

Perspectives

A VIEW OF FAMILY MEDICINE
IN NEW JERSEY

VOLUME 12, ISSUE 3 • 2013

**Rich Corson runs
for AAFP Board
of Directors**

**Tom Shaffrey, MD
is installed as
NJAFP President**

CME Inside:
**Are You Asking the
Right Question?**

*Evidence-Based
Questions & Answers*

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Volume 12, Issue 3 • 2013



On the Cover

Tom Shaffrey, MD is installed as NJAFP President at the 2013 President's Gala in Atlantic City. See NJ View for meeting highlights.

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Asking the Right Question

We live in a world where more and more often we are asked to consider the evidence. The web abounds with blogs and websites devoted to evidence-based strategies, and not just in medicine. The Office of Justice Programs has a blog on using evidence-based strategies in the criminal justice world.¹ There is a blog on evidence-based living, where you can read about the evidence on gun violence in America or the evidence around winning streaks in sports.² There are blogs devoted to debunking pseudoscience by presenting evidence, and of course there are any number of evidence-based medicine blogs.

However, today, we spend so much time analyzing evidence that I wonder if we have forgotten the most important part of research, asking the right question. Asking the right question is not as easy as it seems.

I am working on the data analysis section of a research study that I designed. As I work through the analysis, I am realizing just how difficult it is to make sure you ask the right question. The majority of the data related to the primary research question reveals usable results (for which I am profoundly grateful to the research gods). However, there are also secondary questions whose answers are a bit of a surprise. I am left wondering if I asked the right question. Only a continuing analysis of the data will reveal the answer.

Asking the right question to determine the best evidence-based answer is the theme of this quarter's CME View. Thanks to the efforts of the residents and physicians from Rutgers/Robert Wood Johnson School of Medicine we have provided five evidence-based answers to five clinical questions. You will be able to read the evidence supporting the answers to such questions such as "Does self-monitoring of blood glucose affect hemoglobin A1c levels in non-insulin dependent type 2 diabetics?" and "Does an aerobic exercise regimen affect glycemic control in type 2 diabetic patients?"

Let us know what you think about these evidence-based questions. Perhaps we can begin to include this as a regular part of *Perspectives*. And, as always, if you would like to contribute CME content to the magazine (or letters to the editor, or an opinion column), just contact me at editor@njafp.org.

Happy Reading,

Theresa J. Barrett, MS
Managing Editor

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We spend so much time analyzing the evidence that I wonder if we have forgotten the most important part of research, asking the right question.



What it Means to be a Family Physician

Thomas A. Shaffrey, MD

Dr. Shaffrey is the President of the New Jersey Academy of Family Physicians. He is in private practice in Bound Brook, NJ.

Upon graduating, we all took an oath to our profession. On that day, my father, a World War II field surgeon, took me aside and had me take another vow. To him, being a physician was the most sacred of professions, requiring great sacrifice, but also providing great satisfaction. Here is what he had me promise:

"What you have accomplished is extraordinary. Few have the intelligence and desire to do what you have done. There is great value to what you can do for patients and for that you deserve to be paid by those who can afford to pay you. But you will never, never deny care to anyone who cannot pay you. That is part of being a physician. And each day when you are practicing you will be faced with difficult decisions about the care of your patient. The only way you can make those decisions is to promise to do for that patient exactly what you would do for your brother, sister, for your family. If you do that for each patient, you will never be wrong."

I have always believed that the oaths I swore that day are the foundation of being a good family physician.

What It Means to Be a Family Physician

Being a family physician is a great accomplishment and a great responsibility. We touch patients' lives in ways no other profession can even imagine. There is great value in what we have been taught and learned, and what we can do. Family medicine has always had the potential to make an enormous difference, but has never received the widespread support it deserves. As family physicians, we must place a priority on advocating for our specialty because without us, health care simply will not work. And as we advocate for all family physicians, we must advocate for our patients. There has never been a separation of those precepts.

Can Advocacy Change the Future for Family Physicians?

The issues that family physicians have been confronting since the beginning of the 20th Century have changed little over time. Despite dramatic proposals to change the delivery of health care, we have been unable to create a primary care base strong enough to make a difference.

Take a look at the headlines in the national press over the last century:

1900s: The American Medical Association represented about half of the physicians in the country. The United States lagged behind Europe in cost and medical value.

1910s: Hospitals focused on ensuring cleanliness and reducing infections. Progressives pushed for insurance reform, and the nation was occupied with funding a war effort.

1920s: There was a strong emphasis on the cost of medical care.

1930s: Health insurance was a priority, but progress was hindered by internal government conflicts.

1940s: President Roosevelt asked Congress for an "economic bill of rights," including the right to adequate medical care. President Truman then offered a single universal health insurance program that would include all Americans.

My goal is to continue the work of my predecessors, to represent all members, and to ensure that our accomplishments and efforts in the field of family medicine are recognized.

1950s: The United States adopted a system of private insurance for those who could afford it and offered welfare services for the poor. The number of medications available to treat diseases had increased and hospital costs had doubled.

1960s: Those outside the traditional workplace, especially the elderly, had difficulty affording care/insurance. Concern about the "doctor shortage" grew and the need for more "health manpower" skyrocketed, leading to federal measures to expand education in health professions. More than 70 percent of physicians identified themselves as full-time specialists.

1970s: Healthcare costs increased rapidly due to a combination of Medicare expenditures, economic pressures, expansion of hospital expenses and profits, and greater use of medications and technology. American medicine was in crisis. President Nixon's plan for national health insurance was rejected. The final plan included federal endorsement, certification and assistance for commercial health plans (now HMOs).

1980s: This decade was characterized by hospital systems expanding into many other healthcare-related business areas and consolidating their control of local markets.

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What I Did On My Summer Vacation

EXECUTIVE
VP'S VIEW

Ray Saputelli, MBA, CAE

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.

While on vacation earlier this summer, as I sat in an idyllic beach setting with a good book, a cold beverage, and great jazz in my ears, the sky began to cloud over. With my peace disturbed at the thought of a less-than-perfect vacation day, I grumbled some words of dissatisfaction with Mother Nature – I thought this complaint was made in private, but not so. From about five feet away I heard a “local” say, “Don’t forget where you are. If you don’t like the weather just give it 10 minutes and it’ll change.” Since then I have been thinking about change quite a bit; the pace of change, how difficult change can be, the fact that change just “is,” but it’s our reaction to the change that matters, and mostly how often the old axiom “the more things change, the more they stay the same” proves true. Consider these quotes from reports published in 1966 and 1967:

“The patient wants, and should have, someone of high competence and good judgment to take charge of the total situation, someone who can serve as coordinator of all of the medical resources that can help to solve his problem. He wants a company president who will make proper use of the skills and knowledge of more specialized members of the firm. He wants a quarterback who will diagnose the constantly changing situation, coordinate the whole team, and call on each member for the particular contributions that he is best able to make to the team effort.”¹

“Every individual should have a personal physician who is the central point for integration and continuity of all medical services to his patient. Such physician will emphasize the practice of preventive medicine... He will be aware of the many and varied social, emotional and environmental factors that influence the health of his patient and his family... His concern will be for the patient as a whole, and his relationship with the patient must be a continuity one.”²

“The family physician is one who: 1) serves as the physician of first contact with the patient and provides a means of entry into the healthcare system; 2) evaluates the patient’s total health needs, provides personal medical care within one or more fields of medicine, and refers the patient when indicated to appropriate sources of care while preserving the continuity of his care; 3) assumes responsibility for the patient’s comprehensive and continuous health care and acts as leader or coordinator of the team that provides health services; and 4) accepts responsibility for the patient’s total health care within the context of his environment, including the community and the family or comparable social unit. The family physician is a personal physician, oriented to the whole patient...”³

A few weeks ago, I asked a group of people to complete the sentence “a family physician is...” Some of the people in that group were themselves family physicians, and some were non-physicians with strong ties to family medicine. The answers were strikingly similar to those 50+ year old quotes.

“Your one-stop shop for relationship-based, comprehensive, broad-scope care.”⁴

“Someone who cares for the entire patient as a human being, who is on the front line of today’s complex medical care system who cares for newborns to the elderly and is usually someone who knows the patient best, like a good, trusted friend.”⁵

“A family physician is someone who looks at the big picture, not just the

medical conditions, but also their mental health and social/family situation and advises and supports the patient accordingly.”⁶

On first glance, one might argue that it is only natural that the specialty would be defined or define itself similarly from one generation to the next. Accountants are still accountants, attorneys remain attorneys, and while the surrounding environment may change and grow more complex, the basis of a profession is likely to be consistent. Still, the focus of so many conversations and articles (even this one) is how much change family physicians must endure and navigate. I do not disagree with the premise, but I was also struck by the simplicity of the truth. At the end of the day, through all the change, the basic nature of family medicine, the value of family physicians, and the role they play in their patients’ lives and in the healthcare economy are strikingly similar to the earliest visions of family medicine. Family physicians are ultimately, as one respondent stated with eloquent simplicity, “your family’s healthcare partner for life.” As family medicine travels the winding road that is health care in the 21st century, I maintain a hopeful perspective that this basic foundation of the quintessential primary care discipline will not change, and that my ability as a patient to have that life-long relationship with “the health professional [I] trust most to advise and guide [me] to be or stay healthy” will not be relegated to historical recollections of a reality long past.

Unfortunately, not all similarities with the past are as positive.

“We believe the cost of medical care can be reduced, the availability of medical care increased, and the quality of medical care improved, if the American people will accept the policy of each person turning to a general practitioner as his family doctor, personal medical guide, and health advisor.”⁷

Yes, it is far too simple to suggest that we have been saying the same thing for more than 60 years. It is foolish to overlook the dramatic changes in our capabilities and understanding of science and medicine that have helped to drive cost over that time, and to merely suggest that we have been promoting a solid primary care foundation as the answer to skyrocketing costs with little success. Still, the words were almost exactly the same in 1949 as they are today. The call to embrace primary care is not a new one. We’ve made progress, but perhaps not enough, and I am reminded of a potential version of the future included in the 2000 Keystone III report where Dr. Larry Green, then of the Graham Center, looked ahead to the “2020 Keystone V” Conference to discuss “why family medicine failed.” While he suggested that this fictional group came to no consensus, there were four main points of view for the “failure” of family medicine.

The first was that the specialty didn’t fail, but rather abdicated.

