Highlights from the 2012 Summer Celebration & Scientific Assembly

Perspectives
A VIEW OF FAMILY MEDICINE IN NEW JERSEY

Sal Bernardo, Jr., MD is installed as NJAFP President in Atlantic City

Rich Corson, MD runs for AAFP Board of Directors

CME Inside:
Stroke Reduction in Atrial Fibrillation
You probably are...

While rates for malpractice insurance have increased dramatically in the past 15 years, a shocking chart like this indicates the medical malpractice insurance industry is enjoying some very sizeable profits. That’s good for stock insurance companies, which are in the business of making profits for their shareholder’s, but bad for physicians insured with them.

So what insurance carrier would ever share this incriminating chart to physicians? Only NJ PURE, a not-for-profit medical malpractice insurer that is required to return unused profits to its policyholders by law.

Isn’t it time that you called the only not-for-profit malpractice insurer carrier in New Jersey that doesn’t use agents and brokers? You’d be surprised at the rates you get when your insurance carrier doesn’t make a profit from you.
It’s Not the Change...

I HEARD SOMETHING somewhere that went something like, "Nothing is sure in this life except death and taxes...and change." My apologies for not being able to cite the originator of this thought, but it is quite true. In 1965, Moore stated that the number of transistors on an integrated circuit chip would double approximately every two years.¹ This axiom became known as Moore's law and has proved to be quite accurate. In 1965, Moore predicted that by 1975 up to 65,000 integrated circuits would fit on a single chip. In 2006, chips existed that contained up to 1 million transistors per square centimeter.²

The changes occurring in the world of technology grow at an ever increasing pace. Nanotechnology, the manipulation of matter on an atomic and molecular scale, will change drug delivery systems, gene therapy, diagnostics and at some point, probably clinical practice. Scientists have created nanobots that target cancer cells to deliver drugs right in the cancer cell nuclei and nanofibers to create wound dressings. If you want a good overview of nanotechnology in medicine, I suggest Dr. Catharine Paddock's article in Medical News Today.³

Circuit chips and nanotechnology are change on a large scale. For most of us it doesn’t take too much thinking to become overwhelmed with the enormity of what these changes mean to us as individuals and to the human race in general. But change on a small scale can seem just as huge and overwhelming when we find ourselves standing on the edge of change and knowing we have to take that leap. Consider practice transformation. The evidence is clear that the old way isn’t working and something has to change. Many New Jersey practices have already undergone the process, more are in progress, and still more are waiting on the edge, not yet willing to make that leap into the neutral zone – the place where the old is over, but the new has not yet begun.⁴

In the words of change expert William Bridges, “It isn’t the change that does you in, it’s the transitions...change is situational...transition is the psychological process people go through to come to terms with the new situation. Change is external, transition is internal.”⁴

Change happens all around you, whether you acknowledge it or not. Learning to acknowledge and honor the complex feelings that arise from change, for even a good change can evoke feelings of loss and fear of the new, is the key to navigating through an increasingly changing world.

Happy Reading,

Theresa J. Barrett, MS
Managing Editor

References
Interesting Times

Salvatore Bernardo, Jr., MD

Sal Bernardo, MD is President of the New Jersey Academy of Family Physicians. He is in private practice in Freehold, NJ.

As I was pondering what to write for my first Perspectives article, I thought to myself, “Do I have anything profound to say?” Probably not. What I do know is that it is an honor and privilege to serve as President of the NJAFP for the upcoming year. This has been a journey that started as early as my first year in medical school when I used to regularly attend board meetings at a time when our Academy was a small organization with one employee, renting space from MSNJ in an office building in Lawrenceville. Today, here we are a flourishing organization with a permanent home and a staff to serve the needs of the organization and its membership.

It is said that, “May you live in interesting times” is viewed as a curse, but I see it as a blessing in disguise. Interesting times like these test the mettle of an organization like the NJAFP. It is the hard work and dedication of staff, leaders and members that make this organization what it is today. Your Academy was able to intervene and assist in averting a threat to the viability of a residency program, as well as a medical school family medicine department. This year has seen the completion of the first PCMH pilot program. Our Academy has gained notoriety with the AAFP by introducing the concept of the distressed practice environment, and as a result the AAFP developed a task force to research this issue and how it affects family physicians across the country. We were also recently able to open up a dialogue with a commercial insurance payer to discuss issues and concerns we have. This is your Academy at work.

In order for me to look forward at what I want to do as president, I must first look back at what has been done until now – specifically what Bob Eidus, MD, our outgoing president, has done in the past year. Bob dedicated his efforts to looking at the inner workings of the Academy, how we do things, and we as a leadership group worked on the organization’s mission and vision with input developed from a previous leadership retreat. We also had a strategic planning meeting in the late summer and have better prepared our leaders through an orientation program after the elections at the House of Delegates. Bob has worked on what I would call, “getting the house in order.”

In picking up where Bob left off, it is my desire to work on what I call, “getting the yard in order.” It has always been my opinion that as family physicians our greatest strength is not our ability to act or react, but rather to adapt. As you look at family physicians across the state you will notice that each practice is unique in its own way; adapting to suit the wants/needs of the physicians or the environment in which the practice is located. There are physicians that practice the full breadth of family medicine. Some may only see older patients. Some may not see children, or children below a certain age. Some are solo; some are in small groups and some in large groups. Some own their practice and some are employed physicians working either for a group or a hospital system.

But in thinking about this entire picture, I begin to wonder if our greatest strength is also our greatest weakness? Given the great variability that we see from practice to practice, I think we give mixed signals to patients and the public in general. Many times they do not fully understand what family medicine encompasses, and they may not seek us out for certain types of care that we provide. Also, as I write this article, I think about a comment I made a number of years ago at a leadership retreat which still holds true today. I had said, “If I am not healthy I cannot keep my patients healthy.” For me, the term “healthy” encompasses that which is physical, mental, spiritual and financial. I think it is the goal of all of us not only to survive but rather to flourish as well and be happy in the process. In order to accomplish this we need strong leadership and the involvement of our membership.

As family physicians, our greatest strength is not our ability to act or react, but rather to adapt.

To that end, it is my desire to accomplish the following in the next few years. It is my desire to get more members engaged and involved in the House of Delegates (HOD). For those of you who participate in the HOD, I recognize you as being the most important component of this organization because you represent the membership. You have given your time to attend because you recognize the importance of being involved in determining the direction of this organization. But as many of you know, not all the seats are filled. I think you will all agree that we will work best by filling as many of those seats as possible. For those members who have never attended, I would like to issue a challenge to you to make a difference, to come to the HOD and represent your

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Change the World

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

“It feels great! At 63, excited again about medicine!”

That brief email lit up my inbox and immediately reinforced my belief that we are on the verge of a primary care renaissance in New Jersey. That morning the sender learned that his practice was one of 73 selected by the Centers for Medicare and Medicaid Services (CMS) to participate in what we all hope is the first round of the Comprehensive Primary Care Initiative (CPCI). Until the email arrived I truly believed that this program, designed by the Center for Medicare and Medicaid Innovation, had the potential to be a game-changer with regard to how primary care services are delivered and valued in our state and across the country, but I may have underestimated the potential for CPCI to change the culture of family medicine in our state. Certainly, we all recognized the increased payment that would support our struggling members, and the implicit underlying statement that CMS was making about the importance of restoring our primary care infrastructure. These were among the reasons that the NJAFP worked so diligently to bring the program to New Jersey, and ultimately played such an instrumental role in CMS choosing the Garden State as one of the seven markets in which they would roll out the program. Still, the nine words in that email were a sudden acknowledgement that the work we began at NJAFP more than four years ago was truly beginning to make a difference to our members and the patients that they serve.

In 2007, at what we will choose to call a brainstorming and strategy meeting (it was more like a conversation in the hallway of the academy offices), during a time when the term “Patient Centered Medical Home” (PCMH) was newly attached to the recently adopted Joint Principles, we decided to change the world. Really. It was that easy. I think someone may have even said, “How would we change the world if we could?” We discussed the possibility that opportunities to participate in pilots and demonstrations that would test the PCMH model would likely begin to pop up everywhere. Even while we knew that these pilots would have a great deal of variation in their design and, ultimately, their value, we were also well aware that the only way to guarantee that such pilots would find their way in to our state was to create a pool of physicians and practices who were at least willing to make the commitment to change the way they deliver care, if not actually having already demonstrated that they were indeed transforming. Shortly after that meeting, our first collaboration with a major payer in the state was born and we were able to begin to offer assistance to practices who wished to set out on the transformation journey.

Five years, multiple projects, and mega-joules of staff and volunteer work later, family physicians in New Jersey have demonstrated that they are committed to changing the way healthcare is delivered in this state. Several payers are now offering some form of enhanced payment for care coordination, PCMH recognition, or other advanced care delivery. New Jersey is at the top of the list across the entire country in the percentage of primary care practices that have embraced the Patient Centered Medical Home. The CPCI offers a glimpse into how CMS believes primary care should be valued and the NJAFP is committed not only to the initiative’s success but also to its expansion into more primary care practices across the state as quickly as possible. At the same time we continue to assist practices of all sizes to become more efficient, to embrace change, to mentor and support their colleagues, and to lead the way to a redesigned system that values quality and de-emphasizes costly and redundant procedure-based care.

It isn’t easy to change the world; it requires dedication, perseverance, a healthy sense of humor to get you through the rough patches, and unmitigated optimism. There were times when we weren’t sure how our efforts were going to play out. Certainly there were many who thought we were wasting our time, but in the words of Gandhi, “First they ignore you, then they laugh at you, then they fight you, then you win.” We may not yet have secured the victory, but the odds seem suddenly in our favor. Clearly there are many members who still struggle each day to survive, a condition that must be corrected if we are to mitigate the growing shortage of primary care physicians in our state. Still, I am more convinced than ever that the change we see is not luck, or serendipity, but rather the beginning glimpses of the effects of years of working to change the world. I am convinced because the words of one member in a brief email on a Sunday afternoon resonate for me, and I hope for you as well; “It feels great! At 63, excited again about medicine.”
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The Comprehensive Primary Care (CPC) initiative is a multi-payer initiative fostering collaboration between public and private healthcare payers to strengthen primary care. Medicare will work with commercial and State health insurance plans and offer bonus payments to primary care physicians to better coordinate care for their Medicare patients.

As was reported in a previous edition of Perspectives, New Jersey was chosen as one of the states to participate in the CPC Initiative.

There are currently 73 participating practices in New Jersey. There are 252 providers, 5 payers - Amerigroup, AmeriHealth New Jersey, Horizon Blue Cross Blue Shield of New Jersey, Teamsters Multi-Employer Taft Hartley Funds, United Healthcare - and an estimated 42,000 Medicare beneficiaries.

