleep apnea, hypertension, hyperlipidemia and diabetes.

Inge, et al.[3] recommend bariatric surgery for adolescents only after the child has met certain medical, psychologic and anthropometric criteria and has failed more than 6 months of organized attempts at weight loss. Inge, et al. recommends a multidisciplinary team of healthcare providers, which includes experts in bariatric surgery and adolescent weight management, carefully review the risk and benefits, as well as the indications and contraindications for each individual patient. Aikenhead, et al.[5] stated that until there is an improvement in the quality of evidence on child and adolescent bariatric surgery, an academic approach is warranted and surgical techniques that are reversible are advisable over approaches that permanently alter the patient's anatomy.

Barriers to surgical treatment of obesity in adults also exist among family physicians. According to a study by Phelan, et al.,[15] physicians reported that they based their weight loss recommendations more on clinical experience than on the medical literature or personal experience. Another study by Ferrante, et al.[16] showed that medication and bariatric surgery were infrequently recommended, especially by those physicians who had a higher volume of extremely obese patients.

Family physicians are in the best position to care for obese patients and must be knowledgeable and comfortable in discussing surgery as a treatment option.[17] They must know the procedures available, the risks and benefits, and the proper post-surgical management in order to appropriately counsel and care for their patients.[17] Family physicians must impress upon their patients that surgery is not a solution to the problem, it is just a tool and lifestyle modifications are going to be critical to long-term success for all bariatric patients.[5] Using the PCMH model, the involvement of the multi-disciplinary team to coordinate care both pre- and post-operatively is critical to positive outcomes for the patient.[11] ▲

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Members in the News...

Robert Eidus, MD, MBA *(Cranford)* and **Jeffrey Brenner, MD** *(Camden)* were quoted in the NJSpotlight article entitled "New Jersey Tapped to Participate in National PCMH Trial," which discussed New Jersey's nomination as part of the CMS initiative (see Government Affairs View). To read the full article, go to: http://www.njspotlight.com/stories/12/0412/0051/

Richard Corson, MD *(Hillsborough)* wrote an op-ed featured in *The Press of Atlantic City,* commenting on New Jersey's selection as part of the federal pilot program by Medicare and Medicaid Services that will place the Patient Centered Medical Home at the center of health care. This model reduces costs, eliminates fragmented and unnecessary treatments, and recognizes family physicians as key players in healthcare delivery. The New Jersey Academy of Family Physicians strongly supports the PCMH model. (http://www.pressofatlanticcity.com/opinion/ commentary/dr-richard-l-corson-program-puts-n-j-at-center/article_ 759eda2d-6e69-5554-94e6-28aaeecf92d6.html)

Tom McCarrick, MD *(Verona)* of Vanguard Medical Group was highlighted in an article in *Healthcare Informatics* for his work in helping his colleagues through the stages of the PCMH. (http://www.healthcare-informatics.com/article/wiring-our-home-pioneers-patient-centered-medical-home-concept-see-mix-strategic-process-and?page=2)

Special Congratulations...

Jeffrey Brenner, MD, *(Camden)* Executive Director, Camden Coalition of Healthcare Providers and Director, Institute of Urban Health at Cooper Hospital was awarded the Edward J. Ill Physician Award®

John F. Tabachnick, MD *(Westfield)* of Summit Medical Group earned the 2012 MDx Medical Inc. Patients' Choice Most Compassionate Doctor Award for his outstanding care and services, including his bedside manner, approach to patient visits, follow-up care, availability for appointments, and the courtesy of his office staff.

With Sympathy

The NJAFP extends its deepest sympathy to the family, friends and colleagues of **Payman Houshmandpour, MD.** Dr. Houshmandpour was a third year resident at Virtua Family Medicine Residency.

NJAFP
New Jersey Academy of Family Physicians

Around the State

The NJAFP was recognized by the AAFP at the Annual Leadership Forum for having the highest percentage increase in Student membership for a medium chapter and for 100% Resident membership in AAFP.

Congratulations to **Mary F. Campagnolo, MD**, who was installed as President of the Medical Society of New Jersey on May 5, 2012

Do you need to complete your MOC Part IV?
Why not consider NJAFP's Colorectal Cancer (CRC) Screening Program? Research has shown that a physician recommendation is the strongest indicator that a patient will get screened. Learn more things that you can do to help your patients get the recommended screenings they need. What you learn in the CRC program is transferrable to other screening programs. Go to http://www.njafp.org/education/maintenance-certification.

Dr. Mary F. Campagnolo was installed as the 220th president of the Medical Society of New Jersey (MSNJ) at its meeting in early May. Dr. Campagnolo is only the third woman to serve as president since the MSNJ was established in 1766.

Don Addison, *Photos by Don*

Dr. Campagnolo practices family medicine at Virtua Lumberton Family Physicians and is chief of the department of family medicine at Virtua Memorial in Mount Holly. At Virtua Health and Rehabilitation Center she cares for nursing home and subacute rehabilitation patients. She also serves as the director for primary care at the Virtua Medical Group in Evesham.

Dr. Campagnolo served at the president of the NJAFP in 2000-2001. She currently serves the Academy as an Alternate Delegate to the AAFP Congress of Delegates.

For the last three years, Dr. Campagnolo has headed the Virtua Medical Group Quality Committee. She is a member of the Mandated State Health Benefits Committee of the Department of Banking and Insurance and appointee to the New Jersey Department of Health and Senior Services' Nursing Home Administrators Licensing Board.

Dr. Campagnolo earned her undergraduate and medical degrees at George Washington University in Washington, D.C., She completed her residency in family medicine at Overlook Hospital in Summit, and received a master's degree in business administration at the Rutgers School of Business in Camden.