“In the specifics of specific places, it made sense to turn over the care of the dying, the newborn, the adolescent, the athlete, the discouraged, the pregnant, the bed-bound, the post-operative person – to someone else...but the ultimate result of these adaptations was the erosion of the functional domain until it lost its coherence, that essential totality that made it what it was.”⁸

The second point of view was that “Family Medicine Went Down as a Part of the Old Paradigm.” Here Dr. Green suggested that in addition to well discussed issues within organized medicine and the academic health centers, the demise of family medicine was hastened by the “nearly absent local family doctors” whose “near worship of their

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What it Means to be a Family Physician continued from page 4

There was a strong shift toward “corporatization” of health care and growing complaints by insurance companies that doctors were exploiting traditional fee-for-service payments.

1990s: This decade ushered in an era in which healthcare costs continued to rise well above the rate of inflation.

In 2013, family physicians are confronting these same issues. Headlines pulled from each decade are almost interchangeable with topics we are reading about today. It is past time for things to change. In the words of Edmund Burke: “Those who don’t know history are destined to repeat it.” It is time to understand our history and to stop repeating it.

Moving Forward, Not Repeating History

How do we do this? I have always been fascinated by how a few chosen words can convey a powerful message. That is why I admire simple, thought provoking quotes.

Recently our colleague, Bob Eidus, shared this quote from Rabbi Hillel: “If I am not for myself, then who will be for me? And if I am only for myself, then what am I? And if not now, when?” If you do not value yourself and stand up for yourself, who will? And if you stand up only for yourself and not others, then what are you? Don’t wait; now is the time to act to ensure the future of family medicine.

I am also fond of this Dave Barry quote: “A person who is nice to you, but rude to the waiter is not a nice person.” Actions speak louder than words. I think this is especially important with the changes that have happened in the practice of medicine, as well as those that are coming. If we allow some of our colleagues to be treated differently, we will be allowing a great wrong to our profession and our future presence

and ability to treat our patients. We must all succeed, together.

And finally, in the words of another colleague, Salvatore Bernardo: “I cannot keep my patients healthy if I’m not *healthy*.” We live and practice in one of the most expensive states in the nation – the only state designated as a “distressed primary care practice environment” by the American Academy of Family Physicians (AAFP). Research is clear that a healthy and established primary care base is the best means to keep costs down. Yet New Jersey has fared poorly in *both* Dartmouth studies.^{1,2} Of the 50 states, our services are valued at the lowest in the nation, despite the proclaimed recognition that we are the foundation of improving health care for all. Penalizing primary care will not foster success, but actively supporting it will.

I have been a member of this organization as a county delegate and now serve as president. And, as with the oaths I took upon graduating, I recognize this to be both a great honor and an enormous responsibility. My goal is to continue the work of my predecessors, to represent all members, and to ensure that our accomplishments and efforts in the field of family medicine are recognized. Our profession is the foundation of an efficient and affordable healthcare system; as family physicians, we must commit to making this a reality. ▲

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Supporting New Jersey Residents During Sandy Recovery

As New Jersey recovers and rebuilds from Superstorm Sandy, many New Jersey residents are still facing challenges. Great progress has been made in restoring our communities but some are still in the midst of recovery. Many families are still repairing their homes and some are still displaced because their homes were badly damaged. The Department of Health's recovery plan has focused on increasing awareness and providing resources for social and medical support and environmental health impacts resulting from Sandy.

The stress of a major cleanup and the financial losses incurred as a result of the storm and additional expenses are daunting. Stress disables people, causes disease, precipitates behavioral health issues, leads to substance abuse and destroys relationships and families. The psychological effects of a disaster can be long-lasting, and this can impact an individual's overall health and well-being. No one who experiences a disaster is untouched by it. It is up to health care and public health professionals to recognize how people are affected by disasters and to refer them to appropriate resources for help. I have been working with healthcare providers throughout the state to increase awareness of signs of stress in patients and refer those who are having difficulty during this time of recovery to case management services and medical and behavioral health resources.

The psychological effects of a disaster can be long-lasting. No one who experiences a disaster is untouched by it.

The New Jersey Hope and Healing program helps residents cope with the emotional impact of Sandy. This initiative offers confidential mental health information and referrals at 1-877-294-HELP (4357) (TTY: 1-877-294-4356). The phones are answered by trained counselors who can assist anyone experiencing anxiety or depression. Crisis counselors have been canvassing the state since Sandy, meeting with survivors in their neighborhoods, town halls, churches, and anywhere else where people need help to deal with the damage that goes beyond bricks and mortar. To date, 208,000 residents have been provided information or counseling by Hope and Healing staff.

The Department of Health has been working to prevent and mitigate post-storm environmental health problems so these issues don't cause additional or new challenges to already impacted residents. Individuals and families are at risk from environmental health threats like mold, lead and asbestos as communities repair and rebuild damaged residences and businesses. After the renovation and rebuilding

of communities following Hurricane Katrina, increased lead levels were found in soil—so it is imperative that providers renew their focus on screening children in affected counties. New Jersey has a universal screening law, which requires all children to be tested for lead poisoning at age 1 and age 2 or at least once by age 6. Early diagnosis is critical—it allows children to get treated sooner so serious health and learning consequences can be avoided.

To protect against injury while rebuilding, the Department of Health has launched a public awareness campaign that includes radio public service announcements, op-eds, and educational flyers encouraging people working on recovery efforts to protect their health by wearing goggles, rubber gloves, boots and a respirator and getting a tetanus booster. At the end of June, I joined the Ocean County Health Department and its mobile outreach van at the Ortle Beach A&P to distribute educational materials about West Nile Virus, swim safety, mold remediation and the need for recovery workers to protect themselves.

The Department has distributed more than 10,000 pamphlets (in English and Spanish) providing guidelines to residents on how to assess mold and hire contractors to remove mold. With financial support from the Department, the Rutgers School of Public Health is providing free training classes for home and business owners and volunteers. More than 240 residents have participated in these classes, which have been held throughout the state. There are also classes targeted to public health and building code officials, which more than 500 public officials have already participated in. The brochure and information on training classes are available on the Department's Recovery website at nj.gov/health/er/hurricane_recovery_resources.shtml.

The Department also has a West Nile Virus public education campaign that includes radio public service announcements and advertising on New Jersey Transit trains and busses. Superstorm Sandy created new places for mosquitoes to breed such as wet debris piles and depressions left by fallen trees. Last year, New Jersey had 48 human cases of West Nile Virus, including six deaths. We can reduce the risk of the disease by reminding the public that they should wear insect repellent, repair screens, dispose of debris and remove standing water on their property. More information for residents on West Nile Virus can be found at nj.gov/health/cd/westnile/index.shtml.

Recovering after one of the most devastating storms to ever strike our state can be overwhelming. By partnering with healthcare providers, we can ensure more residents have the resources they need.



Mary E. O'Dowd, MPH

Mary E. O'Dowd, MPH

Commissioner of the New Jersey Department of Health

What Have You Done For Me Lately?

If you are seeing or hearing more of NJAFP or its members lately, there is a good reason for it! Earlier this year, NJAFP created a Rapid Response Media Team to handle reporter inquiries. The word is out and NJAFP is in the spotlight. In case you missed it, some recent communication activities include:

- EVP, **Ray Saputelli** (Trenton), was interviewed on Jim Brown's Common Sense, a syndicated radio program produced by Genesis Communication Network. Ray spoke on the primary care workforce shortage and NJAFP's position on how to address it.
- Opinion pieces from **Ray Saputelli**, written on NJAFP's behalf, on why the role of the APN is best suited to be part of a physician-led healthcare team were published in *the Press of Atlantic City*, *the Asbury Park Press* and on *Lawrenceville Patch*, an electronic news site owned by AOL.
- **Claudine Leone, ESQ.** (Trenton) and **Peter Carrazzone, MD** (North Haledon) were quoted in an article that appeared on the first page of the *Star Ledger* (August 18, 2013) discussing the Affordable Care Act and Medicaid payments.
- A new member testimonial video series called "What is NJAFP?" can be found on YouTube and on NJAFP's Facebook page.
- NJAFP also fielded media calls on Legionnaire's Disease, safeguarding patient data from third party vendors and the prescription drug monitoring program. Calls came for *the Bergen County Record*, *New Jersey TV* and *NJ Spotlight*.

To join NJAFP's Rapid Response Media Team, contact our PR relations specialists, Leza Raffle and Beth Drost at 215-884-6499 or email mediarelations@njafp.org

WHAT DOES HEALTHCARE REFORM MEAN?

Are you looking for information on what healthcare reform really means for you and your patients? Check out these sites for more information...

FamilyDoctor.org features an article entitled *Healthcare Reform: What it Means for You*. The article, which is written for patients, explains what healthcare reform means for children, adults, and seniors. It also answers questions about what reform means if you already have insurance, if you don't have insurance, and if you have preexisting conditions. <http://familydoctor.org/familydoctor/en/healthcare-management/insurance-bills/health-care-reform-what-it-means-for-you.html>

Need information on health insurance? Check out **HealthCare.gov**. This marketplace helps patients and business owners find health coverage that fits their budget and needs. The full site is scheduled to launch October 1, 2013. <https://www.healthcare.gov/>

Want to know more about the Affordable Care Act (ACA)? Visit the Advocacy section of **AAFP.org** for an overview and a comprehensive list of links to relevant information. <http://www.aafp.org/advocacy/informed/coverage/aca.html>

FamilyDoctor.org

HealthCare.gov

AAFP.org

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independence, lack of curiosity and solid contributions to better medicine, and focus on payment systems, resulted in their getting lost in their administrative methods and being 'out-competed' by others in the best execution of specific tasks...the idea of a healer-person was, at least for now, replaced by a healer-virtual, residing somewhere in the healthcare system as a whole.⁸

Additionally, Dr. Green suggested a third and fourth viewpoint; that family medicine failed because it "chose the wrong tasks" and "never became part of the culture." Both of these viewpoints offer equally chilling foreshadowing as we sit closer to the year 2020 that the paper envisioned than the year 2000 in which Dr. Green authored the paper. The pessimist can look at this set of predictions and draw clear parallels to the reality of today. Many will suggest that the most dangerous crisis in family medicine today is the loss – or abdication – of comprehensiveness, which coupled with the inability or unwillingness of many family physicians to embrace change is not only killing, but in fact may have killed, the specialty. Others will point to the same set of facts and suggest instead that it is rather rigidity coupled with a focus on integration, reporting, and validating at the expense of the traditional physician-patient relationship, which is the core of the problem. I understand both points of view, and while I have concerns, I still choose optimism for the future.