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The NJAFP congratulates the following practices who were chosen to be part of the CPC Initiative:

- Advocare Family Health
- Advocare Grove Family Medical Associates
- Alexander Biener, MD, PA
- Annandale Family Practice, LLC
- Avenel Iselin Medical Group
- Branchburg Family Health Center
- Borowski & Borowski
- Central Jersey Internal Medicine Associates
- Columbus Family Physicians
- Comprehensive Family Medicine
- Cornerstone Family Practice
- Craig M. Wax, DO, LLC
- East Hudson Primary Care
- EHMG - Cedar Crest Village
- EHMG - Seabrook Village
- Dein Shapiro, MD
- Dennis Novak, MD, PA
- Farmingdale Family Practice
- Family Medicine Center
- Family Practice Associates of Voorhees
- FirstMed Family Healthcare
- Forest Hill Family Health Assoc., PA
- Hampton Family Practice
- Harvey R Gross MD, PC
- HealthCare for Life
- Highlands Family Health Center
- Heritage Family Medicine
- Hopewell Family Practice
- Hudson Primary Care Professionals
- Hunterdon Family Practice & Obstetrics
- Inman Medical Associates
- Immedicenter
- Immedicenter Totowa
- Integrated Medicine Alliance
- Chapel Hill Family Medicine
- Fair Haven Internal Medicine
- Family Practice of Middletown
- Jeanne Tomaino, MD
- Red Bank Medical
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- Middlebrook Family Physicians
- Marc Feingold, MD, LLC
- Moreno Medical Associates
- New Jersey Physicians, LLC
- Nandini Moray, MD, PA
- Ocean County Internal Medicine Associates
- Orlando Mills Associates PA
- OmniMed
- Pranay Bhatt, MD, LLC
- Partners in Freedom, LLC
- Princeton Health Affiliated Physicians
- Raritan Family Health Care
- Richard Corson, MD, LLC
- Riverfield Family Health Center
- Riverfield Family Health Center
- RWJMG Family Medicine at Monument Square
- Summit Medical Arts Associates, LLC
- Summit Medical Group
- Summit Medical Group
- Summit Medical Group
- Vanguard Medical Group
- Water Street Physicians
- William P Boyan MD, MBA, LLC
- Woodbridge Medical Group, PA
- Woodbridge
- Woodbridge Internal Medical Associates
- Your Doctors Care

- Flanders
- Haddonfield
- Woodcliff Lake
- Lebanon
- Iselin
- Somerville
- Linden
- Somerset
- Columbus
- Warren
- Flemington
- Mullica Hill
- West New York
- Pompton Plains
- Tinton Falls
- Branchburg
- Forked River
- Farmingdale
- Manahawkin
- Voorhees
- Northvale
- Newark
- Hampton
- Englewood
- Eatontown
- Hampton
- Moorestown
- Hopewell
- Jersey City
- Flemington
- Colonia
- Clifton
- Totowa
- Red Bank
- Fair Haven
- Middletown
What Have You Done For Me Lately?

This summer Ray Saputelli, MBA, CAE and Claudine Leone, Esq. of NJAFP joined Senate Majority Leader Loretta Weinberg in a meeting to discuss the education, training and retention of primary care physicians in New Jersey. Senator Weinberg invited all four Deans representing UMDNJ - NJ Medical School, UMDNJ - RWJ Medical School, UMDNJ - School of Osteopathic Medicine, and Cooper Medical School of Rowan University to discuss each school’s plans to address the state’s shortage of primary care physicians. The NJAFP, working with Senator Weinberg plans to continue this dialogue with the state’s medical schools to ensure there is a focused plan to address the state’s primary care workforce needs.

In August 2012, NJAFP, MSNJ, AAP-NJ and several other medical specialty societies met with Governor Christie’s Counsel’s Office to continue our discussions on eliminating administrative hassle factors and other related practice issues that make New Jersey a distressed practice state for physicians. Our goals for these meetings tie directly into Governor Christie’s economic development agenda, which includes overhauling the State government’s regulatory system and reducing the red tape that stifles economic growth and imposes costs on businesses and citizens.

Interesting Times continued from page 2

colleagues and your specialty and help to steer the ship in the direction that we need to go.

I also want to address part of this organization’s mission: member services. In the last few years the climate has definitely changed with regard to practice environment and the wants and needs of the newer generation of family physicians. There is currently some work in progress and it is my hope the Academy will evolve to better suit the needs of all of our membership. It is my goal to get a greater breadth of involvement in our Academy, especially among our younger members. The good news is I am optimistic as I am starting to see younger members getting involved, but we still have a long way to go. In addition to involving our younger members, we will also continue to develop our leadership team and further develop our strategic plan through a strategic planning meeting this fall. Last year, I was very pleased to see how well that meeting was attended and I look forward to seeing another good meeting very soon.

To paraphrase President Kennedy; although it is important to ask what your Academy can do for you, given the current environment in which we practice, it is even more important to ask what you can do for your Academy.

In conclusion, I would like to thank the members of the board, the executive committee and the staff for all of the support they have given me over the years. It has been a truly great experience to this point. I am truly humbled by the fact that you have placed your faith in me to serve as your president, and I look forward to working with you in the upcoming year. Thank You.

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Stroke Reduction in Patients with Atrial Fibrillation  
Charles A. Goldthwaite, Jr., PhD

The most common cardiac rhythm disturbance identified in clinical practice, atrial fibrillation (AF) affects an estimated 0.4%-1% of the population.1 AF incidence increases with age with the median age of patients being 75 years.1 AF appears to affect an equal number of men and women, although approximately 60% of patients over 75 years of age are female. Based on limited data, Caucasian race or European ancestry is associated with increased risk of developing AF.2 African-Americans appear to have an age-adjusted risk of developing AF, roughly half that of Caucasians.2,3

Atrial fibrillation accounts for approximately one-third of hospitalizations for cardiac dysrhythmias.4 Factors such as an aging population, increased incidence of chronic heart disease, and methods to enable more frequent diagnosis have led to an increase in AF-related hospitalizations during the past two decades.1 As such, AF creates a significant financial burden for the healthcare system. In a retrospective analysis of 2001 cost data, Coyne, et al. estimated that treating AF costs $6.65 billion annually, including hospitalizations ($2.93 billion), incremental inpatient costs of AF as a comorbid condition ($1.95 billion), outpatient treatment ($1.53 billion), and prescription drug costs ($235 million).5 These numbers likely underestimate the true economic cost of treating AF (e.g., inpatient drug costs or physician fees, stroke prevention treatments); some estimates place the total incremental healthcare costs in patients with AF as high as $26 billion.6

Definition and Classification

Atrial fibrillation is a tachyarrhythmia characterized by uncoordinated atrial activation that leads to deterioration of atrial mechanical function.1 AF may occur in isolation or in association with other arrhythmias, and its pattern may change over time. It is primarily diagnosed through history, clinical examination, and electrocardiogram (ECG) reading. Patients with AF may report rapid heartbeat, chest pain, shortness of breath, or dizziness, although 15-20% of persons with AF are asymptomatic.7,8 As such, it is important for the physician to distinguish a first-detected episode of AF and ask the patient about previous episodes, with the understanding that the patient may be uncertain about these events. AF is considered recurrent if a patient experiences two or more episodes. Recurrent AF that self-resolves is termed “paroxysmal,” whereas recurrent AF that persists beyond seven days is designated as “persistent.” Because a given patient may experience both paroxysmal and persistent episodes of AF, the physician should seek to identify the most frequent presentation.

Causes

Atrial fibrillation can result from acute causes, such as excessive alcohol intake, surgery, or pulmonary embolism.1 AF may also represent a manifestation of an underlying medical condition, such as heart disease or obesity.1

AF and Stroke Risk

Atrial fibrillation promotes the pooling of blood in the heart, which can create clots that can become dislodged. Stroke is thus one of the most prevalent and devastating complications of AF. Outcomes from numerous large-scale studies suggest that persons with AF have nearly a five-fold greater risk of stroke than do persons unaffected by AF.9 Approximately 5% of persons with non-valvular AF will experience an ischemic stroke in a given year.1 AF is also associated with an increased long-term risk of heart failure and all-cause mortality, especially in women.10 AF causes approximately 45% of all embolic strokes1 and increases the severity, mortality, and frequency of recurrence of stroke.11 The presence of AF confers the same risk of stroke regardless of characterization (e.g. paroxysmal versus persistent) or symptom status. Managing stroke risk is therefore a cornerstone of treating patients who have AF.

Assessing Stroke Risk in Patients with AF

Patients with AF can be stratified for their risk of stroke by calculating their CHADS2 score (Table 1).12 CHADS2 is a validated, convenient, and widely-used classification scheme that assigns points for common stroke risk factors. It should be noted that this scheme is weighted; two points are given for a history of prior cerebral ischemia (versus one point each for other risk factors) because a history of cerebral ischemia increases the relative risk of subsequent stroke commensurate to two other risk factors combined.12 Patients with a CHADS2 score of 0 are considered low risk for stroke, whereas those with a score of 1 are at intermediate risk, and persons with a score of 2 or above are classified as being at high risk. CHADS2 scores can stratify patients with AF as to the potential benefit of receiving antiplatelet and antithrombotic therapies.

Table 1. Assessing Stroke Risk using CHADS2 Score

<table>
<thead>
<tr>
<th>Clinical Parameter</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Congestive heart failure (any history)</td>
<td>1</td>
</tr>
<tr>
<td>Hypertension (prior history)</td>
<td>1</td>
</tr>
<tr>
<td>Age &gt; 75 years</td>
<td>1</td>
</tr>
<tr>
<td>Diabetes mellitus</td>
<td>1</td>
</tr>
<tr>
<td>Stroke or transient ischemic attack</td>
<td>2</td>
</tr>
</tbody>
</table>

Preventing Stroke in Patients with AF

Oral antithrombotic therapies commonly used for primary prevention of stroke in patients with AF include anticoagulants and antiplatelet agents. An appropriate regimen that incorporates one or more of these agents reflects a balance between preventing ischemic stroke and avoiding hemorrhagic complications, or assessing the risk of stroke versus the risk of bleeding in a patient.

Anticoagulants

Following the approval of the vitamin K antagonist, warfarin, in 1954, use of anticoagulant medications has become standard practice to treat patients with cardiovascular or cerebrovascular disorders. While warfarin’s efficacy has been long established, challenges with warfarin dosing and compliance and concerns about bleeding risk have led researchers to explore new classes of anticoagulant agents applicable to patients with AF (Table 2). Recent evidence has led to the FDA approval of the direct thrombin inhibitor, dabigatran, and the direct factor Xa inhibitor, rivaroxaban, for stroke prevention in patients with AF.