It's Not Too Late To Register for the 2012 Summer Celebration and Scientific Assembly

Why do you need to be at the Scientific Assembly? Keep reading

- NJAFP House of Delegates
  A chance to participate in setting Academy policy for the next year
  Run for a Trustee position
- Town Hall meeting with AAFP Board Member Laura Knoble, MD
- CME Highlights
  Learn the latest developments in evaluating the elderly driver, changes in pre-participation physicals, improving immunizations, hypogonadism, osteoporosis and more. Plus this year, Saturday (6/16) will feature an entire track to improving diabetes care for your patients.
- Complete your 2012 SAM (Asthma) with a guaranteed passing grade
- Tools for Survival: Part 3 – Primary Care Boot Camp
- View the posters from the Family Medicine Research Poster Contest
- Come see the JFK Residency program defend their winning streak at the Resident Knowledge Bowl
- Visit the Exhibit Floor and try your luck with our Treasure Chests.
- Keynote Speaker: Paul Grundy, MD
  Dr. Grundy is an active speaker on global healthcare transformation…driving comprehensive, linked, and integrated health-care and the concept of the PCMH. Don't miss this opportunity to hear one of the national champions of family medicine and a leader who is changing the way health care is delivered.

Registration and other meeting information is available at http://www.njafp.org/SCSA

Patient Satisfaction Surveys for Physician Practices

Susan Orr, Esq.

Susan B. Orr, Esq. is a partner in the law firm of Tsoules, Sweeney, Martin & Orr, LLC in Exton, PA.

Patient satisfaction surveys, like any consumer surveys, are useful tools to analyze a physician practice's strengths and weaknesses from the perspective of the consumer or the patient. However, in today's expanding regulatory and payer world, these types of surveys are not just useful marketing tools, they can identify patient concerns and issues that may ultimately affect the practice's bottom line. In fact, the trend is growing, especially for physicians employed by hospitals, to tie physician compensation directly into patient satisfaction scores.

The healthcare reform bill, the Patient Protection and Affordable Care Act (PPACA), requires the Centers for Medicare and Medicaid (CMS) to develop a physician comparison website. In January 2011, CMS posted this website, called Physician Compare, at medicare.gov/find-a-doctor. It features data on the comparative performance of physicians for the purpose of assisting patients in selecting physicians. By January 1, 2013, this website will also include patient satisfaction ratings gathered through surveys, along with information on clinical quality. Data collection will begin in 2012. This publication of standardized survey data will introduce a whole new level of competitive physician selection for patients seeking physicians.

CMS is expected to use the Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) survey to collect input and to measure patient satisfaction. CG-CAHPS was developed by the Agency for Healthcare Research and Quality and is the only survey approved by the National Quality Forum (NQF, who developed the Physician Quality Reporting System) which CMS is required to use. Many large physician groups are already using the CG-CAHPS survey in anticipation of their needing to submit a report to CMS. It is also accepted by accrediting organizations and meets qualification measures for patient-centered home recognition.

Physicians are cautioned that while the survey reporting process is voluntary, Medicare's hospital quality program also started out as voluntary. However, the PPACA ties a portion of hospital reimbursement to patient satisfaction scores starting in October, 2012. These scores are derived from the Hospital Consumer Assessment of Healthcare Providers and Systems survey which is administered randomly to hospital patients after discharge. Hospital payments will be reduced by 1%, but by meeting certain quality standards the hospitals can defray that loss. It is quite likely that this might also happen with the physician quality program. In addition, according to the American Medical Association, "experts say that Medicare is likely to integrate that measurement of patient experience into a pay formula for physicians by 2015."

In addition to using a survey for the Physician Care website, there are other areas where the need for patient surveys will increase, such as private health plan contract requirements, participation in accountable care organizations, and achievement of PCMH recognition by the National Committee for Quality Assurance and others.

So what are the other benefits for conducting patient satisfaction surveys?

1. **Decrease Risk of Liability.** Studies show that liability risk is closely tied to patient satisfaction. When patients lack a connection to their doctor, or feel there is poor communication, they are often not satisfied and are more likely to sue when something goes wrong, whether or not there is actual negligence.
2. **Maintain Staff Retention.** Satisfied patients and satisfied workers go hand in hand. When patients are dissatisfied, they are argumentative, negative, and stressful for employees, creating more hassles and work for them.
3. **Increase Marketability.** Since the Physician Compare site is available for anyone to access on the web 24/7, it really broadens the potential audience of patients. Once the physician satisfaction ratings are added in 2013, there is the potential for more specific positive marketing as satisfied patients post their results.
4. **Enhance Practice Environment and Operations.** The results of the surveys should be summarized and reviewed periodically, ultimately resulting in consequential changes and improvements where needed.

To prepare for the use of their practice survey information, physician practices should begin to use a patient satisfaction survey as soon as possible. If they already do, they may want to consider switching to the CG-CAHPS survey, since they are very likely to achieve a higher score when CMS publishes patient ratings. ▲

For more information about how to construct a patient satisfaction survey, contact Susan B. Orr, Esq. at Tsoules, Sweeney, Martin & Orr, LLC at 610-423-4200 or sorr@tshealthlaw.com.

A Win for Primary Care Patients and Physicians in New Jersey

NJ Selected by CMS Innovation Center for its Comprehensive Primary Care Initiative

Claudine Leone, Esq.