I believe that the rumors of the demise of family medicine have been greatly exaggerated. To be certain, there is great change all around us. Today's family physician is far different than the GP of 1949, the family doctor of 1966-67, and even the family physician of 2000.

"A family physician is more than a doctor of medicine. A family physician can throw a curveball or change a diaper, watch his or her child play little league soccer or baseball and most importantly, provide care to the whole

*family and the whole person with a unique quality of care with caring, which is different than most other physicians."*⁹

Practice environments, patterns, and even the people practicing family medicine are changing. Still the more they change, the more they remain the same. Family physicians are still the centerpiece of a healthy healthcare system, they are still the best opportunity we have as a culture to "bend the cost curve" and by far the most well equipped to keep us and our children healthy now and in the future. They are "the ultimate life coach – [working] tirelessly to care for the physical, mental and emotional health of their patients." And while I maintain my role as determined realist, I also remain boldly optimistic about the future – 2020 and beyond.

Many people contributed quotes to this article, each with my promise that they would remain anonymous. My gratitude to each of you – as well as to each family physician who reads this article while continuing to be my inspiration to go to work on your behalf every day – is endless. ▲

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Evidence-Based Questions and Answers

From Rutgers/Robert Wood Johnson School of Medicine

Prevention of Falls in the Nursing Home Setting

Maria Song, MD; Barbara Jo McGarry, MD; Beatrix Roemheld-Hamm, MD, PhD

University of Medicine and Dentistry of New Jersey; Department of Family Medicine and Community Health, New Brunswick, NJ

Question: What Interventions Reduce Falls in Elderly in Nursing Care Facilities?

Evidence-Based Answer

Vitamin D supplementation and multifactorial interventions reduce the rate of falls in the elderly residing in nursing care facilities. Participation in weight-bearing exercises does not show consistent evidence in reducing falls. (SOR A, based on meta-analyses)

Evidence Summary: A 2010 Cochrane meta-analysis about preventing falls in older people in nursing care facilities and hospitals included 41 randomized control trials (RCTs) with 25,422 patients. Five trials of vitamin D supplementation of varied doses on falls were included. The mean baseline vitamin D levels were 22 nmol/L to 49 nmol/L. These studies provided rate data and pooled data from 4,512 participants showing a statistically significant reduction in rate of falls after supplementation with vitamin D (Rate Ratio [RaR] 0.72; 95% CI, 0.55 - 0.95). (Rate of falls means number of falls in a population over a set time period.)

Pooled risk data from all five studies with 5,095 participants did not show a reduction in the risk ratio (RR) of falling (RR 0.98; 95% CI, 0.98 - 1.09).¹ (Risk of fall means the chance that an individual has of falling.)

Nine trials with 3,753 participants in nursing care facilities studied multifactorial interventions. Multifactorial interventions included exercise, medication, surgery, psychological, environmental/assistive technology, social, knowledge, management of urinary incontinence, and fluid or nutritional therapy. Only two of these trials showed statistically significant reduction in rate of falls. Pooled data from the other seven multifactorial trials with 2,997 participants showed no significant difference between intervention and control groups in the rate ratio of falls (RaR 0.82; 95% CI, 0.62 - 1.08).¹

Results relating to the effectiveness of exercise in reducing the rate of falls and risk of falling are inconsistent.² Exercise modalities examined included gait, balance, coordination, functional tasks, strength/resistance, flexibility, 3D (tai chi, qi gong, dance, yoga), general physical activity, and endurance. Two studies (n=53) showed statistically significant reduction in rate of falls, (RaR 0.45; 95% CI, 0.24 - 0.85), but not in risk of falling (RR 0.72; 95% CI, 0.43 - 1.19). In a nursing care facility, 11 trials involved supervised exercise as a single intervention. Pooled data from seven studies (n=1,205) showed no reduction in the rate of falls (rate ratio (RaR) 1.00; 95%

confidence interval (CI), 0.74 - 1.35). Pooled data from another seven studies (n=1,248) showed no significant difference in risk of falling (RR1.03; 95% CI, 0.88 - 1.21).

Studies in this review varied widely in quality with majority of studies (24 out of 41) not having adequate allocation concealment. However, it was recognized that in some studies, it was not possible to blind the participants and treatment providers such as in exercise interventions.

In January 2011, the American Geriatric Society published evidence-based guidelines for the reduction in falls in elderly people and recommended multifactorial interventions such as medication review (SOR B), supplementation with vitamin D (SOR A) and exercises for balance, gait and strength training (SOR A).²

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Usefulness of Self-Glucose Blood Monitoring in Non-Insulin Dependent Type 2 Diabetics

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Question: Does self-monitoring of blood glucose affect hemoglobin A1c levels in non-insulin dependent type 2 diabetics?

Evidence-Based Answer

Regular self-monitoring of blood glucose levels does not seem to improve hemoglobin A1c (HbA1c) values in patients with non-insulin dependent type 2 diabetes (NIDDM), except possibly in patients with HbA1c levels above 8.0%. (SOR A, based on meta-analyses and individual randomized clinical trials (RCT).

Evidence Summary: A 2008 meta-analysis evaluated the efficacy of self-blood glucose monitoring (SBGM) among patients with NIDDM. Patients who monitored their HbA1c levels regularly were compared to those who did not. Nine trials (total n= 29,988) met the selection criteria (SMBG [self-monitoring of blood glucose] with HbA1c as an outcome). Five of these trials were identified for a 6-month duration showing an average HbA1c level reduction of -0.21% (95% CI, -0.38% to -0.04%). Four of these trials were identified for a year long duration showing an average reduction of

HbA1c levels of -0.16% (95% CI, -0.38% to 0.05%). The authors concluded that self-monitoring produced a statistically, but not clinically, significant change and questioned the value of this intervention in meeting target HbA1c goals.¹

A different 2009 meta-analysis examined the benefit of SBGM in NIDDM patients. A literature search was performed searching for RCTs comparing SMBG with non-SMBG in patients with NIDDM, using HbA1c levels as an outcomes measure. Eleven out of 19 trials met these criteria. SMBG resulted in an overall reduction of HbA1c levels by -0.24% (pooled mean difference) (95% CI, -0.34% to -0.14%). A subgroup analysis of nine trials (n=2,419) was also completed to measure differences based on baseline HbA1c levels. Subgroups were divided into three sections: baseline <8.0%, between 8.0%-10.0%, and >10.0%. In the >10.0% subgroup, HbA1c levels were reduced -1.23% (pooled mean difference) (95% CI, -2.31% to -0.14%). In the subgroup 8.0% to 10.0%, HbA1c levels were reduced -0.27% (pooled mean difference) (95% CI, -0.40% to -0.14%). In the subgroup <8.0%, HbA1c levels were reduced only -0.15% (95% CI, -0.33% to 0.03%). The authors concluded that SMBG is useful for patients with HbA1c levels >8.0%.²

A separate RCT assessed the effect of SMBG on glycemic control in patients with newly diagnosed type 2 diabetes mellitus. The trial was conducted in diabetes clinics rather than a primary care setting (n=184 patients <age 70). Those requiring insulin or already doing SMBG were excluded. Two groups were followed for one year: a control group and a SMBG group, where subjects were instructed to test their blood sugar four times per day. Both groups received additional education on diabetes and nutrition. Each group was monitored every three months. No difference was found between the groups in HbA1c levels after 12 months (CI 95%, -0.25% to 0.38%).³

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Does Exercise Affect Glycemic Control in Type 2 Diabetic Patients?

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Question: Does an aerobic exercise regimen affect glycemic control in type 2 diabetic patients?

Evidence-Based Answer

Aerobic exercise with an intensity of more than 10 metabolic equivalents (METs) per hour per week significantly decreases HbA1c levels. (SOR A, based on a meta-analysis and RCT [randomized controlled trial].) In the geriatric population, walking 2.5 to 2.75 miles daily is associated with better glycemic control than less activity (an epidemiologic association, no SOR).

Evidence Summary: A meta-analysis of 14 controlled trials (n=504) with 11 RCTs reviewed and quantified the effects of physical activity on hemoglobin A1c (HbA1c) and body mass in patients with type 2 diabetes.¹ Included were adults, average age 55.0 (standard deviation (SD) 7.2) years, 50% female, with type 2 diabetes for 4.3 (SD 4.6) years with therapy duration greater than 8 weeks. Pharmacotherapy was allowed but not required for inclusion. There were 2 resistance training studies and 12 aerobic activity studies with a mean of 3.4 times per week (SD 0.9) for an average of 18 weeks. The average time of each training session was 53 minutes with a moderate intensity of walking or cycling. Meta-analysis of the 12 aerobic training studies demonstrated that the weighted mean HbA1c values between the control and post-interventional groups decreased by 0.66% (P<0.001), with insignificant HbA1c differences in subgroup analysis between aerobic and resistance exercise groups.¹

One randomized clinical trial (RCT) (n = 179) determined the long-term impact of physical activity of various intensity on HbA1c levels in type 2 diabetes patients.² The study population was adults with type 2 diabetes, mean age 62. Subjects were randomly assigned to one of six interventions of differing METs (metabolic equivalents) per hour per week. (Table 1).

An observational study with 142 adults, mean age 72 years, and mean body mass index (BMI) 29, investigated the relationship between exercise duration and HbA1c levels in a multi-ethnic geriatric population. Oral hypoglycemic medications were allowed but were not an inclusion criterion.³ Data included anthropometric measurements, HbA1c levels, and pedometer readings. On average, the subjects reported taking 3,939 +/- 232 steps (approximately 2.0 miles) daily.³ Results demonstrated that subjects with HbA1c levels lower than 7.0% and fasting serum glucose levels lower than 100 mg/dL walked approximately 1,343 steps (0.5-0.75 miles) daily more than those with abnormal HbA1c levels and/or fasting plasma glucose levels.³

Table 1. Effect on HbA1c of Increasing Exercise Intensity in Patients with Diabetes after 2 Years²

METs Increase (hrs/week)	Group Size (n)	HbA1c Change (mg/dL)
0.6 +/- 0.3	28	+0.03
6.3 +/- 0.4	27	-0.06
17.1 +/- 0.4	31	-0.4
27.0 +/- 0.5	27	-0.9
37.5 +/- 0.5	32	-1.1
58.3 +/- 1.8	34	-1.0

Physical exercise with energy expenditure greater than 10 METs per hour per week (i.e., jogging at 6 mph for 1 hour/week or brisk walking at 4 mph for 2 hours/week miles per hour) significantly affected HbA1c levels in adults with type 2 diabetes.