Table 2. FDA-Approved and Investigational Anticoagulants for Patients with AF

<table>
<thead>
<tr>
<th>AGENT</th>
<th>MODE OF ACTION</th>
<th>STATUS OF DRUG DEVELOPMENT</th>
<th>MODE OF ADMINISTRATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Warfarin</td>
<td>Vitamin K antagonist</td>
<td>FDA Approval (1954)</td>
<td>Oral (QD/QHS; with monitoring)</td>
</tr>
<tr>
<td>Dabigatran</td>
<td>Direct thrombin inhibitor</td>
<td>FDA Approval (2010)</td>
<td>Oral (BID)</td>
</tr>
<tr>
<td>Rivaroxaban</td>
<td>Direct factor Xa inhibitor</td>
<td>FDA Approval (2011)</td>
<td>Oral (QD)</td>
</tr>
<tr>
<td>Apixaban</td>
<td>Direct factor Xa inhibitor</td>
<td>Under FDA Review</td>
<td>Oral (BID)</td>
</tr>
<tr>
<td>Edoxaban</td>
<td>Direct factor Xa inhibitor</td>
<td>Clinical trials</td>
<td>Oral (QD)</td>
</tr>
</tbody>
</table>

ACC/AHA/ESC Guidelines

The ACC/AHA/ESC Guidelines note that oral anticoagulation is most beneficial for patients with AF who are at higher intrinsic risk for thromboembolism; in patients at low risk, reduction in relative risk and absolute rate of stroke is modest relative to that provided by aspirin. At a CHADS\textsubscript{2} score of 0, 417 persons with AF would need to be treated with warfarin to prevent one stroke, as compared to 125 persons with a CHADS\textsubscript{2} score of 1, 81 patients with a CHADS\textsubscript{2} score of 2, and 33 patients with a score of 3.\textsuperscript{13}

Warfarin

Warfarin is considered the most effective agent for reducing stroke risk in patients with AF,\textsuperscript{14} lowering stroke incidence in this population by 68% relative to no treatment with virtually no increase in the frequency of major bleeding.\textsuperscript{15} Warfarin’s efficacy in patients with AF has been clearly established in multiple trials, and its cost is low relative to other oral anticoagulants. Nonetheless, several factors hamper optimal use in clinical practice. Warfarin’s benefit over an antiplatelet therapy such as aspirin depends on how well the dose can be maintained within a relatively narrow, therapeutic, international, normalized ratio (INR) window, a measure of the blood’s tendency to clot.\textsuperscript{16} An INR of 2.0-3.0 has been established as therapeutic in stroke prevention trials in AF and in cohort studies as a range in which the odds of stroke and hemorrhage are relatively low.\textsuperscript{16} Beyond this therapeutic window, the relative risk increases for ischemic stroke (at lower INR values) or intracranial bleeding (at higher INR values).

Ongoing warfarin dose adjustment is necessary to maintain the target INR value. Dose response varies among individuals and from day-to-day in a given individual, thereby requiring frequent blood tests for monitoring. Furthermore, warfarin interacts with foods (e.g., those high in vitamin K content), alcohol, and numerous drugs, including (but not limited to) omeprazole, fluconazole, and anabolic steroids.\textsuperscript{17} Maintaining target INR thus requires provider vigilance and patient compliance; a recent meta-analysis suggests that AF patients treated in the United States are within therapeutic INR approximately 50% of the time.\textsuperscript{18}

Hemorrhage is the major complication of treatment with vitamin K antagonists, although intracranial hemorrhage, the most devastating of bleeding complications, is uncommon.\textsuperscript{19} The risk of major and intracranial hemorrhage in AF patients relates mainly to inadequately oral anticoagulation therapy; overtreatment that achieves a persistent INR > 4.0 is associated with an increased risk of major hemorrhage, especially among older patients.\textsuperscript{19}

Direct Thrombin Inhibitors (Dabigatran)

Dabigatran is an oral direct thrombin inhibitor approved by the FDA in 2010 to reduce the risk of stroke and systemic embolism in patients with non-valvular AF. A randomized controlled trial (RE-LY; n=18,113; median follow-up of 2.0 years) that compared warfarin with twice-daily doses of either 110 mg or 150 mg of dabigatran in patients with AF and at least one risk factor for stroke concluded that the twice-daily administration of 150 mg of dabigatran was associated with lower rates of stroke and systemic embolism but similar rates of major hemorrhage, as compared to warfarin.\textsuperscript{20} Dabigatran at 110 mg was associated with rates of stroke and systemic embolism similar to those associated with warfarin, albeit with a lower rate of major hemorrhage. Based on data from RE-LY, the ACCF/AHA/HRS updated its 2006 guidelines on the management of patients with AF to include a Class I recommendation for dabigatran as an alternative to warfarin for preventing stroke and systemic thromboembolism in patients with paroxysmal to permanent AF and risk factors for stroke or systemic embolization who do not have a prosthetic heart valve or hemodynamically significant valve disease, severe renal failure (creatinine clearance < 15 mL/min), or advanced liver disease.\textsuperscript{21}

The most common side effects of dabigatran are gastritis-like symptoms and bleeding, and the drug is contraindicated in cases of active pathological bleeding and previous hypersensitivity to the agent.\textsuperscript{22} Recommended dosing is based on renal function; patients with a creatinine clearance above 30 mL/min can receive twice-daily doses of 150 mg, whereas persons whose creatinine clearance is 15-30 mL/min should receive 75 mg twice-daily. Use of dabigatran does not require INR monitoring, although dose must be monitored when transitioning to the agent, as there is no available reversal antidote. If a patient with AF is converting from warfarin to dabigatran, warfarin should be discontinued and dabigatran started when the INR is less than 2.0. If a patient with AF is converting from dabigatran to warfarin, it is recommended to begin warfarin three days before discontinuing dabigatran for persons with creatinine clearance above 50 mL/ min, two days for those whose creatinine clearance is 31-50 mL/min, and one day for persons with creatinine clearance of 15-30 mL/min.

Direct Factor Xa Inhibitors (Rivaroxaban, Apixaban, and Edoxaban)

The oral direct factor Xa inhibitor rivaroxaban was approved by the FDA in November 2011 for reduction of stroke risk in patients with AF. A recent double-blind trial (ROCKET-AF; n=14,264) that assigned AF patients at increased risk for stroke either to rivaroxaban or warfarin concluded that rivaroxaban was non-inferior to
Current Recommendations for Reducing Stroke Risk in Patients with AF
In 2006, the ACC/AHA/ESC released evidence-based guidelines for using antithrombotic therapy to prevent thromboembolism in patients with AF.1 When the FDA approved dabigatran for this indication in 2010, the ACCF/AHA/HRS reviewed data from the RE-LY trial and issued a focused update with recommendations for dabigatran use.21

Conclusion
Atrial fibrillation, the most common arrhythmia encountered in clinical practice, can often be managed in primary care using oral antithrombotic agents, thereby decreasing the risk of preventable stroke. While the efficacy of oral anticoagulants such as warfarin has been firmly established, new classes of oral anticoagulants, including direct thrombin inhibitors (e.g., dabigatran) and factor Xa inhibitors (e.g., rivaroxaban and apixaban), may help patients and physicians overcome barriers that have traditionally inhibited therapeutic implementation of warfarin. In 2011, the ACCF/AHA/HRS updated their 2006 recommendations for managing patients with AF to include the use of dabigatran as an option for stroke prevention in patients with non-valvular AF. Stroke risk can often be managed in primary care within the rubric of the patient-centered medical home using shared decision-making between the patient and the healthcare team. By informing patients about the benefits, safety, and efficacy of new oral anticoagulant agents, the primary care provider can ensure that appropriate patients receive this preventive measure. As such, the primary care practice is in a unique position to help patients with AF reduce their risk of a potentially devastating stroke, thereby improving patients’ quality of life. ▲

References
Transformation Challenges

Cari Miller, MSM

As the Centers for Medicare and Medicaid Services gets ready to launch the Comprehensive Primary Care Initiative (CPCI) in New Jersey, I thought it timely to discuss challenges that our practices, physicians and healthcare team members face as they strive to deliver enhanced healthcare quality through a more coordinated, patient-centered approach.

To successfully meet CMS and the participating health plan’s expectations, practices will need to undergo a significant metamorphosis—“marking change in appearance, character, condition, and function.”1 Change in any environment is challenging. Kotter, a leading change expert, estimated that less than 50% of changes initiated within organizations are successful.2 He developed an eight-step model to guide transformation projects.

Literature indicates that to change or transform, organizations must go through certain steps to ensure that transformation takes hold and is completely embedded in the practice. According to Kotter, “The most general lesson to be learned from the more successful cases is that the change process goes through a series of phases that, in total, usually require a considerable length of time.”3

There are many reasons that contribute to the failure rate noted by Kotter and acknowledged by other experts in the field. DiGioia, et al., writing about the Patient and Family Centered Care (PFCC) model, indicated that those who are embarking on transformation efforts should perceive change as a “circle that never ends, as opposed to a straight line that goes from start to finish,” and that those who work on transformation should view the teams working on such as “mini tornados of change.”4 Specifically, to be successful, current practices must transform from antiquated protocols and operations to systems that “optimize care processes, including the patient-centered management of clinical operations, the development and utilization of appropriate information systems and information, and the organization of care according to performance and outcomes measures.”5

There are several cross-cutting basics that need to be in place to ensure that organizational change occurs. These basics include acceptance and engagement that change is needed, strong leadership with the abilities to lead change, and a vision and plan for the change that needs to be executed which includes alignment, accountability and communications.

Acceptance and Engagement

Research indicates that there are many reasons people resist change. For some the disruption and challenges involved in the change creates an unsettling and unbalanced environment.6 Perceived or real changes within the group’s status quo provide additional reasons to disregard, abandon or object to changes within the work environment.6 Historical perspective also contributes to resistance. Familiarity and comfort with the old way leads to resistance to change. People do not like to appear as if they do not know what they are doing, and change in process, procedures and skills, can shift the balance of power within the organization. For example introducing technology into a previously paper-based environment can shift the balance of power between those individuals with tenure but less knowledge of technology and younger individuals who grew up in an era of computers, Internet and wireless capabilities. The result can be individuals who undermine, discredit or act-out against the proposed changes.

Leadership and Leadership with Abilities to Lead Change

Leadership is an important factor in change. Leaders who are not trusted, credible or respected contribute to change barriers.7 To lead a successful change initiative, a leader should be respected among all members of the organization, be perceived as credible and trustworthy, be able to emotionally engage and motivate members of the organization and have the talent to communicate the new mission, vision and goals to all involved in the change.

Being able to initiate and manage change are two key components for leaders seeking transformation within their organization.7 Kotter, author of Leading Change, stated leaders must be able to cultivate and communicate a sense of urgency throughout the or-
organization to demonstrate the need for change. Hughes, Ginnett and Curphy define leadership as “the process of influencing others toward the achievement of group goals.” The authors specifically demonstrate how mission, talent, norms, buy-in, power, morale and results are all critical change components that can be positively or negatively impacted by the leader. The team leader must make the mission for the team clear, understandable and meaningful. If this is done correctly, followers will understand the anticipated result and the direction needed to get there.