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

One of the NJAFP's key advocacy efforts is to promote and pursue opportunities for the adoption of the Patient Centered Medical Home (PCMH) model of care in New Jersey. In addition to NJAFP's support of its members in the transformation process through National Center for Quality Assurance (NCQA) and our efforts developing PCMH programs with private insurers, there is a policy and advocacy piece to this that has played an important role in the advancement of this effort.

On the public policy side, over the last 4-5 years, the NJAFP has worked with two Administrations and the Legislature to raise awareness and educate key policymakers on the PCMH model. NJAFP supported legislation sponsored by Senator Barbara Buono (D-Middlesex) that established a PCMH demonstration project through the New Jersey Division of Medicaid and has worked with the Division to assist them in the implementation of these projects with their participating Medicaid managed care plans.

While we have had success developing PCMH programs with NJ Medicaid and commercial insurers, individually, NJAFP's ultimate goal is the development of a multi-payer PCMH program in New Jersey. This would include a collaborative effort from the state and commercial payers to advance a PCMH program.

Needless to say, New Jersey is far behind other states as far as multi-payer projects; and we have used that to our advantage selling this to the state and anyone who will listen!

The efforts paid off in the fall of 2011 when the New Jersey Association of Health Plans working with the support of NJAFP helped facilitate the state's payers to submit applications to the Centers for Medicare and Medicaid Services Innovation Center to participate in a multi-payer PCMH program made possible under the Patient Protection and Affordable Care Act.

In April 2012, New Jersey was selected by CMS as one of seven geographic markets to carry out the Comprehensive Primary Care Initiative (CPCI). The CPCI is a new multi-payer approach that aims to strengthen the primary care system while achieving better health care and lower costs through improvement. Markets were selected based on a pool of applicants that proposed to pay for and support comprehensive primary care coordination in partnership with Medicare. More information on these markets and the Comprehensive Primary Care initiative is available at www.innovation.cms.gov/initiatives/comprehensive-Primary-Care-Initiative.

Since the submission of the application, the NJAFP has been actively promoting CMS's selection of New Jersey for inclusion in the CPCI. We organized grassroots support through a 36 member coalition who signed onto a letter submitted to CMS on behalf of New Jersey. This, in and of itself, was a big achievement. The diversity of New Jersey organizations supporting PCMH through this Coalition is a statement to the credibility of NJAFP's work on PCMH. A copy of the letter of support is available at http://www.njafp.org/cpci_support.

While the implementation of the CMS program is still in the planning stages, the ultimate success is New Jersey now has more than one payer in the state committed to innovative healthcare delivery with common administrative processes through a multi-payer PCMH effort.

One of the key factors for CMS's selection of New Jersey was their recognition that they would find an energized and well-equipped group of primary care physician practices to choose from for the CPC Initiative. The selection of New Jersey recognizes the overwhelming readiness of the state's primary care physicians to embrace innovative delivery models, like the PCMH. The NJAFP has invested a great deal of time assisting their family physician members in the transformation of their primary care practices. New Jersey has over 530 primary care practices recognized by the NCQA as Patient Centered Medical Homes.

One of the key factors for CMS's selection of New Jersey was their recognition that they would find an energized and well-equipped group of primary care physician practices to choose from.

While there were multiple plans that submitted initial applications to CMS, Horizon BCBSNJ and AmeriHealth New Jersey ultimately obtained CMS's approval for New Jersey. The NJAFP has been very pleased with both carriers commitment to patient centered, high quality primary care. We also believe that this program will be the incentive for other plans in New Jersey to follow.

The NJAFP is gearing up for the coming months working with Horizon, AmeriHealth and CMS as they identify the 75 practices that will be part of the CPC Initiative. ▲

Bizology 101

Donald H. Sebastian, PhD

Dr. Sebastian is the Senior Vice President for Research and Development for the New Jersey Institute of Technology and Chairman of NJ-HITEC, New Jersey's Regional Extension Center.

The national debate over healthcare reform is again front page news. The Supreme Court challenge to the Affordable Healthcare Act that was signed into law on March 23, 2010 has continued to place the focus of discussion on aspects of the legislation pertaining to healthcare insurance. Lost in the shuffle have been the measures to reduce the cost of healthcare delivery.

Adopted in February 2009, the American Recovery and Reinvestment Act (ARRA) of 2009, often called the Stimulus Bill, included $19 billion in federal funds allocated to accelerate the adoption of electronic health records (EHRs) as a critical strategy for improving efficiency and productivity across the national healthcare delivery system. The package includes $643 million to establish regional extension centers to assist physicians with the transformation and substantial incentive payments for eligible physicians to underwrite the cost of hardware and software purchases. New Jersey Institute of Technology (NJIT) won one of the largest awards in the national program to form the New Jersey Health Information Technology Extension Center (NJ-HITEC), the Regional Extension Center (REC) serving the entire state of New Jersey.

These awards are reimbursements for assisting New Jersey physicians in achieving "Meaningful Use" (MU) of EHR systems. Like any governmental program, an entire language has evolved to capture the program goals and metrics. It is easy to get lost in the "gov-speak" and lose sight of the physician perspective – what we like to refer to as "doc-speak." Even worse, this program deals with the confluence of information technology and medical practice so there is a language of health IT, "tech-speak," that is often inscrutable to those outside of that industry or on the wrong side of the generational divide.

Too often, physicians are perceived as luddites; technophobes who are resistant to change, and unable to appreciate the inherent beauty of computer-based strategies. We have found the opposite. Irrespective of age, physicians are selected from the high-end of the bell curve, with a long record of superior academic achievement including rigorous training across all of the scientific disciplines. Their training as diagnosticians makes them highly intuitive problem solvers that combine formal and experiential knowledge to come to well-reasoned judgments. That makes them properly skeptical of accepting claimed benefits of health IT introduction that do not square with their personal perception. Federal incentives and even the prospect of fee penalties in the future are not enough to change this dynamic.