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Does Treating Depression Improve Glycemic Control in Diabetics?

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Question: Does treating depression improve glycemic control in diabetics?

Evidence-Based Answer

In diabetic patients with comorbid depression, treatment of depression can improve glycemic control. Psychosocial interventions (lifestyle or psychological interventions) alone can improve diabetes control; antidepressant pharmacotherapy alone does not appear to be sufficient. It is unclear which psychosocial intervention is the most beneficial. (SOR: B - inconsistent meta-analyses)

Evidence Summary: Patients with diabetes have an increased rate of comorbid depression, and those with depression are less adherent to medical care¹ and have more complications.² Two meta-analyses published in 2010 explore the effect of treating depression on glycemic control in patients with comorbid depression and diabetes mellitus.

The first meta-analysis³ included 14 randomized controlled trials (RCTs) with 1,724 patients with depression and either type 1 or type 2 diabetes, comparing the effects of antidepressant treatment, including psychotherapeutic interventions and/or medications, on depression symptoms and glycemic control. Patients in these studies were on average between 50 to 60 years of age; only one study included a wide range of ages (21 to 65 years old). Treating depression resulted in improvement in glycemic control in only 6 of the 14 studies, 5 of which included a psychotherapeutic intervention (cognitive behavioral psychotherapy [CBT] or supportive therapy, including psychoeducation and diabetes self-management training). Only one study demonstrated improvement in glycemic control when comparing pharmacotherapy (sertraline) alone with placebo. The overall meta-analysis demonstrated a small effect size on glycemic control, -0.274 (95% CI -0.402 to -0.147), measured by HbA1c levels or fasting blood glucose (FBG) levels. This effect size indicates that the intervention group's mean HbA1c level was decreased by approximately 0.27 as compared to the

control group. The meta-analysis also demonstrated a larger effect size on depressive symptom severity, -0.512 (95% CI -0.633 to -0.390), as measured by different validated questionnaires including BDI (Beck Depression Inventory), SDS (Shwachman-Diamond Syndrome), HAM-D (Hamilton Rating Scale for Depression), HADS (Hospital Anxiety and Depression Scale), and SCL-20 (Symptom Checklist-20). Secondary analysis from only the 8 strongest RCTs yielded similar results.

The second meta-analysis⁴ included 49 RCTs with patients with type 1 or type 2 diabetes who received psychosocial interventions where both mental health outcomes and HbA1c levels were reported. In contrast to the first meta-analysis, comorbid depression was not a specific inclusion criterion of these studies. The majority of the studies included only patients who were over 50 years of age and the studies were performed in a specialist setting. Only 10% of patients had baseline depression. Mental health scales were described as "standardized measures of depression, anxiety, or mental health; the SF36 (Medical Outcome Survey Short Form) was given as an example. Psychosocial interventions were either lifestyle interventions to manage diabetes (education, exercise) or psychological intervention to manage mental health (CBT [cognitive behavior therapy], problem solving, or social support). Pharmacological interventions were excluded from this analysis. Although there was improvement in both HbA1c levels and mental health as a result of psychosocial interventions, there was only limited correlation between the improvement in HbA1c levels and mental health scores. Psychosocial interventions were shown to modestly improve HbA1c levels (-0.29 [95% CI -0.37 to -0.21]) and mental health outcomes (-0.16 [-0.25 to -0.07]).

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Which Weight Loss Diet is Most Effective for Improving Glycemic Control in Type 2 Diabetics?

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Question: Which weight loss diet is most effective for improving glycemic control in type 2 diabetics?

Evidence-Based Answer

Restricting carbohydrate intake in type 2 diabetics appears to result in short-term reductions in weight, hemoglobin A1c (HbA1c) levels, fasting blood sugar levels, and triglyceride levels (SOR A, based on meta-analysis). However, these effects are not sustained in the long term, and similar reductions in weight and HbA1c levels are observed in patients consuming either a low-carbohydrate or a low-fat diet at 12-month follow-up. (SOR B, based on individual RCT).

Evidence Summary: A recent meta-analysis evaluated the effects of dietary carbohydrate restriction on weight, blood glucose levels, and lipid levels over a 120-day period in type 2 diabetics. Studies with a wide range of restricted dietary carbohydrate content (4% to 45% of caloric intake) were included. The analysis excluded children as well as patients with type 1 diabetes, gestational diabetes, and prediabetes. A total of 329 abstracts were initially reviewed, and 13 studies were included for analysis. (Average age 57, five studies included at least some participants on insulin, and seven studies were isocaloric by design.) The data indicated that fasting blood glucose and triglyceride (TG) levels improve with lower carbohydrate content diets, and that a 10% increase in carbohydrate caloric intake correlates with a 3.2% increase in glucose levels ($p=0.047$), and a 7.6% increase in serum TG levels ($P=0.001$). However, a statistically significant trend in weight loss was not found.¹

A small study compared two different diets in an inpatient setting, investigating the short-term effects of a low-carbohydrate diet on body weight, glucose, and lipid metabolism in obese patients with type 2 diabetes ($n=10$, average age 51, 70% male, 70% black, 30% white, BMI 40.3 \pm 5.7). In short, study participants were observed for 7 days on a usual diet, and then switched to a low-carbohydrate diet for an additional 14 days (low-carbohydrate diet consisted of 21 grams of carbohydrates per day, with an allowance for unlimited dietary protein and fat intake). During the initial phase, weight remained stable. The carbohydrate restriction intervention resulted in an average weight loss of 2.02 kg ($p=.042$), markedly improved glycemic control (HbA1c level reduction from 7.3% to 6.8%; $p=0.006$), a decrease of plasma triglycerides (TG) by 35%

(from 162.83 \pm 5.58 mg/dL to 105.31 \pm 2.65 mg/dL; $p<0.001$) and decrease of total cholesterol by 10% (from 180 mg/dL to 163 mg/dL; $p<0.02$).²

A two-arm, non-blinded RCT compared the effects of a one-year intervention using a low-carbohydrate diet modeled after the Atkins diet vs. a low-fat diet modeled after the Diabetes Prevention Program ($n=154$, average age 54, 78% female, 63% black, 14% white, 16% Hispanic, 3% Asian, 2% other). Overweight adults with type 2 diabetes achieved significant weight reduction in both arms, with faster weight loss during the first three months in the low-carbohydrate diet group (1.7 kg/month, 95% CI, 1.4-2.0) than in the low-fat group (1.2 kg/month, 95% CI, 0.86-1.5), but some weight gain in months 3 to 12 in the low-carbohydrate group (+0.23 kg/month, 95% CI, 0.09-0.35) vs. the low-fat group (<0.01 kg/month; 95% CI -.13 to .14). Sustained weight loss was similar in both groups (3.4%), but no significant difference in HbA1c or TG levels was observed between each group at 1-year follow-up.³ ▲

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STRENGTH OF RECOMMENDATION

DEFINITION

A

Recommendation based on consistent and good quality patient-oriented evidence

B

Recommendation based on inconsistent or limited quality patient-oriented evidence

C

Recommendation based on consensus, usual practice, expert opinion, disease-oriented evidence, and case series for studies of diagnosis, treatment, prevention, or screening

<http://www.aafp.org/journals/afp/authors/ebm-toolkit/strength.html>

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Evidence-Based Questions & Answers

- 1. Which of the following is a short-term effect of adhering to a low carbohydrate diet?** a) Decrease of plasma triglycerides; b) Decrease of total cholesterol; c) Reduction of fasting blood sugar levels; d) Weight loss; e) All of the above.
- 2. Evidenced-based guidelines for reducing falls in elderly people include which of the following interventions?** a) Balance exercises; b) Gait exercises; c) Medication review; d) Strength training; e) All of the above.
- 3. To reduce falls in elderly patients in nursing care facilities, randomized controlled trials measured supplementation with which of the following vitamins?** a) A; b) B; c) C; d) D; e) E.
- 4. An analysis of type 2 diabetics who regularly self-monitored their blood glucose levels compared with those who did not showed that self-monitoring of blood glucose levels is useful for patients with HbA1c baseline levels:** a) less than 1.5%; b) between 2.0% and 4.0%; c) between 5.0% and 6.0%; d) equal to 7.0%; e) greater than 8.0%.
- 5. Patients with type 2 diabetes who jog once weekly at what pace will expend enough metabolic equivalents to decrease HbA1c levels?** a) 2 mph; b) 3 mph; c) 5 mph; d) 6 mph; e) None of the above.
- 6. True or False:** Psychosocial interventions have been shown to modestly improve HbA1c levels and mental health outcomes in patients with diabetes.
- 7. True or False:** Aerobic exercise with an intensity of more than 10 metabolic equivalents (METs) per hour per week significantly decreases HbA1c levels in patients with type 2 diabetes.
- 8. True or False:** In a randomized clinical trial that assessed the effect of self-monitoring blood glucose (SMBG) levels in patients with newly diagnosed type 2 diabetes, no difference was found between the control group and the SMBG group after 12 months of testing their blood sugar levels four times/day.
- 9. True or False:** Patients with diabetes have a decreased rate of comorbid depression.
- 10. True or False:** Results relating to the effectiveness of exercise in reducing the rate of falls and risk of falling in elderly persons are inconsistent.

ANSWERS ON PAGE 30

The Affordable Care Act 101 – Implementation and Implications *The Healthcare Crisis*

Tara Zahodick, MHA

Tara Zahodick, MHA contributes to the Comprehensive Primary Care Initiative and the Immunization CME Project for the NJAFP.

The nation's healthcare crisis starts with the 50 million uninsured residents, as well as approximately 10 million additional residents who are underinsured in the United States. To add insult to injury, there are also 129 million residents with preexisting conditions, resulting in increases in their insurance premiums, making coverage unaffordable. The state of New Jersey has approximately 900,000 uninsured residents, accounting for about 12% of its population.

THE STATE OF NEW JERSEY HAS APPROXIMATELY 900,000 UNINSURED RESIDENTS, ACCOUNTING FOR ABOUT 12% OF ITS POPULATION.

The Affordable Care Act (ACA) is the largest, not to mention among the most complicated, piece of healthcare legislation to be ratified since the Medicare and Medicaid programs were passed in 1965. With an effective date of January 1, 2014, many patients and healthcare professionals have not yet been exposed to educational opportunities regarding the impact of the ACA. It is important to learn and understand the implication the ACA will have on primary care in New Jersey.