Leaders must be accountable for their role and actions, or lack thereof, within the organization. If an environment of accountability is not established activities can continue to have dire results with no consequences, and change is not likely to occur. Environments that encourage, reward and recognize loyalty instead of performance undermine the change system because individuals are not held accountable for their actions.

**Change Execution and Alignment**

Planning is one of the important keys to successfully initiating change within an organization. For change to succeed all involved need to know “where they are heading and how they are going to get there.” Without this vision, it will be difficult, if not entirely impossible, for those engaged in the changes to understand the need for change and what the change will result in. The end result of an effective vision is one that results in the “direction for a future that is desirable, feasible, focused, flexible and is conveyable in five minutes or less.”

Alignment is another critical factor needed to successfully introduce change within an environment. If alignment of personal, professional and organization attitudes and goals are fostered, the atmosphere will be infused with excitement, communications, and achievements. When physician goals and attitudes are not aligned change is difficult. This is evident in many factors. Currently, physicians receive payment for care based on quantity, not quality. The more patients seen in a day, the more revenue generated. For change to take place payment models need to align with care and cost models; payments aligned with quality measures, patient satisfaction, appropriate utilization of services are much more aligned with a patient-centered approach to care, than the current model. If professional goals for roles and responsibilities are not directly linked to the change model there is minimal to no incentive for the change to occur, and may even dis-incentivize physicians and other healthcare team members from changing, for fear of a reduction of pay or loss of job. In a change environment direct links must be established connecting responsibilities, attitudes and norms with the desired organizational outcomes.

Communications is critical to the change process. Without communications, leaders cannot motivate, staff will not know or understand the new vision and direction, conflict cannot be resolved and problems cannot be solved. In a national demonstration project involving 36 primary care practices undergoing transformation to a patient-centric model of care, a critical lesson included that for change to be successful it was critical to plan and think about how to best communicate the needed changes and provide opportunities for open dialog among and between all staff in the practice to describe what was, and what was not, working.

Communication can assist in reducing or mitigating complications that arise when myths or misinformation begins to wean its way through an organization embarking on transformation. It is important for leaders to address misinformation with facts, so that the myths do not become realities. Often when left unaddressed, the perceived myths become the actual realities and can undermine and significantly derail the change process.

NJAFP congratulates the practices selected to embark on this healthcare transformation project, and is here to provide support and guidance as physicians, practice teams, and the overall healthcare system work together to make healthcare better, safer and less expensive for all.

**References**


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**NJAFP offers CME online**

Several unique e-learning programs are available on the NJAFP website, ranging from programs in cultural competency to performance in practice programs centered on improving colorectal cancer screening rates.

Visit [www.njafp.org](http://www.njafp.org) and click on the education tab.
Members in the News…

Sal Bernardo, MD, (Freehold) NJAFP President was quoted in an article on the adoption of EHR in NJBiz. The article is available at http://www.njbiz.com.

Jeff Zlotnick, MD (Easton, PA) was featured in an interview about his experiences as a family doc for the AAFP’s Virtual Family Medicine Interest Group (fmignet.aafp.org).

James Lampariello, MD, (Wayne) NJAFP’s 2012 Family Physician of the Year, was featured in an article in WaynePatch. You can read the article at http://wayne.patch.com.

Kennedy Ganti, MD (Virtua Family Physicians, Lumberton) and Frank Sonnenberg, MD (Robert Wood Johnson Medical Group, New Brunswick), represented New Jersey (NJ HITEC) on June 18-19 in Washington, DC participating in two national Health IT events focusing on how health information technology can help improve care quality and patient health. Dr. Ganti and Dr. Sonnenberg are two of only 82 physicians selected to participate in these sessions.

Congratulations to…

Caryl Heaton, DO (Montclair) was named the Chair of Family Medicine at UMDNJ-School of Osteopathic Medicine. As department chair, Dr. Heaton will oversee the department’s educational, clinical and research components, which includes more than 20 physicians who treat patients in five area clinical offices and 26 graduate physicians in its nationally acclaimed residency training program.

News You Can Use

Feedback from the two sports medicine sessions presented at this year’s annual meeting let us know that this is a topic of interest to NJAFP members. If you are interested in learning more about concussions visit the “Online Concussion Education Programs” on the Athletic Trainers Society of New Jersey website: http://www.atsnj.org

Update on 2012 Summer Celebration & Scientific Assembly (SCSA)

For those of you who missed it, we truly hope you will not deny yourself this exceptional opportunity next year. So first – SAVE THE DATE! The 2013 SCSA will be held from June 21-23, 2013 at Bally’s Atlantic City Hotel. Mark your calendars and watch for invitations and updates as they become available over the next nine months.

Those of you who participated this year received state-of-the-art CME geared toward what family physicians have been asking to know more about. A total of 19.5 credits were available. We kicked-off this year with a Pre-Conference Workshop (6 credits) on June 14. Blueprint for Survival: Part 3, Primary Care Boot Camp focused on HIT updates, physician compensation models, EHR and work flow, and practice transformation. This was followed by the Scientific Assembly – which provided up to 13.5 credits to attendees, and we ended with the SAM Study Hall on Diabetes. Attendees who completed the SAM walked away with everything they needed to meet their ABFM requirements, including the complete set of answers to the SAM. And as you know, as NJAFP/AAFP members, we will report your credit for you to the AAFP. All you need to do is turn in your CME tracking form and we do the rest for you.

Research Poster Contest Winners for 2012 are:

First place in the Physician category - Voice to Voice Language Translation Study Using Handheld Devices in a Simulated Clinical Environment by Bennett S. Shenker, MD, MS, MSPH, FAAFP from CentraState Medical Center (Freehold).

Second place in the Physician category - Publication of Research Presented at Family Medicine Conferences: an Analysis of NAPCRG and STFM by Robert E. Post, MD, MS from Virtua (Voorhees).

First place in the Resident category - Physicians’ Knowledge and Ability to Assess and Counsel Older Drivers by Hortense P. Russell, DO from UMDNJ-SOM (Stratford).

Second place in the Resident category - The Effect of Grant-funded LARC (long acting reversible contraceptive) Devices on Reproductive Health Care in an Academic Family Medicine Office by Jennifer Amico, MD from RWJMS-UMDNJ (New Brunswick).
THE HIGHLIGHT of the NJAFP year is the President’s Gala with election and installation of new Board members. We thank AAFP Director, Laura Knobel, MD from Massachusetts for officiating the installation. The NJAFP’s new President is Sal Bernardo, Jr., MD (Freehold). Tom Shaffrey, MD (Hillsborough) is President-Elect; Vice President: Krishna Bhattacharyya, MD (Trenton); Treasurer: Frank Iannetta, MD (Lake Hiawatha), and Secretary: Robert Gorman, MD (Verona). Tom Shaffrey, MD (Hillsborough) is President-Elect; Vice President: Krishna Bhattacharyya, MD (Trenton); Treasurer: Frank Iannetta, MD (Lake Hiawatha), and Secretary: Adity Bhattacharyya, MD (Trenton) round out the Executive Committee. New NJAFP Board Trustees are Max Burger, MD (Southampton), Frank Iannetta, MD (Lake Hiawatha), and Joe Wiedemer, MD (Verona). The new Resident Trustee is Steve Nguyen, MD a PGYII from Mountainside Family Medicine Residency program.

2012 Honorees at this year’s President’s Gala at the Sheraton Atlantic City Hotel.

1. Salvatore Bernardo, Jr., MD, is installed by AAFP Board Director, Laura Knobel, MD of Walpole, MA.
2. Bob Eidus, MD presents Terry Shlimbaum, MD the President’s Award.
3. The annual Past President’s portrait on the Grand Staircase.
4. 2012 NJ Family Physician of the Year, James Lampariello, MD from Wayne, NJ celebrates with his family and friends.
5. Thomas Shaffrey, MD receives the 2012 Annual Meeting Chair Award.
6. Caryl Heaton, DO is honored with the 2012 Chair Award.
7. Lisa Lucas, DO from CentraState is named the 2012 NJ Resident of the Year.
The Resident Knowledge Bowl saw a stunning victory as UMDNJ–RWJ at Capital Health (Trenton) upset 2-time champions, JFK Family Medicine Residency Program (Edison). Kudos to the new champs on their erudition. We congratulate them on winning the Coveted NJAFP Knowledge Bowl Cup.

Photos (clockwise from top right)

1. 2012 Resident Knowledge Bowl (RKB) Judges: Laura Knobel, MD (AAFP Director), Bob Gorman, MD (NJAFP Secretary, holding Cup), Tom Shaffrey, MD (NJAFP Vice President and Annual Meeting Chair).

2. 2012 RKB Champs - UMDNJ-RWJ Family Medicine Residency Program at Capital Health in Trenton. Program Director Adity Bhattacharyya, MD (in red) is proud of her team. Congratulations to all!

3. John Ruiz, MD is RKB emcee and founder.

4. CentraState shows their solidarity.

5. Ann Dimapilis, DO is score keeper, letter-turner and shoe designer.

6. Ken Faistl, MD reacts as his CentraState team bets his beach house in the “Final Jeopardy” round.
The following resolutions were enacted on by the NJAFP House of Delegates

Resolution #1: Diabetic Supplies (R. Eidus)
Action: Accepted
Resolved: that the NJAFP HOD direct our delegation to the AAFP Congress of Delegates to present a resolution requesting that the AAFP seek relief from the burdensome and non-value added rules requiring a complete listing of diabetic supplies, providing diagnoses, justifying frequency of testing and specifying the exact brand of machines, test strips, and lancets in its Governmental and private sector advocacy agenda. This relief should include but not be limited to allowing physicians to write prescriptions for diabetic supplies that do not require a brand to be specified.

Resolution #2: AAFP Participation in the RUC (NJAFP Board)
Action: Accepted
Resolved: that the NJAFP HOD express its appreciation for the efforts of the AAFP to achieve reimbursement reform, our solidarity with the AAFPs decision to remain in the RUC, and our appreciation for the AAFP’s efforts with CMS to define what constitutes primary care, and be it further
Resolved: that the NJAFP HOD also wishes to convey to the AAFP our strong belief that any system of reimbursement which is based on work rather than value is fundamentally flawed, and request that this be communicated to the RUC, and be it further
Resolved: that a new system of payment based on value must be created and that the AAFP should reconsider their position of staying in the RUC if it determines that remaining in the RUC does not facilitate a change to a value based system of reimbursement, and be it further
Resolved: that the NJ HOD encourages the AAFP to educate all constituents that true reimbursement reform must include payments for care coordination and other aligned incentives.

NJAFP 2012 Resolution #3: PCMH Study Commission (M. Burger)
Action: Accepted
Resolved: that the NJAFP proposes a commission be formed by the AAFP to study the economic impact of the PCMH on the future viability of small practices and in the meantime, support those practices by all means available to it to protect the integrity of the individual doctor-patient relationship. Approved.