We believe that a compelling business case can be made for the adoption of EHR systems.

Recognize that every primary care physician (PCP) is also a small business owner. Physicians are trained in the "A to Z" of life sciences, but in all the years of classroom and clinical education, they are not prepared to understand and manage their business. Their training skips from Anatomy to Cardiology without ever getting "Bizology 101." Filling this gap is critical if one is to appreciate the importance of business process reengineering. This is how the efficiencies are gained; not through the literal translation of paper-based processes into electronic equivalents.

Scientists can debate whether we create systems that mimic the organization of the natural world, or if natural selection has found stability in systems with a high degree of functional organization. From the simplest, single-celled organism to the complexity of human beings, we all share a small set of basic functions that are optimized to define life. So too, a well-structured business is a collection of largely autonomous systems that are optimized for their end function. This is true even in a single physician practice where one or two individuals are responsible for all functions.

Physicians are trained in the "A to Z" of life sciences, but in all the years of classroom and clinical education, they are not prepared to understand and manage their business.

The goal of business process reengineering is not to change the basic functions of practice – they are invariant. Rather, it is designed to evolve those processes to become more efficient by reducing and eliminating time delays, ensuring allocation of roles and responsibilities so that critical actions do not fall through the cracks for lack of attention, and to facilitate the interface with all the external entities with whom the practice must interact. Every practitioner has the same inherent needs, from the obvious clinical functions, to others like financial systems, human resource systems, and legal/compliance systems.

The method of business process mapping identifies the actual structure below

the top-level categories of business function. It is not as onerous as it sounds, and it is part of the assessment methodology that staff can use to identify where a practice lies in readiness for EHR system implementation, and to guide in the selection of appropriate technology for the physician and practice. Based on a number of practices that have worked with NJHITEC, calculations indicate that even a one- to three-person office is losing $100,000 per year through process inefficiencies that proper health IT implementation could weed out of the system. That's a staggering $2 billion per year just by converting the state's PCPs to EHR, without considering specialists and others.

The Office of the National Coordinator for Health Information Technology in the U.S. Department of Health and Human Services manages the federal effort and it is important to understand its focus on Meaningful Use of EHR systems in its terminology. In order to successfully attest to Meaningful Use and receive an incentive payment as a Stage 1 Meaningful User, physicians need to meet 15 core objectives and five objectives from a menu set of 10, as well as demonstrate six Clinical Quality Measures. This is the "gov-speak," and it is important to understand that these criteria are means not ends. It is important to focus on the improvement of the business processes to which these criteria apply and not just focus on a handful of outcomes.

As accustomed as we are becoming to an "app" model, where programs come with no documentation and need no training and an EHR is a complex software system. This makes training fundamental in order to get any real value from the purchase. Software manuals tend to be encyclopedic, giving the full detail of every button and every field on every screen.

The model is more reflective of the software designers' architecture than the medical practice's pattern of use – this is the "tech-speak." In the end you will no doubt want to understand every one of these operations, but our experience teaches us that the best way to learn a software system is to use it in a start-to-finish context. Whether it is enrolling a new patient, logging an office visit, generating a prescription (e-prescription, that is), or making a referral to a specialist and forwarding the patient history, learning the functions of various screens, fields, and buttons are most likely to be retained when integrated into the real-life task the software is supporting.

In addition to the business efficiencies that are immediate outcomes, there is an even greater potential for improvement in clinical practice. Connecting each physician to a global base of experience and observation may make routine what was once a baffling once-in-a-lifetime encounter for a physician. Large scale public health issues can be identified and managed based on redacted patient records. Amazing technologies such as the advanced analytics demonstrated by IBM's Watson computer will be inserted into routine diagnosis and treatment. Perhaps even more impactful will be the growth of IT sophistication on the part of patients, whose mere cell phones are already being elevated to advance computing platforms that support real time monitoring for wellness management, preventive medicine, and even complex outpatient care. Only time will tell. ▲

MY VIEW

Robert Eidus, MD, MBA is the President of the New Jersey Academy of Family Physicians. He is in private practice at Cranford Family Practice/Vanguard Medical Group in Cranford, NJ.

The Effect of Mismatched Incentives in Primary Care Through the Prism of a Classic Business Management Article

Robert Eidus MD, MBA

In 1975, Steven Kerr published a classic treatise[1] in the *Academy of Management Journal* entitled "On the Folly of Rewarding for A While Hoping for B." This treatise is taught in many business schools regarding the effect of incentivizing certain behaviors. He points out that so often we are hoping for one behavior ("B") but the incentives drive us to another behavior ("A"). In medicine, Kerr points out that type one errors (labeling a person sick when they are healthy) are more frequent than type 2 errors (labeling a person healthy when they are sick) and much of the reason for this can be related to the incentive structures for physicians.

In reflecting on the activities that I perform related to caring for patients on a regular basis, I realize that there is wide variation in my ability to fully utilize the skills I have acquired and the value that I bring to my patients and other interested parties (e.g. payers, employers). This article is an attempt to rank those activities, contrast the activities in terms of value to others and internal profitability, and draw some conclusions regarding the consequences of a mismatch between value to others and internal profitability. I am excluding those activities that are purely administrative and not related to the care of patients. Others have studied and commented on the deleterious effects of those activities. This list is not comprehensive but reflects major "buckets" of activities. I will describe them from most valuable to least valuable based on my perception.