Implementation of the Affordable Care Act

The ACA has five major goals for improvement:

1. Expand Medicaid and strengthen Medicare
2. Protect patients from insurance company abuse
3. Make health care more affordable
4. Improve access to health care
5. Improve the quality of care

To improve access to health care, the Centers for Medicare & Medicaid Services (CMS) has created The Health Insurance Marketplace. This Marketplace will provide an insurance exchange with multiple options for coverage; individuals, families and businesses

will have the opportunity to access affordable health insurance coverage. One streamlined application will determine if the coverage will be through Medicaid Expansion or through the purchase of a private health plan policy. Tax credit eligibility for many individuals who purchase their own plan will be based on their income and family size.

The application and enrollment process begins on October 1, 2013 (with the policy effective date of January 1, 2014); open enrollment will be available until March 31, 2014. The application will be available at: <https://www.healthcare.gov/marketplace/>.



Implications for Primary Care

With the enrollment date rapidly approaching, CMS needs help from the healthcare community to disseminate information about The Health Insurance Marketplace to our currently uninsured patients. Since the patients will have multiple options to choose from, it is going to be a bit of a challenge. The ACA provided funding to Federally Qualified Health Centers to train/hire navigators and certified application counselors that can assist patients apply for and select suitable plans. In addition, assistance will also be available online and over the telephone: <https://www.healthcare.gov/>; <https://cuidadodesalud.gov/> or 1-800-889-4325.

Furthermore, Medicaid expansion in New Jersey will help uninsured residents get coverage based on income (it will no longer take into consideration assets and resources). The State of New Jersey projects that of the 900,000 uninsured residents, 300,000 will be eligible to become Medicaid beneficiaries beginning in 2014. As an incentive for physicians to accept and treat the influx of new Medicaid patients in the state, the reimbursement rates for Medicaid will increase and be comparable to those of the Medicare reimbursement rates. This increase will be in effect for two years on a trial basis.

Despite the sometimes-negative stigma, the ACA has the potential to positively affect physicians and patients. Being informed around the Act is the best way to be able to reap the benefits provided through the new legislation. Patients will be able to obtain affordable coverage regardless of preexisting conditions and physicians will be able to increase their patient panels with more insured individuals. ▲

NJAFP SUMMER CELEBRATION & SCIENTIFIC ASSEMBLY HIGHLIGHTS

This year's SCSA saw record-breaking attendance, new and innovative educational programs, a pre-conference focused on physician practice improvements, and a host of other events. If you missed the Assembly, check out the YouTube highlights and get ready for 2014, when we will be returning to the Sheraton Atlantic City Convention Center Hotel, June 13-15.

Actions of the House of Delegates

The 2013 House of Delegates (HOD) convened on Friday, June 21 at 8am. Delegates were present from the following counties: Atlantic/Cape May, Bergen, Burlington, Essex, Hunterdon, Mercer, Monmouth, Morris, Ocean, Passaic, Somerset, Sussex, and Union.



2013 House of Delegates

The following resolution was adopted this year and will be presented to the Congress of Delegates this September in San Diego at the American Academy of Family Physicians annual meeting.

NJAFP 2013 Resolution #1

Proposed by Kathleen Saradarian, MD

Resolved that the NJAFP ask the AAFP to form a new Special Interest Group to assure that the needs and concerns of Solo and Small Group Family Physicians continue to be a priority, focus and consideration of the AAFP.

Action: Approved

In the News...

NJAFP Past-President, **Sal Bernardo, MD** (*Freehold*) was interviewed by the *Star Ledger* on the trend toward recommending the HPV vaccine to teenage males.

Jodie Katz, MD (*Waldrick*) was featured in a story on stress reduction and her presentation at the 2013 Summer Celebration & Scientific Assembly in the *Paramus Post*.

Jeff Brenner, MD (*Camden*) appeared in a June 27th article in *NJ Spotlight* on the need to coordinate health care in New Jersey.

The following resolutions were approved or referred to the NJAFP Board of Directors for further action:

NJAFP 2013 Resolution #2

Proposed by Kathleen Saradarian, MD

Resolved that the NJAFP Board explore the issue of virtual meetings and report back to the House of Delegates in 2014.

Action: Approved

NJAFP 2013 Resolution #3

Proposed by Thomas A. Shaffrey, MD

Resolved that the NJAFP and AAFP be instructed to seek governmental and regulatory relief of such insurance company practices and protect the rights of independent physician practices from such practices which result in restraint of trade by requesting the following provisions be applied for all health insurance companies, regardless of exemptions or provisions of any federal or state law:

1. That health insurance companies be specifically prohibited from denying payment to a patient, or with their approval directly to their physician, by specifying a deductible on any healthcare policy for out-of-network physician benefits, for healthcare services provided by their chosen out-of-network physician, and further that such companies be required to cover for such services at a minimum of the greater of the local Medicare rate or the median amount for such services for which the company has paid;
2. That insurers institute effective and timely internal mechanisms to process and pay patient claims and perform all referral or any such prior approval requests for patients who choose to see an out-of-network physician, and within the same time frame as would be done for services and prior approval requests as provided by a contracted physician.

Action: Referred to the Board

NJAFP 2013 Resolution #6

Proposed by Terry Shlimbaum, MD

Resolved that the NJAFP Board of Trustees form a task force whose mission is to plan a strategy to advocate for the formation of an Office of State Healthcare Planning and Policy, the purpose of which would be to prioritize and integrate healthcare resources, and establish a consistent, focused healthcare policy in the state of New Jersey.

Action: *Approved*

NJAFP 2013 Emergency Resolution #1

Proposed by Richard Cirello, MD

Resolved that the House of Delegates express its deepest sympathy on the passing of our colleague, Edward A. Schauer, MD, FAAFP and the high regard in which he was held. Be it further

Resolved that a copy of this Resolution be sent to his family.

Action: *Approved*

MEETING HIGHLIGHTS

The biggest highlight of the NJAFP year is the installation of our new president and board of trustees. This year we were honored to have AAFP President-Elect Reid Blackwelder, MD as our officiating representative. Dr. Blackwelder performed the installation ceremony for incoming president Thomas A. Shaffrey, MD, as well as the new officers and trustees. Please congratulate our new board:



AAFP President-Elect, Reid Blackwelder, MD administers the Oath of Office to incoming President, Tom Shaffrey, MD

President: **Thomas A. Shaffrey, MD** (*Bound Brook*)
President Elect: **Krishna Bhaskarabhatla, MD** (*Woodland*)
Vice President: **Robert Gorman, MD** (*Verona*)
Treasurer: **Adity Bhattacharyya, MD** (*Trenton*)
Secretary: **Peter Louis Carrazzone, MD** (*North Haledon*)
Board Chair: **Salvatore Bernardo, Jr., MD** (*Freehold*)



Reid Blackwelder shares a laugh with executive officers, Bob Gorman and Adity Bhattacharyya.

New Trustees:

Michael A. Cascarina, MD 2016 (*Brick*)
Maria F. Ciminelli, MD 2016 (*Freehold*)
Christina Medrano-Phipps, MD 2016 (*Bridgewater*)
Kathleen Saradarian, MD 2015 (*Branchville*)
Kelly G. Ussery-Kronhaus, MD 2014 (*Trenton*)
Gerald C. Banks, MD 2015 (*Resident Trustee – Trenton*)
Chelsea Brower 2014 (*Student Trustee – Mountain Lakes*)
Monali Desai 2014 (*Student Trustee – Elmwood*)
Joseph W. Schauer III, MD 2014 (*Voting Past President – Farmingdale*)
Mary A. Willard, MD 2014 (*Voting Past President – Marlton*)
Richard L. Corson, MD 2015 (*AAFP Delegate – Hillsborough*)
Mary F. Campagnolo, MD 2015 (*AAFP Alternate Delegate – Bordentown*)

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The new Board members installed at the President's Gala.

A Special Congratulations to all our 2013 Award Winners:

Annual Meeting Chair: **Krishna Bhaskarabhatla, MD** (Woodland)
 President's Award: **Joe Wiedemer, MD** (Verona)
 The NJAFP Chair Award: **John Ruiz, MD** (New York)

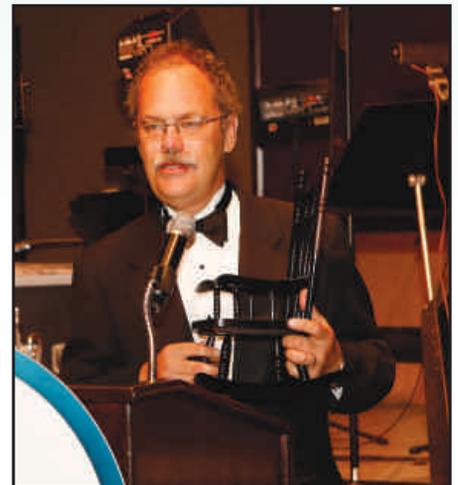
The Academy congratulated **Marcus Magnet, MD** (Woodbury) as the New Jersey Family Physician of the Year and **Marissa Jimenez, DO** (New Brunswick) as the New Jersey Resident of the Year.



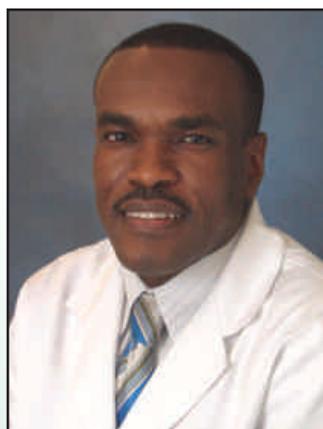
Annual Meeting Chair – Krishna Bhaskarabhatla, MD



President's Award – Salvatore Bernardo, Jr., MD presents Joe Wiedemer, MD the President's Award.



NJAFP Chair Award – John Ruiz, MD



Marcus Magnet, MD is the 2013 NJ Family Physician of the Year. Inspira Health Network, Woodbury Medical Center President, Eileen Cardile accepted on Dr. Magnet's behalf.



Marissa Jimenez, DO flanked by UMDNJ-RWJ Program Director, Karen Lin, MD and Immediate Past President, Sal Bernardo, MD

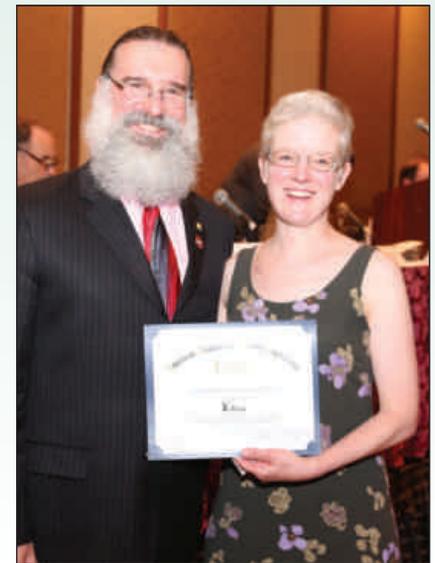
In a Stunning Comeback...