NJAFP 2012 Resolution 4: Integrity and Support for UMDNJ (C. Heaton)
Action: Referred to the NJAFP Board of Directors
Resolved: that NJAFP is sensitive to the issues of the merging of the schools and we instruct the board to advocate for what they feel is the best way to achieve the overarching goal of excellence in primary care higher education in New Jersey.
Physician Reporting Responsibilities to the New Jersey Motor Vehicle Commission

Claudine Leone, Esq.

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

More than likely a day does not pass in which you have concerns about a patient whose visual functions appear compromised or impaired as it may relate to safe driving. And surely your next thought is, “What are my responsibilities, moral, societal, and legal?” “Do we have mandatory or permissive reporting laws in NJ? What are the New Jersey vision requirements? Are there other medical conditions that a physician may encounter that would require mandatory reporting? How does HIPAA play into physician reporting responsibilities? Am I personally at risk when reporting protected health information (PHI), if patients do not wish me to do so?”

Driving licenses are divided into Basic and Commercial classes. The provisions within the New Jersey Administrative Code that govern vision standards are premised on the statutory authority of the Motor Vehicle Commission (MVC) to regulate driver safety, and the Code establishes vision standards for basic license holders. Federal regulations establish vision standards for commercial drivers.

N.J.A.C. 13:21-8.10: Visual Acuity Test Standards for Basic License Holders

A. A minimum of 20/50 in each eye, with or without corrective lenses as measured by Snellen Chart.

B. When the vision in either eye is less than 20/50 and cannot be improved by means of corrective lenses, a certificate adequately explaining the deficiency signed by a physician, ophthalmologist, or an optometrist must be presented.

C. When the vision in either eye is less than 20/50 and corrective lenses will improve the vision, the corrective lenses will be required to be worn while driving; except where corrective lenses show an improvement, but wearing lenses would be detrimental to the applicants well-being - a statement to this effect signed by a physician, ophthalmologist, or optometrist must be presented.

D. When there is no vision in one eye, the good eye must meet the minimum standard of 20/50 with or without corrective lenses.

E. In the event that any special device or equipment is used or needed to meet the minimum requirements outlined in this section, the matter may be referred to the Safety Standards Driver Testing for final determination.

Commercial Driver License Vision Standard

CFR 391.41(b) A person is physically qualified to drive a commercial motor vehicle if that person has distant visual acuity of at least 20/40 (Snellen) in each eye without corrective lenses or visual acuity separately corrected to 20/40 or better with corrective lenses; distant binocular acuity of at least 20/40 in both eyes with or without corrective lenses; field of vision of at least 70° in the horizontal meridian in each eye and the ability to recognize the colors of traffic signals and devices showing standard red, green, or amber.

Regarding Physician Reporting Requirements

NJ Law (N.J.S.A. 39:3-10.4) requires all physicians to report patients to the Motor Vehicle Commission within 24 hours after determining that a patient experiences any of the following:

- Recurrent convulsive seizures
- Recurrent period of unconsciousness or impairment
- Loss of motor coordination due to conditions such as, but not limited to epilepsy in any of its forms which persist or recur despite medical treatment.

The Motor Vehicle Commission website advises that if you believe that one of your patients is no longer fit to drive, please fill out MVC’s FORM MR-4 Medical Emergency Report. This can include a driver that does not meet previously noted vision standards. The form can be accessed at http://www.state.nj.us/mvc/pdf/licenses/mvc-form_MR-4.pdf. If you are unable to download the form or have any questions about its contents, please call (609)292-7500 ext. 5032.

Current New Jersey law and regulations establish an elective reporting system for driver vision deficiencies and a mandatory process for reporting specific neurologic dysfunctions. As to the issue of immunity as it pertains to PHI and HIPAA laws, if a physician in good faith believes that the reporting will serve the public welfare and protect the public best interest, New Jersey Law provides immunity from Civil Liability per N.J.S.A. 39:2-16 (even in light of HIPAA). It should be so noted that there is no statutory protection from liability for a physician who has failed to report a patient that may cause injuries to a third party due to a condition known to the physician, and the physician can in fact be held liable for damages. As always, with any questions relating to potential civil liability, it is best to confer with an attorney.
PAC Donations Make a Comeback

This year at the House of Delegates meeting in Atlantic City, Dr. Bob Eidus issued a strong and inspiring challenge to increase NJAFP PAC donations.

Dr. Eidus reminded the House that many of the organizations that are successful in putting their agenda before the NJ Legislature are able to do so because they have strong PACs supported by a large portion of their membership. If NJAFP hopes to have a seat at the “Legislative Table” we will need to have similar clout and dollars to achieve our goals as well. It is important that a PAC is supported by many so that there is real voting power behind the money.

In answer to this challenge, numerous NJAFP members responded very favorably in recent weeks and their response is worthy of a status update report. Thank you to all of you who have donated so far and to those who have pledged a donation.

Received Contributions

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This is very encouraging and your donations are helping us to build a strong PAC, but we urge you not to stop here. PAC dollars need to be distributed thoughtfully among potential allies in the NJ Legislature in order to do the most good. Please send your contributions to NJAFP PAC, 224 West State St., Trenton, NJ 08608 or go online to http://www.njafp.org/policy-advocacy/njafp-pac and click on DONATE at the bottom of the page.

PAC donations are not tax deductible.
The Department of Labor's Employee Benefits Security Administration (EBSA) released a final rule designed to help America's workers manage and invest the money they contribute to their 401(k)-type pension plans. This new rule will significantly impact employers as plan sponsors and fiduciaries by requiring them to provide their workers with certain information including fees and expenses charged to the worker's plan. Most workers do not recognize that they pay fees on their 401(k) plans that over time can seriously impact their retirement savings. The rule could potentially leave employers liable for failing to meet their fiduciary duty if they don’t disclose these fees or if they limit plans offered to their workers to those with higher fees.

Companies administering 401(k) plans must provide employers who sponsor the plans with details of all fees associated with the accounts. The plan sponsors (employers) must analyze the fees to determine if they meet the rule requirement that they be “reasonable.”

An estimated 72 million participants have invested roughly $3 trillion in participant-directed plans, which are plans that allocate the investment responsibilities to participants. However, while workers in these plans are responsible for making their own investment decisions, prior to the new rule, employers were not required to provide their employees with the information they needed to make investment choices including associated fees and expenses.

Under the new rule, investing plan assets is a fiduciary act that requires employers who serve as plan fiduciaries to act prudently and solely in the interest of their employees. Therefore, employers must on a regular and periodic basis, make employees aware of their rights and responsibilities with respect to the investment of assets held in, or contributed to, their accounts, and provide them with sufficient information regarding the plan and its investment options, including fee and expense information, to make informed decisions with regard to the management of their individual accounts.

An employer as the plan administrator must provide each participant with both “plan-related” information and “investment-related” information, as follows:

“Plan-Related” (or administrative) Information

- General Plan Information: the structure and mechanics of the plan (i.e., how to give investment instructions under the plan, a current list of the plan’s investment options)
- Administrative Expenses Information: an explanation of any fees and expenses for general plan administrative services that may be charged to or deducted from all individual accounts (e.g., legal work, accounting, record-keeping)

Individual Expenses Information: an explanation of fees and expenses that may be charged to a specific participant account or plan

- Statements of Actual Charges or Deductions: quarterly statements, showing the dollar amount and a description of the plan-related fees and expenses actually charged to or deducted from their individual accounts

“Investment-Related” Information

- Performance Data: historical investment performance. 1, 5 and 10 year returns for investments (mutual funds) or for investments with no fixed or stated rate of return, the annual rate of return
- Benchmark Information: for investments with no fixed rate of return, the name and returns of an appropriate broad-based securities market index over 1, 5, and 10 year periods
- Fee and Expense Information: for investments with no fixed rate of return, the total annual operating expenses expressed as both a percent of assets and a dollar amount for each $1,000 invested, and any shareholder-type fees or restrictions on the participant’s ability to purchase or withdraw from the investment
- For investments with a fixed rate of return, any shareholder-type fees or restrictions on the participant’s ability to purchase or withdraw from the investment
- Internet Website Address: to provide participants access to additional information about the investment options
- Glossary: to assist participants in understanding the plan’s investment options, or an Internet website address to access such a glossary

Miscellaneous

Investment-related information must be furnished to participants on or before the date they can first direct their investments, and then annually thereafter. It also must be furnished in a chart or similar format designed to facilitate a comparison of each investment option available under the plan

The participant must be provided with any materials regarding voting, tender or similar rights in the option
Upon request, the plan administrator must also furnish prospectuses, financial reports and statements of valuation and of assets held by an investment option.

Effective and Applicability Dates
For calendar year plans, the initial annual disclosure of plan and investment related information (including fees and expenses) must be provided no later than August 30, 2012. The first quarterly statement must then be furnished no later than November 14, 2012. This quarterly statement need only reflect the fees and expenses actually deducted from the participant’s account during the July through September quarter to which the statement relates.

What Does All This Mean to You as an Employer?
The disclosure requirements will require that employers educate their employee participants about the costs and benefits of various fund offerings. To do this, many employers look to independent third party financial companies to (a) assess their current plan, (b) perform plan re-development activities including investigating other options and developing a framework to ensure compliance with the requirements and (c) plan management that would include performing an annual review and employee education.

One certain outcome of these regulations is that when workers see how plan-related and investment-related costs are chipping away at their retirement savings, they will look to their employers overseeing the plans to behave as the fiduciaries they are.

For more information, contact Susan B. Orr, Esq. at Tsoules, Sweeney, Martin & Orr, LLC at 610-423-4200 or mail to: son@tshealthlaw.com.

CME QUIZ

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

Perspectives: A View of Family Medicine in New Jersey has been reviewed and is acceptable for up to 4 Prescribed credits by the American Academy of Family Physicians. Term of approval is for one year from beginning distribution date of 1/1/12. This issue (Volume 11, Issue 3, 2012) is approved for 1 Prescribed credit. Credit may be claimed for one year from the date of this issue.