1. Collaborative care via direct interaction with other practitioners involved in the care of my patients

C.L. is a 76 year old male with bladder cancer which has definitely spread to the right ureter and possibly to the left. The urologist is reluctant to do any more surgery and referred the patient to an oncologist who is reticent to assume spread to the left ureter without tissue diagnosis. The patient has been through numerous surgeries, including a cystectomy, and has indicated to me that his goal is to have as good a quality of life as possible even at the expense of duration of survival. He called me because he wanted my opinion as to what he should do. This requires discussion with both consultants so I can understand their clinical rationales but also to convey to them both the patient's wishes as well as my personal opinions on the management options.

2. Evaluation of an undiagnosed complex condition

Janet is a 48 year old stoic woman with fatigue and myalgias. She has been diagnosed with fibromyalgia. She states that she has chronic abdominal pains and has mild anemia. After additional questioning and examination, blood work reveals probable celiac disease. This was confirmed with intestinal biopsy.

3. Management of patients with one or more unstable chronic illnesses

James is a 72 year old with diabetes who has congestive heart failure, gastritis with history of GI bleed, chronic alcoholism, and chronic back pain. It is difficult to tell if he is taking his medications properly. He sees other specialists occasionally.

4. Management of patients with mental health disorders

Robert is a 22 year old with symptoms of both anxiety and depression. He recently lost his job and has problems with anger management. He also has a positive family history for bipolar disorder. He has considered going for counseling but cannot afford it. Clinically he seems depressed which is confirmed via PHQ-9 administration. He also scores high on the GAD-7 and bipolar surveys.

5. Preventive services

Mary is a 55 year old female here for a preventive visit. She is mildly overweight and is in need of exercise. She smokes 10 cigarettes per day. She also needs a flu shot and pneumonia shot (stable asthma) and a referral for colorectal cancer screening.

6. Management of patients with chronic stable illnesses

Patty is a nurse with diabetes and mild hyperlipidemia. She exercises regularly, tests her glucose twice a day and takes her medications regularly. She is at ideal weight and her HbA1C, LDL, and blood pressure are all at goal.

7. Office Procedures

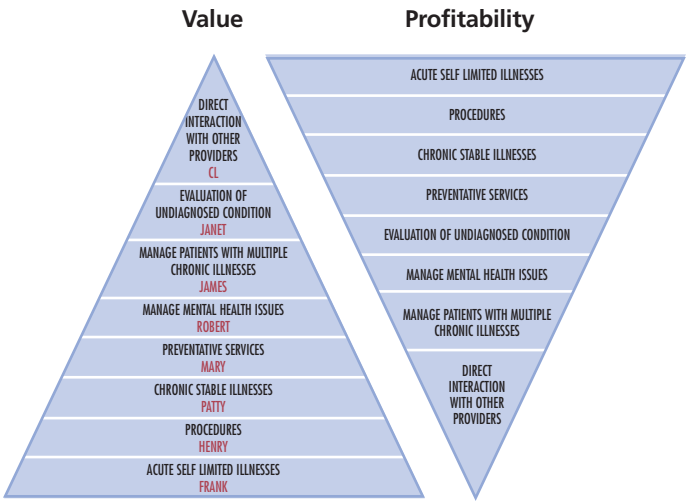
Henry comes in today for a cortisone injection of a trigger finger. He has responded well to this in the past.

8. Management of acute self-limited or minor illness

Frank is a 37 year old male who is otherwise healthy. He comes in with symptoms of common cold for 3 days.

I certainly see patients who do not fall neatly into one of these eight categories and there is overlap. However, what strikes me in looking at these activities is the discrepancy between profitability and value. Those at the top of the list in terms of value are also the least profitable and vice versa. For example, discussion with other specialists regarding management of a patient (which goes well

beyond care coordination) is not compensated at all in traditional fee-for-service model. On the other hand, treating colds (coded as 99213) is by far the most profitable. I can see four patients like Frank (approximately 5 minutes) to seeing one James (20 minutes coded at 99214). What's more, seeing Frank requires virtually no staff support and therefore does not consume additional internal resources. Likewise, the contribution margin of seeing Henry (trigger finger) is very high as compared to treating Robert (depression). In fact, value and profitability seem to be completely inversed!



The conclusions so far are hardly earth shattering and have been described by many others in the past. What is striking is the almost perfect asymmetry between compensation and profitability. Patients, employers, payers, and policy makers would like primary care physicians to be like Marcus Welby- spending lots of time with complex patients and discussing cases and even challenging consultants on proposed management plans for patients we know well. Family physicians are generally well trained and well positioned to do these activities. Payers would like us to manage patients to the full limits of our capabilities. These desires fall into the category of "hoping for B." In reality, the incentive is to see patients with acute, self-limited illnesses and to perform procedures which are overly valued as compared to cognitive services. Consequently C. L. is referred back to his urologist or urged to get a second opinion. James is referred to the cardiologist. Robert's issues are either left unaddressed or he is told to see a psychiatrist or psychologist, neither of which he is willing to do. So the most complex (least profitable) patients are often referred out, resulting in further fragmentation of care, while we take care of the more profitable patients.

Of course, payers, insurers, and policy makers are not getting what they want ("B") but they are getting exactly the behavior that they are rewarding ("A"). To be sure, not every primary care practitioner is so easily persuaded to alter the scope of his/her practice based on financial rewards, nor does each of us consistently refer out complicated patients based on financial consideration. In a situation where primary care physicians are working extensive hours for dramatically less compensation, it is a great burden on us to continue to manage C.L. and James to the fullest of our capabilities. In contrast, Frank who has a cold (high profitability) will be told to come right in as a "work in." Many of my colleagues have observed this effect where the scope of care is becoming more and more constricted. Many specialists have commented that they have been told by PCPs that the patients sent to them should be considered referrals, not consultations.