2013 Coveted NJAFP Resident Knowledge Bowl Cup winners – JFK!

Two-time winners, **JFK Family Medicine Residency Program (Edison)** dethroned the 2012 champs, UMDNJ –RWJ at Capital Health (*Trenton*) and retook the Coveted NJAFP Knowledge Bowl Cup. Congratulations to team members: **Ohad Sheffy, MD; Sadaf Gardizi, MD; Mike Gannon, MD; Jennifer Kneppar, MD; James Thatcher, MD; and Dominica Yi, MD!**

Special congratulations also go to **Patricia Haeusler Kroth, DO** who was conferred the AAFP Degree of Fellow by **Dr. Reid Blackwelder** at the House of Delegates.



Dr. Blackwelder and new Fellow, Dr. Kroth.

Research Poster Contest Winners for 2013

PHYSICIAN CATEGORY

First Place in the **Physician category** went to “A Program to Test the Effectiveness of Computerized Translation Devices in an Office Setting” by **Bennett Shenker, MD (Freehold)** from CentraState Family Medicine Residency.

Second Place in the **Physician category** went to “Assuming Excellence vs. Pursuing Excellence: How Clinician Attitudes Toward Performance Data Impact Quality Improvement Efforts” by **Jeanne Ferrante, MD (New Brunswick)** from UMDNJ Medical School.

RESIDENT CATEGORY

In the **Resident category**, **First Place** was awarded to “Childhood Community Acquired Pneumonia,” by **Jenny Abouselsood, MD (Trenton)** from Capital Health.

And in the **Second Place Resident category**, the award went to “Which of the AAFP’s Recommended Risk Assessment Tools is Most Sensitive in Predicting Aberrant Drug-Related Behavior Among Patients Receiving Opioids for Chronic Pain Management” by **Gerald Banks, MD (Freehold)** from CentraState Family Medicine Residency.



Bennett Shenker, MD (r) and colleague, Vladimir Markovic, MD (l) hold up their winning poster in their CentraState office.

2013 Summer Celebration & Scientific Assembly Highlights

If you missed the **2013 Summer Celebration & Scientific Assembly**, you don't have to miss out on all of the fun. Check out the highlights for the meeting on the **NJAFP YouTube** page at <http://www.youtube.com/watch?v=CurlRQBHzM>



Members attended valuable CME sessions during the day and danced the night away to the rockin' tunes from the Kenny I Orchestra.

ACTION ALERT

What Physicians Must do to E-Prescribe All Controlled Substances

Claudine M. Leone, Esq.

Claudine M. Leone, Esq. is the Government Affairs Director for the NJAFP.

NJAFP has been fielding many questions from practices experiencing a change in the way pharmacies are accepting electronic prescribing of controlled, dangerous substances (CDS). Some New Jersey pharmacies that previously accepted e-prescribing of Schedule III, IV, and V controlled substances are now rejecting these prescriptions.

So what changed?

New Jersey regulations under the NJ Board of Medical Examiners, the NJ Board of Pharmacy, and the NJ Drug Control Unit authorize electronic prescribing of all CDS, *if permitted by federal law*. So, until recently everything but Schedule II drugs were permitted to be e-prescribed under federal law (and New Jersey) and all was good.

In 2010, the Federal Drug Enforcement Administration (DEA) approved interim rules finally authorizing e-prescribing for Schedule II CDS. These rules, however, also developed a new certification process for e-prescribing of all CDS. This is now referred to as EPCS: E-prescribing Controlled Substances. That interim federal rule is now being implemented across the country and is causing some of the changes you may be seeing with acceptance of e-prescribed scheduled drugs at your pharmacies and with your application vendors.

Simply put, while these federal rules now permit the e-prescribing of all scheduled drugs, the federal regulations require prescribers, prescriber software vendors, pharmacies and pharmacy software vendors to complete certain steps to meet the DEA's requirements for EPCS.

This is, again, for all scheduled drugs. So, even though NJ law previously permitted you to e-prescribe Schedule IV drugs, for example, without this certification, the DEA is now requiring it for all EPCS. If you are experiencing rejections of e-prescriptions for any scheduled drugs right now, what is likely happening is that someone in the e-prescribing chain hasn't completed their "step." Let's make sure it isn't family physicians!

For each provider in your practice who wishes to send prescriptions for controlled substances electronically, there are steps you must complete to comply with the federal requirements:

- 1. Verify EPCS is legal in your state** (YES – confirmed by NJAFP)
- 2. Ensure that your e-prescribing software is certified for EPCS:** Check directly with your software vendor or go

to <http://www.surescripts.com/connect-to-surescripts/prescriber-software.aspx> and select the "EPCS certified" field at the bottom.

- 3. Receive an audit report generated by your software vendor indicating compliance with the DEA Interim Final Rules (IFR).**

You must get this directly from your software vendor.



- 4. Adhere to ID verification procedures and access controls: ID Proofing, Two-Factor Authentication, Digital Signing.**

The DEA expects your application providers will work with CSPs (approved credential service providers) or CAs (certification authorities) to direct you to one or more sources of two-factor authentication credentials that will be interoperable with their applications. You should contact your application provider to determine which CSP or CA your provider recommends. NJAFP has been told the ID verification process will take about 15 minutes.

Now with all of this said, the federal interim rule on EPCS is voluntary. But don't get me wrong, if you wish to e-prescribe any schedule of CDS, you must certify through the process above. The DEA, however, did not mandate that all prescribers and pharmacies e-prescribe CDS and accept e-prescribed CDS. So, you may find some of the small independent pharmacies may choose not to certify under these rules and will not accept EPCS, at all. The larger retail chain pharmacies are all working through the process. Walgreens and Rite Aid have already completed certifications nationally and CVS is rolling out its EPCS certification state by state (at the time of this publication, CVS had not rolled out in New Jersey).

For more information, Surescripts does a good job outlining the processes required for all partners in EPCS: <http://www.surescripts.com/about-e-prescribing/e-prescribing-of-controlled-substances>.

The Federal Department of Justice site also has a great Frequently Asked Questions Section on EPCS: http://www.deadiversion.usdoj.gov/e-comm/e_rx/faq/practitioners.htm#individual.

We will continue to provide updates via Magnet Mail (electronic emails from NJAFP) and *Perspectives* throughout this implementation process.

I can be reached at (609) 394-1711 or claudine@njafp.org for any questions or comments. ▲

OpenNotes: Are they for you?

Susan B. Orr, Esq.

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

In response to the growing demand for patient engagement, shared decision-making and transparency in health care, physicians are making their notes available to patients. This was the focus of a recent year-long study called “OpenNotes,” funded by the Robert Wood Johnson Foundation. Providing patients with access to their medical records, including physician notes, has many legal implications for physicians, including CMS’s Meaningful Use Stage II requirements, state law and HIPAA’s privacy and security requirements.

What are “OpenNotes”?

Generally, “open notes” means making physician notes accessible to patients through an electronic health record or a secure patient portal. The OpenNotes project demonstrated and evaluated the impact on both patients and clinicians of granting patients full access, through an electronic portal, to their medical records, including all physician notes.

Three hospitals participated in the study: Beth Israel Deaconess Medical Center, an academic medical center in Boston; Geisinger Health System, a rural integrated health system in Danville, PA; and Harborview Medical Center, a county hospital in Seattle. About 105 primary care physicians participated in the study along with over 13,000 patients who had at least one completed note available during the study period. Patients registered for portal access enabling them to view their medical records, including notes, online for 12 months. After each office visit, patients received a secure email informing them that notes were available for viewing, and they were encouraged to review the notes prior to their next visit.

Physicians expressed initial concerns about sharing their notes, feeling that it would increase their work load as it would be time-consuming to write notes patients could understand and to answer patients’ questions, follow-up calls and emails. They thought medical jargon could confuse patients or create unnecessary stress, worry or anxiety for patients. Patients may misinterpret notes without the physician’s input. Finally, they thought visits would take longer because of increased patient discussions.

Results of OpenNotes Study

The study results yielded positive feedback from both patients and physicians.

Patient feedback from the OpenNotes project:

- 47% to 92% — Opened at least one note (although only 19% reported to their doctor that they used the notes)
- 77% to 87% — Felt more in control of their care

- 77% to 85% — Understood health conditions better
- 76% to 84% — Remembered care plan better
- 70% to 72% — Took better care of self
- 60% to 78% — Increased medication adherence
- 26% to 36% — Had concerns about privacy
- 5% to 8% — Worried more
- 2% to 8% — Found notes more confusing than helpful
- 1% to 2% — Felt offended
- 86% to 89% — Open notes are a “Somewhat” or “Very Important” factor in choosing a physician
- 99% — Wanted continued access



Physician feedback from the OpenNotes project included:

- 46% to 73% — Estimated they had conversations with patients about open notes less than monthly
- 30% to 43% — Reported no or few patients mentioned notes
- 0% to 21% — Reported taking more time writing notes
- 3% to 36% — Changed what they wrote in notes
- 0% to 8% — Spent more time addressing patient questions
- 0% to 5% — Reported longer visits
- 0% — Reported significant changes in email volume
- 0% — Decided to stop using open notes

Physicians also suggested that the hospital provide education or “tip-sheets” for physicians to make them more aware of how the patient will see and interpret the notes. Clearly this was a positive experience for physicians, especially those whose fears were not realized.

Legal Considerations

Patient access to notes can be an empowering experience for patients, an unexpectedly non-invasive experience for physicians, and a positive one for both. As time and technology continue to advance, patient access will become more prevalent, and physicians must be aware of applicable laws.

1. The Stage II meaningful use requirements, effective in 2014, include two core measures involving electronic access and

require that (1) more than 50% of patients are provided timely (within 4 days of availability) online access to their health information, and (2) more than 5% of patients must view, download or transmit to a third party their electronic records. Quantifiably measured electronic interaction by patients will impact physicians' ability to qualify for incentive payments.