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

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Stroke Reduction in Patients with Atrial Fibrillation (AF)
1. A CHADS2 score of 2 indicates that a patient with AF is at what risk level for stroke? a) no risk; b) low risk; c) intermediate risk; d) high risk.
2. True or False: Atrial fibrillation is the most common arrhythmia seen in clinical practice, affecting up to 1% of the U.S. population.
3. As of March 2012, which of the following oral anticoagulant agents are approved by the FDA for prevention of stroke in persons with AF? a) warfarin; b) dabigatran; c) rivaroxaban; d) apixaban; e) all of the above; f) a, b, and c only.
4. According to ACCF/AHA/HRS guidelines as of March 2012, which of the following agents can be considered for patients with AF who have a CHADS2 score of 1 (e.g., intermediate risk for developing stroke)? a) aspirin; b) warfarin; c) dabigatran; d) rivaroxaban; e) all of the above; f) a and b only; g) a, b, and c only.
5. True or False: Persons with recurrent AF are at a higher risk for stroke than those with paroxysmal AF.
6. Which class of agent is most effective at reducing stroke risk in patients with AF? a) antiplatelet agents; b) anticoagulant agents; c) antihypertensives; d) a and b, as they are equally effective.
7. True or False. AF causes nearly half of all embolic strokes and increases the severity, mortality, and frequency of recurrence of stroke.
8. True or False. While oral anticoagulants can modestly increase the risk of major bleeding and intracranial hemorrhage compared to placebo, devastating bleeding complications are uncommon when oral anticoagulants are monitored and adjusted appropriately.
9. When selecting an antithrombotic agent for a patient with AF, which factors should you consider? A) patient’s ability to comply with treatment and monitoring; b) risk of falls/bleeding; c) dietary considerations; d) renal function; e) all of the above.
10. True or False. An antithrombotic agent should be selected based on the absolute risks of stroke and bleeding and the relative risk and benefit for a given patient.

ANSWERS ON PAGE 27

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

Members - To obtain credit:
1. Complete and return this quiz to the NJAFP
2. Report your credit directly to the AAFP

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

Perspectives Volume 11, Issue 3 • 2012
EMR and Metadata, Are You Legally Protected?  

Stevie M. Davidson, CPHIT

In December of 2010, the President’s Council of Advisors on Science and Technology (PCAST) released a 108-page report that contained strong recommendations that Metadata should be utilized to push the growth of Health IT. Metadata standards would provide for a structured and universal language for exchanging health data, and also provide the means around litigation. Data would be separated into the smallest individual pieces that make sense to exchange. The data elements would provide mandatory tags, which describe the data and a patient’s preferences for the data’s uses, security, and privacy protections. This is the foundation for physicians to share electronic health information reliably and with efficiency. However, it does not come without risk.

So what is Metadata? Metadata is structured information that describes, explains, locates, and makes it easy to retrieve and use an information resource. The definition goes much deeper, but for our purpose here, it may be compared to a library catalog system. The 3x5 cards that provided information about a book’s title, author, and content description utilized an alphanumeric identification system that would also locate the book within the library itself. This system allowed for the quick retrieval, identification, and classification of the resource being sought. Welcome to the world of Metadata and e-Discovery.

So how does this affect physicians and their electronic health record (EHR) systems? How does it apply to the success or failure of a medical malpractice lawsuit? For those of you who have already leaped into the EMR realm, experts are saying according to American Medical News, that physicians who have adopted EMRs could face lawsuits or legal problems involving:

- Breaches of electronic patient data;
- Delayed notification of patient data breaches;
- Inaccurate or unauthorized modification of patient data in an EHR.

E-Discovery by way of Metadata is the hot trend in lawsuits against physicians. An attorney who accesses a physician’s EHR and other electronic records as a foundation to build a case against the physician uses e-Discovery.

When a practice makes the transition from paper to EHR, it is critical that the records remain legally sound. The change to EHR brings up some issues with compliance, privacy, and security. Below you will find some important considerations to make when switching your practice over to an EHR system.

When charting and signing off on a paper document, you have created a legal document. Physicians are very much aware of potential complications around any changes to a medical record and the importance of generating good documentation. The Healthcare Information and Management Systems Society (HIMSS) asserts that electronic medical records must be stored legally. Otherwise, these records can be challenged as hearsay and deemed invalid.

This is important; because when electronic medical records do not meet the legal requirements you could create the risk of an adverse outcome in litigation. Unfortunately, there is no “standard” around the definition of a legal medical record. Each state allows for a physician to define their own, however, whatever your definition is, ensure your process and procedures are operational and used consistently across your practice.

How can you ensure your electronic records aren’t being altered or compromised? A good system will allow a user to create, modify, and append a record and still allow the legal integrity of the data to remain intact.

Below are 14 considerations to reduce legal risk:

- Identify an individual or individuals responsible for security;
- Develop and implement security measures to protect the confidentiality of protected health information (PHI) that is transmitted electronically;
- Become familiar with the tracking features of your EHR;
- Understand how the system records who is accessing and writing in the record;
- Understand how the time-stamp feature works and test it accordingly;
- Establish practice policies regarding electronic documentation and order entry;
- Ensure that only appropriate staff members have access to clinical records;
- Print out a note from time to time to ensure entries are in your own name;
- Print out progress notes periodically and evaluate them from the viewpoint of an auditor or expert witness;
- When printing out records for an auditor or for litigation, go over the printout carefully to be sure it includes relevant and necessary data from other tabs or screens. The information that prints out when you perform a “print chart” function should be the foundation for the definition of your Legal Medical Record;
- Beware of generic templates—spend the time to customize and optimize to avoid data that would have normally been captured in a paper environment;
- Do not set up the system so that the template data automatically repopulates or carries over from visit to visit.
Protect records from inappropriate viewing -- set up screen-savers, and require a password for reentry.
Back up. Check the back-up method frequently. You may think you are backing up, but the hard drive or network storage mechanism may be faulty. Ensure you have appropriate back-loading procedures in place if you have a system failure.

In conclusion, there is still a lot of work that needs to be done with regard to development of Metadata standards. Right now, case law is not adequately defined, and this leaves a tremendous amount of latitude for Judges. In the meantime, if you are in the process of purchasing a system stay with the vendors that have a history in the marketplace. Many vendors promote free or inexpensive quick implementation schemes. There is too much risk to compromise your business longevity by taking the cheap route. If you already have one, it is okay to bring your vendor back to the table to understand the system you have. Perform your due diligence, understand the systems safety features and internal flow, customization ability, and customer support.

By taking these necessary steps, you are moving forward to ensuring your electronic medical record system is legal and defensible.

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**NJ-HITEC Providing Programs and Services to Support NJ Physicians on the Path to Meaningful Use and Beyond**

*Bill O’Byrne, Executive Director – NJ-HITEC*

The Meaningful Use (MU) requirements for effectively utilizing an Electronic Health Record (EHR) system are continually evolving and the process, at times, can be very frustrating for providers. In order for physicians to receive their federal incentive dollars, they must meet specific performance criteria that may be challenging.

### Meaningful Use

Deadlines for providers who plan to achieve Meaningful Use in 2012 for Year One Medicare or Year Two Medicaid federal incentives are quickly approaching. Physicians’ last day to start their 90-day reporting period for this year is October 3, 2012.

Some EHR vendors are offering affordable pricing as a result of the upcoming deadline. Providers who have been waiting on the side lines should be encouraged to take immediate action before the opportunity to be eligible for incentive funds is lost.

Qualified providers can earn incentive payments for up to five years if they elect to receive their incentive payment through Medicare or up to six years if they elect to receive their incentive payment through Medicaid. However, no Medicare EHR incentive payments will be made to providers whose first year of participation in the Medicare EHR Program is 2015 or later. Moreover, beginning in 2015, payment adjustments will take effect for Medicare Fee-For-Service providers who cannot successfully demonstrate MU using certified EHR technology. Qualified providers can begin to participate in the Medicaid EHR incentive program until 2016, and there are currently no penalties for not demonstrating MU for Medicaid Eligible Professionals (EPs).

**Medicare Audits:** Medicare audits have started for EPs. Stage 2 Meaningful Use Final Rule will be released shortly. NJ-HITEC will update providers on best practices in achieving this next milestone.

### NJ-HITEC Services

NJ-HITEC’s experience with EHR systems coupled with their practical knowledge of MU and how to meet these criteria, have made it possible for NJ-HITEC to create new service packages and tools that support Stage 1 Meaningful Use. It is likely many will not be able to meet the criteria, and will disappear.

In addition to all of the above considerations, if the Office of the National Coordinator for Health Information Technology (ONC) requires the use of Metadata in Stage 2 of Meaningful Use, EHR vendors will need to meet specified Metadata standards in order to become certified for use in the program. This will have a huge impact on the amount of vendors you see in the industry today that support Stage 1 Meaningful Use. It is likely many will not be able to meet the criteria, and will disappear.

About NJ-HITEC

NJ-HITEC is New Jersey’s sole Regional Extension Center (REC) and understands the demands placed on providers. It is a valuable resource for resolving the simplest to most complex issues in reaching MU.

NJ-HITEC staff has assisted more than 900 Medicare doctors receive over $16 million in incentive funds. NJ-HITEC can assist its member providers through an assessment to ensure that they are in compliance if an audit is requested by the Centers for Medicare and Medicaid Services (CMS).

NJ-HITEC is ranked second in the nation with over 1,100 Meaningful Users, and closing in on the number one ranking, out of 62 RECs across the country. Its membership exceeds 6,100 strong, and is growing, with over 4,100 providers “live” on an EHR system. NJ-HITEC’s strength as an organization is in assisting small practices through the implementation process to achieve the MU milestones. Its highly skilled and innovative staff continues to remain ahead of the curve in developing new programs, tools, and services to assist its members.

NJ-HITEC has convened a panel to develop a host of services which will be offered for sale locally, regionally, and nationally. The goal is to continue to offer many significant core services to all NJ-HITEC members at no cost or at modest prices for those members who wish to retain their membership. NJ-HITEC wants to share knowledge with other physicians, hospitals, and healthcare organizations locally, regionally, and nationally because the success of health IT lies in all of the medical community participating.

NJ-HITEC wishes to express its thanks to all the talented providers that have allowed NJ-HITEC to work through the implementation of EHRs and MU in their practices. NJ-HITEC believes it delivers a valuable and useful service to providers and looks forward to a long, mutually beneficial, and productive relationship with its members. As always, NJ-HITEC remains committed to the core principle that “NJ-HITEC’s only product is a satisfied doctor!”
to assist physicians through the entire process. NJ-HITEC provides personal assistance to their members either by phone or in person at the provider’s office.

**Fast-Track Program:** A “Fast-Track” program has been created by NJ-HITEC which is comprised of cohorts of provider practices that all use the same EHR system. These cohorts consist of small regional groups who come together to solve common problems associated with MU Attestation. This program has allowed NJ-HITEC to attest large groups of providers at one time; making it possible for them to claim their incentive funds.

Clinical Summaries are a major barrier to achieving Stage 1 MU.  

**NJ-HITEC Fast Track Workshops:** Fast Track Meaningful Use Workshops are conducted with a number of vendors to support the ability to achieve MU in real time. Workshops are being held throughout New Jersey so NJ-HITEC analysts can review providers’ dashboards, answer questions, and resolve issues. These forums also provide an opportunity for physicians to network with colleagues using the same system.

Participants in the workshops receive personalized tips as a result of the Gap Analysis that is performed during the session. NJ-HITEC staff is present to assist with any issues and helps participants correct any errors to accelerate their path to Stage 1 MU.