This constriction of the scope of practice is pernicious. Starfield[2] and others have described the value of primary care to our health care system. The value of primary care has also been identified by most high performing health systems in other industrialized countries with better outcomes and lower costs than ours. But primary care is not always of the same flavor. Starfield further identified a key component of primary care and a unique contribution of Family Medicine: comprehensiveness of care. It is reasonable to think that primary care physicians are no different from other people- both professional and non-professional. Although there are exceptions, as a group we will gravitate to activities that are the most profitable and eschew those that are least profitable. The ability to modify physician behavior via incentives has been well established; however dysfunctional rewards will produce dysfunctional behaviors.

One might counter this analysis by stating the RBRVS system was supposed to level the playing field. This is not true for several reasons:

- The RBRVS system has been distorted by the RUC and other bodies over the years
- Payers have not adhered to the RBRVS system
- The RBRVS system does not account for team-based care and the context of new models such as the Patient-Centered Medical Home

Most importantly, the RBRVS is a cost-based, not a value-based system. When we buy a car, we are not interested in the cost of building the car but the value that the car creates. There is a movement to create a value-based insurance design for consumers where copays and deductibles are inversely related to the estimated value of the service. Instead of a cost-based reimbursement system for providers, why not consider at least integrating in a value-based component where high value activities have greater compensation and vice versa.

Conclusions and Suggestions for the future:

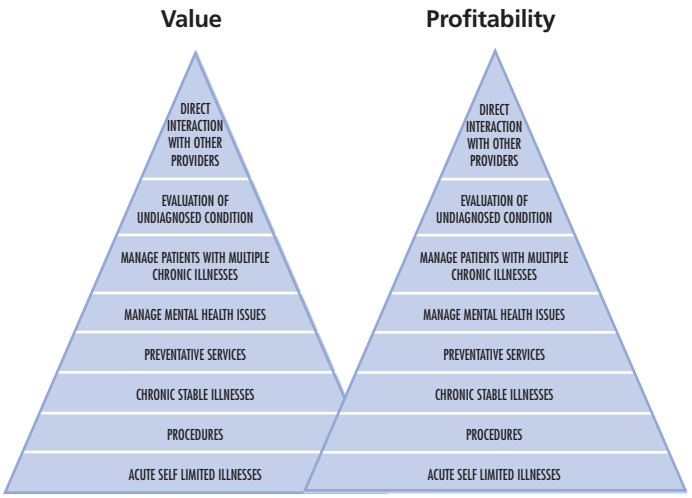
The impact of the current system is harmful not only to patients and the public in general, but also to primary care physicians themselves. Many PCPs are concerned about the intrusion into their space by mid-level practitioners and urgent care centers. However, the current reimbursement system is causing each of us, to one degree or other, to move a little closer to the practice of the minute clinic and a little further away from Dr. Welby.

It is no accident that tightly knit vertically integrated organizations such as Kaiser, Geisinger and Group Health[3,4] have been among the leaders in realizing superior gains in care and cost-savings through the use of a patient-centered medical home model. Since the payers and the providers are essentially one, they have been able to align resources and incentives to the care processes which create the most value. Accountable care organizations may be able to reproduce this symmetry; however they have several hurdles to overcome. First, they need to be able to create effective care processes which in turn can create incremental value. They then need to make sure that the incentives are aligned so that the components of the health system which are creating the incremental

value are getting a commensurate piece of the reward. Even then they will need to make sure that the specific activities which are being rewarded are those which are creating the incremental value to stakeholders.

Goroll[5] has proposed a system where primary care physicians see far fewer patients per day than they do now (presumably only those patients in the highest value tiers). The rest of the time they spend managing and supervising a care team which is empowered and capable of taking care of those patients who are lower on the value creation chain. In addition, many on the lower tiers are assisted via e-visit, group visits, and patient self-management activities, conserving resources. This model makes sense to me.

Clearly there is a need to get rid of what has been coined as "hamster care." Ideally a payment system should be developed where profitability and value are symmetric rather than inverted.



In such a system, Frank's cold would likely be dealt with through e-visits, a nurse visit line, or through the use of algorithms by other members of the care team. Patty, who takes excellent care of her chronic illness, will get periodic blood tests and her biometric profile will be sent to the care team, but she will only be seen physically for her diabetes once a year unless something changes. On the other hand the practice will actively market to recruit patients like C.L., James, and Robert and will also harness the care team's resources to best meet their needs through providing comprehensive and longitudinal team-based care. Patients are then perfectly matched with the care system according to the patient's needs and the component capabilities of the care team. ▲

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Spring MedFest

A young athlete gets her ears checked while her friend looks on in the Ear, Nose and Throat Station at SONJ in Lawrenceville.

On April 23, 2012, NJAFP held its annual Spring MedFest program, marking the tenth consecutive year for this event - at the Special Olympics New Jersey headquarters facility in Lawrenceville. On behalf of NJ Healthy Athletes Coordinator, Dr. Jeff Zlotnick, we wish to thank the many Resident and Attending physicians who volunteered their time to provide pre-participation exams to special needs students, allowing them to participate in Special Olympic activities. Residents joined us from CentraState, Hoboken, JFK, Mountainside, Overlook, St. Joseph's, UMDNJ-Capital Health, UMDNJ-RWJ, Underwood and Virtua Family Medicine Residency programs.