- Both state and federal law grant patients access to physician notes. New Jersey law requires physicians to provide a patient or the patient's authorized representative access to professional treatment records, including physician notes. However, a physician may refuse to provide "the subjective information contained in the professional treatment record" if "in the exercise of professional judgment [the physician] has reason to believe that the patient's mental or physical condition will be adversely affected upon being made aware of" such information.
- HIPAA grants patients the right to review or receive a copy of and request electronic access to their complete medical records, including physician notes (with limited exceptions, such as psychiatric notes). HIPAA permits a physician to deny access when the physician determines access is likely to endanger the life or physical safety of the patient or another person, or when the record refers to another person and the physician determines that access is reasonably likely to cause substantial harm to that other person. The access rights and limitations under both New Jersey law and HIPAA should be clearly laid out in HIPAA privacy policies.

Be sure to have HIPAA-compliant policies and procedures for proxy access to EHRs, including clinical notes. Giving caregivers access to complete medical records can medically benefit patients (e.g., elderly patients). Finally, keep in mind that while the Open Notes Project featured computer-based access to physician notes, patients who are not computer-based must still be given access to records and notes upon request.

Is there potential for increased lawsuits with increased access to Notes?

Some physicians fear that increasing patient and family access to notes could lead to malpractice lawsuits. While notes may reveal dormant errors that are merely minor mistakes, they could also reveal substantial errors that could generate lawsuits. However, other physicians believe that open notes cultivate improved trust and communication that may ultimately reduce liability risk.

Conclusion

Clearly a benefit of open notes is that they enhance transparency, which, in turn, builds partnerships between physician and patients in care management. Ensuring that this process complies with legal requirements enhances this experience. ▲

If you have questions about OpenNotes or other practice management issues, contact Susan Orr, Esq., Tsoules, Sweeney, Martin & Orr, LLC at 610-423-4200 or email her at sorr@tshealthlaw.com.

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Report from the 2013 AAFP National Conference for Residents and Students

Steven Nguyen, MD

Steven Nguyen, MD is the senior Resident Trustee for the NJAFP Board of Trustees.

The 2013 Annual AAFP National Conference for Residents and Students (NCRS) took place in Kansas City, Missouri August 1-3. New Jersey was well-represented this year by NJAFP resident trustees, Jerry Banks, MD and I, and NJAFP student trustees, Chelsea Brower and Monali Desai. There were also students in attendance from New Jersey Medical School and Robert Wood Johnson Medical School, as well as faculty and residents from Hunterdon Family Medicine Residency.

First, and foremost, the NJAFP would like to congratulate Jerry Banks, MD from RWJMS Family Medicine Residency at Capital Health, for being elected to an AAFP national position as Resident Delegate. He will be serving as one of two resident delegates to

Dr. Banks is the first resident trustee to represent New Jersey on the national level in more than 10 years.

the AAFP Congress of Delegates, the most sought after position with 6 candidates running in the election. Dr. Banks was the only candidate to win his seat on the first ballot. He is the first resident trustee to represent New Jersey on the national level in more than 10 years. Dr. Banks had this to say after his election,

"I relish the opportunity to represent family medicine residents through the country, but more importantly, I look forward to representing family medicine residents in New Jersey on the national level."

Elections for AAFP leadership roles were only the tip of the National Conference iceberg. The NCRS was an impressive gathering of more than 1,500 student and resident members of the AAFP. The expo hall was filled with more than 300 booths representing family medicine programs and employers from across the country to meet and greet the attendees. There were various educational programs throughout the three-day conference ranging from procedural skills and joint injection workshops, to courses on CV writing, negotiating a contract, and applying for your first job.

The AAFP National Conference is also home to the National Congress of Family Medicine Residents and the National Congress of Student Members. More than 35 states were represented by a resident and student delegate to serve in the respective congresses this year. The delegates' role during the Resident and Student Congress included electing national officers, taking part in business meetings conducted by parliamentary procedure, and drafting resolutions to be passed on to the AAFP as initiatives or calls to action on issues.

Dr. Jeffrey Cain, AAFP President, spoke to residents and students in an educational session on healthcare advocacy. The broad scope of the session went beyond healthcare reform, encouraging residents and students to share their story and advocate for issues important to them. Dr. Cain shared his story of when he first came to National Conference as a family medicine resident and leaving with an increased passion for rallying against cigarette smoking and use of tobacco products, the number one preventable killer of Americans. He went on to develop Tar Wars, a tobacco awareness program targeted for fourth and fifth grade students that culminates with a poster contest. Today, Tar Wars is a successful program of the AAFP, having recently celebrated its 25th anniversary in Washington, DC this July. (See *Special Projects View* for more information.)

Dr. Cain also announced to us that on August 1st the US Senate and House of Representatives passed a bill to reduce graduate and undergraduate student loan rates to 5.4% and 3.86%, respectively, down from the across-the-board rates of 6.8%. The law will affect the 11 million students that received government student loans after July 1st of this year, and will help reduce the debt burden that is one of the many barriers for medical students choosing a career in family medicine or primary care. The passing of this legislation might not have been possible without the efforts of the AAFP members who rallied on Capitol Hill and spoke directly to congressional representatives on the issue. Those of us in the room with Dr. Cain pulled out our smartphones and followed a link to send a pre-written letter to our state's US senators, thanking them for their efforts and to encourage them to continue fighting for better health care. And you can do the same by scanning this code: ▲



Student View

Our NJAFP student trustees, Monali Desai and Chelsea Brower, both fourth-year medical students from New Jersey Medical School, took part in a small group discussion on medical education, which followed one of the congress business meetings. Back at NJMS, they are leaders of the Family Medicine Interest Group, members of the Arnold P. Gold Humanism Honor Society, and have a passion for the humanities and the arts, especially in medicine. Without any available outlets at school and a number of students that share in their passion for literature, they started their own monthly book club. If medicine has always been considered equal parts science and art, where every visit to the doctor always begins with a story, and the process of healing is as much emotional as it is biological, why are the humanities, the arts, and the development of doctors into caregivers not emphasized in medical education?

Within the small group discussion on medical education, Monali expressed this concern. It led to discussion, which led to an idea written down on paper. After the small group completed, Kristina Dakis, a student from University of Illinois at Chicago School of Medicine, approached Monali and Chelsea to share her passions for humanities and art in medicine. Together, they spent the next hours drafting a resolution, which was submitted to the Student Reference Committee. The following day, Monali, Chelsea, and Kristina gave their testimony in favor of

the resolution amongst the reference committee and other student delegates. The resolution was then moved to the Student Congress business session on the final day of the conference and brought to the floor for deliberations. The following resolution was adopted:

RESOLVED, that the American Academy of Family Physicians create a new curriculum guideline for implementing the humanities including but not limited to, literature, music, drama, art, dance, and associated therapies into medical education led by family physicians, and be it further,

RESOLVED, that the American Academy of Family Physicians send a letter to the Association of American Medical Colleges endorsing the inclusion of humanities into medical education.

This resolution was one of nineteen resolutions adopted by the Student Congress, and the Resident Congress adopted thirteen resolutions from a total of thirty three submitted. Some other resolutions to be adopted by the AAFP include creating guidelines for secure use of smartphone applications in patient care, development of leadership training for the family medicine physician in the patient-centered medical home model, and collaboration with the societies of emergency medicine and hospital medicine to develop strategies aimed to increase access to health care for high-utilizing patients. The list of all resolutions can be found at: <http://www.aafp.org/events/national-conference/congresses/resolutions.html>. ▲

Next year's 2014 AAFP National Conference will take place August 7-9 in Kansas City, MO.



Opening remarks with Dr. Jeff Cain and Dr. Ted Epperly.



(From L to R): Chelsea Brower, Jerry Banks, Monali Desai, Steven Nguyen

Meaningful Use Update

What Physicians Need to Know About Stage 2 Meaningful Use

Denise Anderson, PhD

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

The clock continues to wind down as Primary Care Providers (PCPs) prepare for the implementation of Stage 2 Meaningful Use (MU) on January 1, 2014. Stage 2 MU sets the bar a little higher regarding physicians' use of Electronic Health Record (EHR) systems by focusing on the value of the data collected and the utilization of the data by providers to improve patient outcomes.

NJ-HITEC Executive Director, Bill O'Byrne, explains, "Stage 2 is not about just inputting patient data into an Electronic Health Record (EHR) system; it's about examining the data, understanding the value of the data, and using the data to improve the quality of healthcare delivery. Physicians and their staff need to look beyond the incentive dollars as they continue to meet the Meaningful Use requirements."

The Meaningful Use process, once implemented and effectively utilized, is fluid. NJ-HITEC Meaningful Use Director, Bala Thirumalainambi cautions, "There are some very important changes related to Stage 2 Meaningful Use, EHR system upgrades, and patient portals that doctors need to understand so they can be and remain, in compliance."

Meaningful Use Stage 2 What Providers Need to Know

Some of the Stage 2 rules are simple. For example, for Medicare, once providers have successfully completed two reporting years of Stage 1 MU, they move onto two reporting years of Stage 2 MU. The same rule applies to Medicaid, however providers begin with the Adoption, Implementation, or Upgrade (AIU) of an EHR system, followed by two years of Stage 1 MU, then they move onto two years of Stage 2 MU. Although this is a simple rule, there is a slight exception for Medicare providers who began in 2011; this is because Stage 2 MU reporting begins January 1, 2014 regardless of when a physician began the process.

Some Stage 2 rules are not as straightforward. Below is a brief summary of the Stage 2 MU parameters that tend to be confusing:

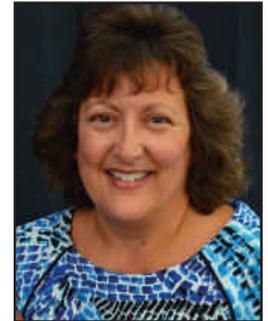
1. In 2014, regardless of your MU Stage (1 or 2), the reporting period will be 90 days. A consecutive 90 days is required for providers who begin Stage 1 MU in 2014. For Medicare providers who started their Stage 1 MU in 2011, 2012 or 2013, the reporting

period will be in quarters as follows: January to March; April to June; July to September; and October to December. Medicaid is the exception because each state will decide if the reporting period will be in quarters or consecutive days.

2. Medicare providers will have to start Stage 2 in 2014, if they started demonstrating Stage 1 in 2011 or 2012.
3. In 2014, regardless of your MU Stage, you are required to implement and use a 2014 Office of the National Coordinator (ONC) certified EHR system. There are no exceptions. You can find the EHR systems that are 2014 compliant on the Office of the National Coordinator (ONC) Certified Health IT Product List (CHPL).
4. In 2014, regardless of your MU Stage, you are required to begin using a patient portal. Stage 1 MU requires 50% patient access; Stage 2 MU requires 50% patient access and 5% of your patients should be using the portal.