If providers cannot attend the Fast Track Meaningful Use Workshops, their dashboards can be emailed to the NJ-HITEC MU analysts who provide the necessary feedback to ensure providers are on the right track. NJ-HITEC MU analysts review the providers’ dashboard for Stage 1 MU compliance and generate a report indicating what needs to be modified, corrected, or changed to assist providers in moving closer to receiving their incentive payment. Dashboards can be emailed to dashboards@njhitec.org. All of the workshops offered are listed on the NJ-HITEC web site at www.njhitec.org.

For those providers who are just starting the MU process, who are further along, or just want to keep up-to-date on the latest MU news, NJ-HITEC developed a series of ongoing webinars that are presented monthly. The webinars are as follows:

- The first Wednesday of each month features a Meaningful Use Update with a Question & Answer session.
- The second Wednesday of each month discusses a Meaningful Use Deep Dive providing information to providers who are further along in implementing an EHR system. This webinar focuses on the 15 Core and the 10 Menu Meaningful Use measures. The presentation gives details about each measure and discusses the best practices that the NJ-HITEC staff has learned from the field in achieving these requirements.
- The third Wednesday of each month introduces Meaningful Use Basics to those who are just embarking on the implementation process.

In addition, NJ-HITEC providers and partners receive a bi-monthly E-Newsletter that describes the most current NJ-HITEC services, applications, and programs as well as the latest news from CMS; changes in CMS and ONC processes or procedures; need to know security and privacy information; audit preparation news and details; MU and CQMR best practices; in addition to other information.

**Registry and Data Submission Vendor:** NJ-HITEC has been accredited by CMS as a Registry and Data Submission Vendor to provide physicians with the ability to submit Clinical Quality Measures (CQMs) to CMS for the Physician Quality Reporting System (PQRS) and E-Prescribing. Participation in PQRS and E-Prescribing programs can yield incentive payments for providers, and will soon help providers avoid payment adjustments to Medicare reimbursements. However, the effort it takes to capture clinical and claims data, the complexity of the submission process, and costs associated with using other qualified Registries has discouraged many providers from participating in these programs. NJ-HITEC, designated as a Registry, makes this process easier for providers. Furthermore, MU Level 2 will require that providers only use a CMS accredited Registry.

**NJ-HITEC 2.0:** Pursuant to the federal contract with the Office of the National Coordinator (ONC), the Regional Extension Center’s (NJ-HITEC) obligation to offer free services to Primary Care Providers (PCPs) ends when a provider attests to Stage 1 Meaningful Use. However, NJ-HITEC offers highly valuable services and products to New Jersey physicians and it intends to continue to offer these same professional services after the federal funding has expired.

NJ-HITEC has established a Specialist Services Program and will continue to offer services free-of-charge for all PCPs with an existing EHR system.

The NJ-HITEC Registry and Data Submission Program is a second service being offered to providers. This offering gives providers the ability to submit clinical quality and claims data/measures to the PQRS Registry and E-Prescribing (eRX), which is mandated by federal legislation.

For more information on NJ-HITEC and its services, please visit www.njhitec.org, email info@njhitec.org, or call 973-642-4055.
A Conversation with Richard Corson, MD, FAAFP
Candidate for AAFP Board of Directors

NJAFP: What do you bring to the table that distinguishes you from other AAFP Board candidates?
Richard Corson: I began my career as a family physician almost three decades ago, and I continue to find family medicine rewarding, challenging and exciting. I am fortunate to have worked in a variety of environments. I started a practice from the ground up, grew an established practice to four providers, served as Vice President of Family Practice and Graduate Medical Education, as well as President of the Medical Staff at Somerset Medical Center, and worked in academic medicine as a residency director. I have a solid foundation and broad perspective to address the issues that the AAFP will consider over the next three years.

NJAFP: As family medicine goes through some trying times, how has your experience influenced your perception of the future of family medicine?
Corson: I am highly invested and closely involved with a specialty that has changed dramatically, yet I remain optimistic about its future. As a candidate for the AAFP Board, I believe that the future of family medicine requires that the patient be positioned at the center of the healthcare system and that family physicians must assume a pivotal role in this setting to improve the quality and efficacy of care and ensure better outcomes.

NJAFP: How do you perceive the Patient Centered Medical Home (PCMH) and the role of technology in family medicine?
Corson: I think technology plays an important role in family medicine and an equally important part in the future of family medicine as we redesign our practices and use systematic methods to try to take care of individuals as well as populations of patients. One of the things I've tried to do is to be a role model for those physicians who may be uncertain about the future of the PCMH in family medicine.

I am happy that I was able to lead my small practice to attain NCQA Level 3 PCMH recognition. I joke and tell people, well, it was either I was in front of the pack leading the charge or I was behind the pack with a pointy stick, but either way we got there. If I can get there, I know that many of the practices in my area can get there. I think role modeling is one of the best ways that we can help our colleagues learn that, yes, it is possible to transform your practice, even as a solo physician.

I applaud the AAFP for its efforts in supporting family physicians as they adapt their practices to the PCMH model. Through education, advocacy and practice enhancements, AAFP has been able to provide us with the tools and the education we need to move that way. I hope to be able to continue to play a role in moving more family physicians in that direction.

AJAFP: What about your colleagues who prefer not to move toward the PCMH concept?
Corson: The AAFP may be an organization of family physicians with much in common, but we are also a diverse organization and definitely not a “one size fits all” group. AAFP’s goal is to make family physicians leaders in the new model of healthcare delivery and encourage them to explore innovative ideas. This is good work that must be fostered. In the process, we must acknowledge and address the needs and interests of ALL of our members.

The AAFP supports the PCMH concept and wants to ensure that family physicians are properly equipped to adapt to the role they play in leading the PCMH model of care. I do understand that some family physicians are not prepared to take that leap. That is fine. The AAFP is a home for all of us who are committed to practicing family medicine. We are all family physicians and we will work together to confront and overcome the financial, administrative and workforce issues that challenge the future of family medicine. For some of us, this may mean being at the forefront of the PCMH model, leading the way; for others, it may not. But we must support one another, regardless of the path we choose professionally.

NJAFP: How can advocacy impact the future of family medicine?
Corson: We are at a great time in family medicine, and I am looking forward to encouraging grassroots member support of the AAFP because I believe it is in a family physician’s best interest and the best interest of his or her patients. Advocacy is important to me. I am working hard to try to encourage my colleagues to become more active on the local and state levels and look forward to working just as hard to get my colleagues working together to advocate on a national level.

NJAFP: How do you perceive the Patient Centered Medical Home (PCMH) and the role of technology in family medicine?
Corson: I think technology plays an important role in family medicine and an equally important part in the future of family medicine as we redesign our practices and use systematic methods to try to take care of individuals as well as populations of patients. One of the things I've tried to do is to be a role model for those physicians who may be uncertain about the future of the PCMH in family medicine.

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AAFP may be an organization of family physicians, but we are not a “one size fits all” group.

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NJAFP: How can we motivate legislators?
Corson: I believe that strong AAFP leadership can motivate our legislators to action and identify achievable solutions to the fragmented healthcare delivery system, replacing it with a coordinated, efficient and patient-focused system that supports the pivotal role of the family physician. I believe my leadership experience, motivation and commitment to change will move the AAFP toward these goals.

NJAFP: What strategies can bring AAFP members into the advocacy process?
Corson: As AAFP members, we must consider innovative ways to bring our members into the advocacy and decision-making process. I believe social media and new technologies are great tools for strengthening the bond among members and increasing the input from members. Face-to-face meetings remain an important strategy for engaging our members.

NJAFP: Please summarize the most pressing issues facing the AAFP and its members.
Corson: This is a challenging time for family physicians and family medicine. As we confront these challenges, we must prepare ourselves as physicians and as an organization. I believe the five issues that I have identified will equip the AAFP and its members to emerge even stronger and poised to participate successfully in the changing healthcare environment.

1. I believe there are key workforce issues that must be addressed.
   We must confront the precipitous decline in medical students specializing in family medicine and offer incentives to attract students to the specialty. We must also address practice environment issues and administrative burdens that impose onerous costs and requirements on family physicians.

2. I know that the AAFP is a powerful organization. We must harness the full power of its influence to educate and inform legislators and the business community about emerging and significant family medicine issues.

3. I am a strong advocate of patient-focused health care. Placing patients at the center of the healthcare system and ensuring that family physicians assume a central role in this setting will improve care and achieve better outcomes.

4. I support increasing the advocacy efforts of the AAFP and encouraging members to engage in advocacy at the local, state and national level.

5. I also believe it is critical that the AAFP remain relevant to all family physicians. As an organization, the AAFP must listen and adapt to the needs and viewpoints of all of our members.

NJAFP: Is there anything you would like to add?
Corson: I love being a family doctor. It’s the greatest job ever. I look forward to the future of family medicine and hope to be part of the AAFP’s leadership team that will transform family medicine. Elect me to the AAFP Board of Directors and I pledge to be a strong advocate for family physicians and the healthcare issues that will empower the specialty.

Colleagues gathered at President, Bob Eidus’ penthouse to enjoy the Jersey City skyline views as NJAFP hosted the Ten State Conference earlier this year. Pictured from left to right are: NJAFP board members - Tom Ortiz, MD, Rich Corson, MD, and Arnie Pallay, MD; AAFP board directors, Conrad Flick, MD and Reid Blackwelder, MD; and Indiana deputy executive, Deeda Ferree.
The NJAFP Foundation would like to extend its sincere appreciation to fellow board members, Ruth Corson and Sue Zlotnick for volunteering their time to staff the Foundation booth at this year’s Scientific Assembly. Sue and Ruth work diligently each year to make the Foundation booth interesting and productive, and to hopefully elicit generous donations from our members and SCSA guests. Their efforts raised $280 over the 2-day period, which will be used for student initiatives.

However, the Foundation needs your support year-round in order to truly realize its mission. You can donate at any time by going to www.njafp.org and click on About NJAFP, scrolling down to Make a Donation under the NJAFP Foundation heading. For your convenience, there is also a coupon below if you prefer to donate by mail.

In addition to monetary contributions, the NJAFP is looking for ideas from members on how to provide support to students and residents to encourage them to remain in New Jersey, rather than seek greener pastures in other states. We welcome your input in this area and encourage you to brainstorm with colleagues and friends to become more involved in the Foundation. Send us a note at office@njafp.org.

“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

Thank you for your generosity!