We would also like to thank the Athletic Trainers Society of New Jersey, who has joined us in this effort for as many years, manning the musculo-skeletal station. Their commitment to this event has been an important and welcome addition to this program.

The 2012 MedFest set a new record for a single NJ event—we qualified over 110 students in just under 3 ½ hours, making this the most successful MedFest to date. Thank you to everyone for your participation.

Residents pose in the Heart and Lung Station as they wait for the next group of athletes to receive their pre-participation exams.

U.S. Surgeon General and family physician, Dr. Regina Benjamin has released a new Surgeon General's report: Preventing Tobacco Use Among Youth and Young Adults.

"This report examines the social, environmental, advertising, and marketing influences that encourage youth and young adults to initiate and sustain tobacco use. Tobacco products are among the most heavily marketed consumer goods in the U.S. Much of the nearly $10 billion spent on marketing cigarettes each year goes to programs that reduce prices and make cigarettes more affordable; smokeless tobacco products are similarly promoted. Peer influences; imagery and messages that portray tobacco use as a desirable activity; and environmental cues, including those in both traditional and emerging media platforms, all encourage young people to use tobacco. These influences help attract youth to tobacco use and reinforce the perception that smoking and various forms of tobacco use are a social norm—a particularly strong message during adolescence and young adulthood" (piii).

– Regina Benjamin, MD, MBA
Surgeon General

To read the Surgeon General's full report on preventing tobacco use among teenagers and young adults, visit http://www.cdc.gov/tobacco/data_statistics/sgr/2012/.

Tar Wars®

Poster Contest and Conference

The 2012 National Tar Wars Poster Contest and Conference will be held in Washington, D.C. July 16-17, at the Hyatt Regency Washington on Capitol Hill. NJAFP fully anticipates participating in this event, as we have in past years. As of this writing, we are currently receiving posters and will commence judging by May 11. Our New Jersey State winner will be announced after May 18, 2012.

Let's Play!

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

This May, Choose You, the American Cancer Society's national movement to help women live well today and stay well tomorrow, invites you to join us at **chooseyou.com/play** to discover fun ways to get active.

chooseyou.com/play

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Reflections on the Decision to Give

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

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

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

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

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

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

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

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

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

Thank you for your generosity!

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CLOSING VIEW

Being on the other side of the stethoscope

Joseph P. Wiedemer, MD

Dr. Wiedemer is a Trustee of the NJAFP, is on staff at the Phillips-Barber Family Health Center, Lambertville, NJ, and is Acting Director of the Family Medicine Residency program at Hunterdon Medical Center in Flemington, NJ. In addition to developing a large patient following at Phillips-Barber, he also serves on the Asthma Task Force at Hunterdon Medical Center. He has been an Academy member since 1995 and resides with his family in Ringoes, NJ.

"My side still hurts after that operation last year. Why is that? And what's this pill for?" My 83-year-old father questioned me over the phone. He lives about five hours away. I have six siblings, many of whom live near him, but he calls me for medical advice. He does not like doctors, and I suspect he has a mixture of pride and distrust of me and my profession.

My dad lives alone since my mother's death last year. He does fairly well keeping his medicines straight, but he has little medical knowledge, and I think, very little understanding of internal anatomy. His most challenging problem is his hearing loss. He has two hearing aids which seem to work intermittently.

He doesn't complain to me unless his symptoms are significant or he is significantly concerned. Thankfully, many of his concerns are able to be relieved over the phone. He will develop a minor symptom, not tell anyone about it, and then begin to worry to the point where he is convinced it could be something lethal. Then he calls me, and we talk.

When he gets any pain or discomfort in his abdomen, he worries that it's cancer. Rarely are his symptoms from a significant medical problem. Although two years ago, while I was driving to the NJAFP Scientific Assembly, he called me complaining of right upper quadrant pain, fever and vomiting that began that morning. I advised him to go to the ER with what I thought was, and turned out to be, cholecystitis. He had a gangrenous gallbladder which had eroded into his liver. He stayed in the hospital for three weeks and had a JP drain for a month. Since that call, he relies on my medical advice more, which I try my best to discourage him from doing. When he told me about the pain this time, I told him "You should call and tell your doctor."

"I told him the last time, and he didn't say anything." He replied. I suspected that my dad's hearing difficulties may have contributed to his not understanding what the doctor had said.

Usually my sisters take him to his appointments, but sometimes he goes alone. I sighed, took a deep breath and said, "How about if I come out and go with you to your next appointment?"

"Would you do that? I have another appointment in six weeks."

"I'll call to make it sooner," I replied.

"No. The pain is not that bad. I told him last time that you thought it was adhesions," he responded.

So, six weeks before the scheduled 15-minute appointment, the worry, thoughts, planning and discussion for his appointment actually began. We talked several times in the ensuing six weeks about the appointment. I'm sure he spent hours and hours lying in bed, feeling his side, bending and stretching his body, trying to uncover the source of his symptoms. He told me how much he appreciated me coming in to go with him. He also told his friends, the rest of my family and anyone else who would listen.

The weekend before the appointment finally arrived. I drove the five hours to his home. He met me at 10 o'clock at night, long after his usual bedtime. We stayed up and talked until I began to fall asleep. All weekend we talked on and off about his appointment. I reviewed his medicines, filled his weekly pillboxes, talked to him about when he last had a colonoscopy and reassured him. It wasn't the only thing we talked about, but it heavily peppered the conversations that weekend.

On the day of the appointment my dad got up at 6:00AM and showered for his 10:30AM scheduled appointment time. He made sure he had all clean clothes, he ate his breakfast, he put on his shoes and laid out his jacket, all by 8:00AM.

"I'm all ready!" He beamed at me.

"Well, we have about two hours before we have to leave," I replied.

"I know. My side hurt a little last night, but it feels good now. What do you think causes that?" he asked.

"I'm not sure, but it's probably adhesions." I replied, sounding a little more than frustrated.

"Well, I'm all ready," he said again.

I ate breakfast, cleaned up the dishes and dressed. We still had over an hour before our 10:30AM appointment. We talked, and I tried to occupy our time. The closer it got to 10:30, the more apprehensive my dad became.

We left for the appointment early and arrived at the office at 9:55AM. We checked in and sat in the waiting room until we were escorted back to an exam room. The CMA checked his pulse and blood pressure and quickly asked some Meaningful Use questions and stepped out of the room with her voice trailing behind.

"Doctor will be right in..."

We waited in the cramped room, under the hum of the fluorescent lights, reading the posters recommending the flu vaccine and brochures on various procedures the office provided. After about 15 minutes, the door handle clicked, and a rush of air whooshed in as the doctor entered, cradling his laptop in one arm and clicking keys with his other hand as he foot kicked the door closed.

"So, what's going on?" queried the doctor.

"This is my son, Joe. He's a doctor too!"

"Oh! I've heard about you. Nice to meet you. We've talked on the phone a few times too," the doctor replied.

"Yes. I'm here because my dad has had pain in his side since his operation, and to review his medicines," I answered.

"Right. Operation was two years ago. It's probably adhesions," he replied. "Let's check it out."

The doctor examined Dad and looked at records of previous studies. We talked and left with an updated list of medications, which included the addition of one medicine and the deletion of another. We also had an order for an x-ray and ultrasound and plans for a possible CT. All in all, the time with the doctor was less than 15 minutes.

I think it went rather quickly for my dad. He asked "What happened? What am I doing?"

"He changed your medicines and you're getting an x-ray and ultrasound." I answered in a loud voice, as his hearing seemed to be worse now.

"Oh. Okay. Hey, thanks for coming in," he smiled and looked visibly relieved.

I reflected on the whole odyssey of his less than 15-minute appointment. We still had to get his new medicine, remove one of his medicines from the pill box, and get two studies done and perhaps schedule a third.

Over the six weeks before the appointment he had spent time preparing, planning, worrying, checking and thinking about this visit, which lasted less than 15 minutes. It struck me that his 10:30AM appointment really began months earlier. It struck me as I reflected on our time with the doctor, how little thought we give to our patients before they come to our office.

My dad's visit with the doctor was completely appropriate. The results reflected exactly what I have done thousands of times. But until I sat on the other side of the stethoscope with my dad, I don't think I clearly recognized what is packed into those 15-minute visits. What does it take for our patients to decide to visit us, to make the appointment, to prepare themselves for the visit and then actually show up in our office? What do they expect to hear from us and what do they hope we can do to help them? And, when they are finally sitting across from us, how do we interact with them when they finally get to our office?

Being on the other side of the stethoscope is something we will probably all do at some point in our lives. I think it's important to remember what our patients do to get there, even when we are acting as family and not physician. As always I look forward to your comments. ▲

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

Highlight on Diabetes endeavors to improve the management of patients with diabetes by providing educational resources for family physicians and the patients they serve.

AAFP FOUNDATION | Highlight on DIABETES

Date:

June 16, 2012

Time:

7:00AM
Presenter: Jeffrey A Zlotnick, MD

Location:

2012 Summer Celebration & Scientific Assembly

Exhibit Floor ~ Crown Ballroom

Support for this program is made possible by the AAFP Foundation through a grant from Sanofi.

CME

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

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

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School Breakfast in America's Big Cities

1. Robust breakfast programs through schools play an important role in ensuring the food security of children, while supporting improved attendance, greater academic success, improved health, and reduced obesity. **T or F**
2. FRAC's research showed that breakfast in the classroom had little impact on improving participation rates in school breakfast programs. **T or F**
3. Newark, NJ has one of the highest participation rates in the Breakfast in the Classroom project. **T or F**
4. School breakfast improves children's diets, increases school achievement, promotes positive student behavior, reduces obesity and food insecurity, and builds lifelong healthy eating habits. **T or F**
5. Research has shown that eating a healthy breakfast plays only a minimal part in a child's ability to learn. **T or F**
6. Children who eat breakfast at home as opposed to in the classroom, perform better on standardized tests. **T or F**
7. Children and adolescents who eat breakfast are significantly less likely to be overweight, while skipping breakfast is associated with a higher risk of obesity. **T or F**
8. Offering all children breakfast at no charge reduces the stigma associated with low income, making school breakfast more attractive to students. **T or F**
9. Second Chance Breakfast allows children the opportunity to obtain a second breakfast. **T or F**
10. In the Newark Breakfast in the Classroom project, children eat during the first 10 minutes of class and the teachers found that the program does not interfere with their instruction time. **T or F**

A Brief Overview of Obesity

11. NIDDK and the WHO define obesity as a chronic disease with a body mass index (BMI) of ≤30 kg/m^2. **T or F**
12. Obesity is the fifth leading cause of death in the United States. **T or F**
13. The American College of Physicians recommends surgery for those patients with a BMI of at least 40 kg/m2 who have failed on traditional therapy and present with obesity- related, co-morbid conditions. **T or F**
14. Researchers have found fewer cardiovascular deaths and a lower incidence of cardiovascular events in obese adults who underwent bariatric surgery. **T or F**
15. The indications for bariatric surgery for adults and children are the same. **T or F**

ANSWERS ON PAGE 7

IT'S TIME YOU LOOKED RISK IN THE FACE.

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