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New Jersey’s First Resident Caucus
Sara Leonard, MD

Residents from 8 of the 13 Family Medicine residency programs in New Jersey came together to discuss key issues facing residents and medical students in NJ at the first NJAFP Family Medicine Resident Caucus hosted at CentraState Medical Center in Freehold on May 8, 2012. The meeting was moderated by the 2011-2012 NJAFP Resident Trustees, Meera Patel, MD and me, Sara Leonard, MD. Our goal for the caucus was threefold. We wanted to create a forum through which residents could make their voices heard. As Resident Trustees, Meera and I aimed to accurately represent the interests and concerns of our fellow residents. Additionally, we sought to encourage greater resident participation in the NJAFP and to deliver the message that residents are important members of the organization. As residents, we not only represent the future of family medicine in New Jersey, we also represent a generation of future leaders. The future leadership potential of those in attendance was channeled into our third goal, which was to begin a discussion and strategize solutions for two major issues that threaten the future of family medicine in New Jersey: 1) resident retention following graduation and 2) NJ medical student pursuit of family medicine residencies.

Residents and practicing family physicians need to drown out the naysayers, dispel the myths, and share our enthusiasm for the specialty.

Financial barriers were unanimously identified during small group break-out sessions as the reason residents leave the state for employment. Student loans are a key factor in new physicians’ decision-making regarding employment. Graduates are finding generous loan forgiveness in other parts of the country, which combined with lower costs of living and special incentives makes relocation seem quite appealing. Residents agreed that keeping more young physicians in New Jersey would require competitive loan forgiveness, more incentives, and salaries commensurate with the higher cost of living and higher cost of insurance in the state. Some were hopeful that the transformation of practices into Patient Centered Medical Homes would create more revenue and thus more opportunities. Others believed that a government loan forgiveness program would need to be developed to address New Jersey’s primary care shortage. The idea of offering more fellowship opportunities in New Jersey to attract and keep residents in the state was received favorably by most in attendance as well. Ultimately, there was general agreement that Jersey-trained residents without strong family ties to the state will continue to go elsewhere until action is taken to change New Jersey’s current status as a net exporter of young family physicians.

The most passionate discussion came in response to the topic of encouraging New Jersey medical students to pursue family medicine. Multiple barriers were identified including the fact that family medicine is not always clearly defined and medical students often fail to recognize its broad scope. Suggestions were made to look at third-year clerkship curriculums and consider making changes to provide exposure to a broader range of opportunities within family medicine. There was also discussion about making clerkship opportunities more available to students from off-shore medical schools, such as those from the Caribbean, as those students historically fill a large number of family medicine residency spots in New Jersey. Another barrier identified was the naysayer; whether it be an academic advisor, a professor, a resident, or a friend. Everyone in the audience had at least one story to share detailing the efforts made by these naysayers to deter them from pursuing a career in family medicine. It was agreed that both residents and practicing family physicians need to be more present at both the pre-med and medical school levels to drown out the naysayers, dispel the myths, and share our enthusiasm for the specialty.

There was a great deal of enthusiasm surrounding ideas such as developing a buddy system to provide mentoring for medical students who show interest in family medicine, initiating a “Family Medicine Day” at the medical schools, and exploring ways to promote interest at the pre-med level. Preliminary plans were even made for a video competition among residents that would both raise awareness of the full scope of family medicine as well as represent it in a more positive light.

I would like to call on the general membership of the NJAFP to assist us in continuing the momentum of the Resident Caucus in working towards finding solutions for these issues. Please seize every opportunity to mentor and encourage future family doctors. Also, please remember that the NJAFP website is a valuable resource for graduating residents seeking employment in New Jersey. Posting employment opportunities is easy and free for members. Tell your colleagues. Every job posted is a chance that one less resident will be taking his/her excellent Jersey training elsewhere.

Please share your thoughts on these issues and others with the NJAFP Resident Trustees by emailing me at resident_trustee@NJAFP.org.
DO YOU REMEMBER ROBIN INCE, RN? Robin Ince is Westfield, New Jersey’s secret weapon in the fight against youth smoking and tobacco use (which has been dramatically on the rise again in recent years).\(^1\) Ms. Ince is the school nurse from Franklin Elementary School who has made it her mission to teach young students about making healthy choices in life and remaining tobacco free. By incorporating the Tar Wars program into her fourth grade health curriculum, she ensures that all the students at Franklin Elementary who pass through her class will learn the important message Tar Wars brings to schools across the country.

The 2012 New Jersey State Tar Wars Poster Contest Winner is Sara Wheatley – and yes, she is a student of Robin Ince, RN.

The Wheatley family standing next to Sara’s winning poster. Pictured are (clockwise from l), Sara Wheatley, Dad: Matt Wheatley, Mom: Maria Suarez, sisters: Anabel (6) and Emmy (8).

2012 Tar Wars National Conference – Washington, DC

The Tar Wars National Conference in Washington, DC was full of excitement with anxious young Tar Warriors eager to spread the word on Capitol Hill to create a clean and safe smoke-free environment.

The program began on Monday, July 15 with a keynote address from Rebecca Hart, MD, the current chair for the Tar Wars Program Advisors, who spoke about the value of Tar Wars and how the program continues to evolve to meet the needs of our current target audience. Following Dr. Hart, was the amazing Parade of Champions. This fun event is emceed by Master of Ceremonies, Sara Saccocio, MD of Virginia, who with her very personable and endearing rapport introduced all the state winners and interviewed them on their posters’ artistic concepts.

Following the ‘Parade,’ Dr. Li-Lun Chen, MD from the FDA spoke on the Center for Tobacco Products’ role protecting public health. We also heard from the Campaign for Tobacco-free Kids. Their representative, Ritney Castine gave an energetic presentation advising kids how they can be involved in clean air and good health advocacy.

The Monday evening program is the highlight of the conference – the Annual Awards Banquet. While everyone is a winner at the Tar Wars Conference, special recognition is given to those who display exceptional work. Additionally, the Tar Wars Contest created a new category last year for Best Video. Several video submissions were made this year and each was unique. The 2012 video winner is Lauren Buete, a fourth-grader from Tierra Verde, FL, who performed a song she wrote about being tobacco-free. The 2012 Tar Wars Poster contest winner is Juan Elizondo from Texas – and New Jersey’s own Sara Wheatley received 7th Place Honorable Mention with her creative message depicting a road being resurfaced: “Tar is good for your avenue, but not good to have in you!”

To see all the winners for the 2012 program, go to http://www.tarwars.org/online/tarwars/home/studentcontests/poster-contest.html.

On Tuesday, July 16 we made our annual trek to the Hill. We met with Senator Menendez’s Legislative Correspondent, Sarah Reinprecht giving Sara Wheatley an opportunity to practice her message before meeting with Senator Lautenberg. Our visit with Senator Lautenberg was very personal and the entire Wheatley family was truly impressed with this octogenarian’s wit and charisma. Senator Lautenberg also personally inscribed a children’s book to Sara and her sisters written by his friend, the late Senator Ted Kennedy about his days on Capitol Hill with his dog, Splash (written from the dog’s point of view).

The day was rounded out with a tour of Capitol Hill and a late afternoon visit to Congressman Lance – the Wheatley’s representative, who also took special time with Sara to talk to her about her future endeavors.

Tar Wars will celebrate its 25th birthday in 2013 and we hope to make it a banner year for the program. One of the best ways to contribute to this success is to become a presenter yourself to teach and share the Tar Wars important message within your community: make healthy choices in life and great things will always be possible.

Every year the tobacco industry must recruit new members in order to maintain its market. The easiest targets are our young children who are mislead by false advertising. Tar Wars blasts through the myths and educates children on the truths of tobacco and the harm it causes. To learn more and to become a presenter, go to www.tarwars.org.

Please contact Candida Taylor at candida@njafp.org if you would like assistance setting up a presentation at your local school.

Reference


CME TEST ANWSERS: 1) D; 2) True; 3) F; 4) G; 5) False; 6) B; 7) True; 8) True; 9) E; 10) True
After 14 years at the same practice, I am leaving for another position. One thing I underestimated about leaving is my attachment to my patients. I have become part of my patients’ lives – and they have become part of mine. It has been very hard to say goodbye.

As I began the transition of telling patients I was leaving, I found that I told some patients in the office, some by telephone, most by a letter and some took me out to lunch. For one patient though, I made a “social” housecall. I have cared for her, her husband, their children and grandchildren for most of the last 14 years.

“Sue”* is a 74 year old with a history of breast cancer; alcoholism, for which she has been sober for the last 30 years; tobacco abuse in the distant past; hyperlipidemia; chronic back pain; and she is a vasculopath. I last saw her in the office about six months ago for two separate visits. On the first visit I entered Exam Room 4.

“Hi!” I beamed.

“Hello, dear. How are you?” she chimed in her prim but warm way. She taught grade school for years and carries herself in a certain style.

“I’m great. Great to see you,” I gush.

“Harry”* is in North Carolina, and I wanted to have my side checked. Sue’s husband is also retired. He was a professor at a college in Pennsylvania and continues to travel with friends and former students. Sue mostly stayed home for the last two or three years due to her back pain, but she still travels with him at times.

“What’s going on with your side?” I ask.

“I don’t know, Joe. I have a lump or something and it hurts sometimes,” she tells me familiarly.

“Let’s look.”

She stands and pulls her trousers down to reveal a moderately sized direct hernia.

“How long have you had this?” I ask.

“I don’t know – two, maybe three months. It doesn’t bother me,” she replies.

“Does it hurt now?”

“Yes. It’s tender,” she answered.

“I know a surgeon you should see who can repair this. What’s your schedule like?” I ask.

“I’m available. Harry gets home next week, so he can take me.”

I call the surgeon’s office and arrange an appointment for the initial evaluation.

Sue had the surgery uneventfully, but developed worsening back pain in the ensuing days. I saw her again in the office and diagnosed a herniated disc, which an MRI confirmed.

She went to an orthopedic surgeon who did a series of injections, which improved the pain, but the orthopedist thought she may have claudication as well and sent her to a cardiologist who did a cath.

The cath showed blockage in her right femoral artery, multiple blockages in her heart and critical carotid stenosis. Without me knowing, she went for a PTCA and four vessel stenting.

After the two caths, her creatinine rose to 3.5 and the cardiologist had to wait to for the carotid procedure. Sue called me to tell what had happened.

“I’m available. Harry gets home next week, so he can take me.”

“Let’s slow down before we do this procedure. There are risks and consequences to consider.” The struggle comes from sometimes knowing that we might not have a choice. It’s difficult to know whether Sue had stable CAD or if she would have had an MI or stroke if we did not intervene.

We “beat ourselves up with the retrospectoscope” a colleague from medical school once told me. Sometimes we are in the role of an advocate to “do less in order to first do no harm.” As family physicians we have a special relationship with our patients. They look to us to guide them through the myriad of choices. Most times we do not have enough information to know the “right choice,” but sometimes we do.

I don’t think I would have recommended that Sue had anything differently done, had I been included in the decision process. I do wish I were included in the process, though.

I talk to Sue’s family several times a day to get updates on her status. I will continue caring for her as I transition into my new practice. She, and all of my patients, teach me more than they could ever know - as I am sure yours do for you - as we humbly practice Family Medicine. As always, I look forward to your comments.

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

*Names changed
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