Thirumalainambi explains, "There are two critical factors in the Stage 2 requirements. The first is that a physician must be on a 2014 ONC certified EHR system to begin Stage 2. It is important for providers to speak with their vendors and find out when the upgrade to their EHR system will be available. Second, as the focus is shifting toward the patient in Stage 2, doctors should be thinking about patient portals and what works best for their patient population."

The bottom line is that EHR technology and Health IT, as part of the practice of medicine, is not going away. Paper charts will eventually be obsolete. Physicians in every field need to meet the challenges of implementing EHR systems not only for the good of their patients, but for the good of overall public health. ▲



HE SAID, THEY SAY

Richard Corson, MD, FAAFP, Candidate for the AAFP Board of Directors

Richard Corson has been described as a family physician who is not only driven by ideals and passion but also is committed to addressing the challenges of family medicine and outlining solutions to the broad range of needs among family doctors. We asked Rich to discuss the issues and asked his colleagues to discuss Rich.

NJAFP: What are the most significant issues in family medicine?



Corson: In the next few years, family medicine will continue to confront significant issues: residents who eschew family medicine for more lucrative specialties to cover spiraling student debt; escalating healthcare costs; excessive overhead costs and a dysfunctional payment system that creates a financially untenable practice environment; and an increase in the number of patients lacking access to quality medical care provided by family physicians.

These challenges are real. As family physicians we cannot conquer them alone. We must support and participate with powerful organizations like AAFP. Whether the issues are PCMH, common administrative rules, strengthening primary care pipelines, or promoting change through the use of incentives, AAFP should take the lead. I believe that strong AAFP leadership will motivate our legislators to action and to 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.

David Swee, MD: I've known Rich as an educator and leader and I believe he will make a significant contribution to the national dialogue on health care. I particularly like his perspective on family medicine. At the board level, AAFP needs more reality-based discussions about what health care is really like. Rich can help AAFP move in that direction.

NJAFP: AAFP's central role is advocacy. How will you encourage your colleagues to take a more active advocacy role?

Corson: As family physicians we need to support AAFP efforts for our own good and the good of our patients. In New Jersey, I've been working hard to harness the support and participation of my colleagues in the political arena. It's imperative to generate the same commitment and enthusiasm for key family medicine issues on the national level. While I understand the time constraints imposed by hectic schedules and multiple responsibilities, advocacy remains one of the most important ways to influence the future of our specialty.

Gerald Banks, MD: I met Rich at the Family Medicine Congressional Conference in D.C. He has a wonderful rapport with state legislators and is a tireless advocate on behalf of NJAFP. I know he will work just as enthusiastically on behalf of AAFP.

NJAFP: There is a growing divide within family medicine. On one hand, you have doctors who believe we should fight to support the viability of small independent practices. On the other hand, you have doctors who are embracing transformation. How do you respond to both concerns?

Corson: I am in a position to understand the concerns of both parties. As a family doctor in a small independent practice, I have transformed my practice, bringing it into compliance with the new healthcare model. And while the transformation for my small practice was challenging, it was not impossible. There are a lot of resources available to practices, such as those developed by the NJAFP, including collaborative learning groups and more. But there is a large overlap with meaningful use. For practices that have made the decision to achieve meaningful use, the PCMH transformation will help them with their goal.

But, there are practices that feel transformation is not the right way to proceed. It could be because the physician is close to retirement, or because Internet connectivity is not sufficient to support IT needs, or it could be due to other, unique reasons. In these situations, I would defend with vigor the physician's right to decide not to move forward with transformation.

AAFP must be attentive to the concerns of small practices and help them thrive during these challenging times. However, I believe the future of family medicine is the PCMH.

Mary Campagnolo, MD: Rich brings to the AAFP the knowledge of a person working in a small practice. He is very tech savvy and understands the importance of electronic records and how to organize them to meet expectations of quality of care. He is also very well versed in family medicine issues.

NJAFP: How has your work with NJAFP and AAFP prepared you to serve on the AAFP Board of Directors?

Corson: I have assumed leadership positions and served on committees, subcommittees and workgroups within the NJAFP and AAFP. My dedication to the Academy spans decades. In 2006, I received the NJAFP's Lifetime Achievement Award. Recently, I was recognized by the New Jersey Primary Care Research Network for outstanding contributions to furthering practice-based research.

Bob Eidus, MD: Rich brings a tremendous amount of experience, integrity and wisdom. He has been an integral part of the growth and success of positioning NJAFP as the "go-to" organization.

Sal Bernardo, MD: Rich is a dedicated physician who lives, breathes and eats family medicine and the Academy. ▲

Tar Wars Celebrates 25 Years of Success!

Candida Taylor

Candida Taylor is the Tar Wars State Coordinator for the NJAFP.

Twenty five years ago Tar Wars was a mere hopeful glimmer in the eye of a younger Jeff Cain, MD from Denver, Colorado. Today, it is a successful tobacco awareness program implemented to some degree in almost all of the constituent chapters of the AAFP. Indeed, the very first child to win the Tar Wars Colorado Poster Contest is today a family physician herself!

The key to running a consistently successful program may be characterized as the ability to fluidly change with societal values and demands, to evolve technologically and find creative solutions when current tactics seem to falter. But perhaps the most important secret to any success is the ability to continually inspire with your message. Inspire your target audience and those who will deliver it to them.

And so it is with Tar Wars today. The 2013 National Tar Wars Conference and Poster Contest convened once again on Capitol Hill in Washington, DC on July 15-16 with a bit more than the usual festivities to commemorate its 25th Anniversary! Keynote speaker, Rear Admiral Boris Lushniak, MD, MPH, Deputy US Surgeon General (and a trained family physician) gave an inspiring talk to poster contest winners about the importance of reaching young people before they pick up their first cigarette. "If we can stop people from picking up a cigarette between... let's say, 14 and 26... we can have an incredible impact on this country."¹ He praised Tar Wars for helping him in his responsibility to protect the public health. Other notable speakers were AAFP President and Tar Wars Co-Founder, Jeff Cain, MD; AAFP Tar Wars Program Advisors Chair, Ashok Kumar, MD; Master of Ceremonies, Saria Carter Saccocio, MD; and representing the AAFP Foundation, Jane Weida, MD.

NJAFP attended with our New Jersey State Poster Contest Winner, Juan Rivera-Giraldo of the Martin Luther King Intermediate School in Piscataway, NJ. Juan was accompanied by his parents, Erika and Wilkin, and little sister Sophie. Juan's poster (see inset) beautifully depicted a meadow with a serene brook meandering its way toward the sun. He wrote the simple message, "The air is sweeter without smoke." Juan's creative talent earned him 6th Place Honorable Mention in the National Contest, in which 36 other AAFP chapters participated this year.

Juan visited Capitol Hill with us and received a special personally-guided tour of our capitol, courtesy of Senator Robert Menendez's office.



Juan standing beside his winning poster at the Tar Wars National Conference in Washington, DC.

He was also able to successfully advocate and relay his feelings about smoking and the importance of anti-smoking/healthy air legislation to the senator's health policy aide.

Special thanks also go to John Torro, MD, a recent graduate of the Somerset Residency program. Dr. Torro kindly accompanied us to serve as our Spanish/English interpreter since Juan and his family only recently moved to the US from Columbia.

As we get ready for the upcoming 2013-2014 school year, we urge our members to consider presenting Tar Wars in their communities. Imagine the impact that you as a presenter could make on a young student considering that first cigarette. Tar Wars asks students to look beyond the hype and the peer pressure, to truly explore the possibilities that a healthy life has to offer. Good choices lead to great possibilities. [TarWars.org](http://www.tarwars.org) has all the materials necessary to present a program in a school near you. We at NJAFP are also at your service to help you make that first contact – whether to a school nurse, principal or teacher, we can help. Consider the difference you can make in the life of a single child if you are able to say one thing that will help them make a better decision for their future.

Please visit www.tarwars.org (you will be redirected to the AAFP site) for more information or call Candida Taylor at 609-394-1711 or email at Candida@njafp.org.

References

1. AAFP News Now. Tar Wars Winners Visit Capitol Hill; Deputy Surgeon General Applauds Activism. Available at <http://www.aafp.org/news-now/inside-aafp/20130718tarwarswinners.html>. Accessed August 7, 2013.



The Special Olympics New Jersey Healthy Communities Project is in full swing!

With the purchase of a mobile health vehicle, Special Olympics New Jersey will increase awareness in communities and provide health services to previously under-served athletes and families. The mobile health vehicle has been outfitted and designed to be used as a screening clinic by healthcare professionals trained in working with people with intellectual disabilities. Screenings will be provided at various locations throughout New Jersey, including schools, area/sectional events and state chapter events. Along with wireless Internet and flat screen monitors, clinicians will be able to input live health data to improve efficiency of recording and tracking athlete information for better health outcomes.

NJAFP Summer Celebration & Scientific Assembly Foundation Booth

The NJAFP Foundation (NJAFP/F) would like to thank everyone who stopped by the Foundation booth and donated to the cause. Your contributions help to provide substantial and unique support for the advancement of Family Medicine in the areas of research, education, student interest, and academic achievement.

We would like to thank our booth representatives and Foundation Board Directors, Ruth Corson and Sue Zlotnick, for their continued support and volunteering their time to make the NJAFP/F booth a success. Sue and Ruth have been manning the booth for many years now and their good will and volunteer spirit have been essential not only to the booth, but in monitoring the Treasure Chest contest as

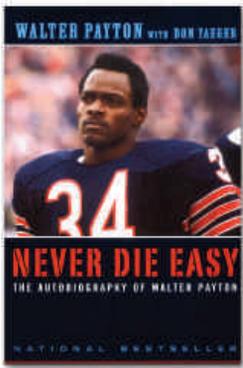
well, which also has enjoyed much popularity.

Please continue to support the NJAFP Foundation with your tax-deductible gifts. The philanthropic arm of the Academy enables us to provide programs and support to students and residents pursuing Family Medicine as a career path – and hopefully remaining in New Jersey as their chosen practice community.

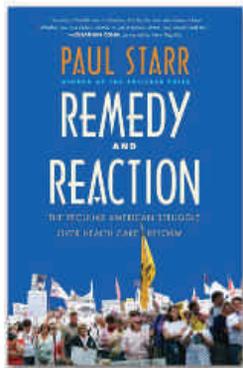
Book Promotion:

This 3rd Quarter fund drive highlights the various books we have available to our members. For a minimum donation of \$50, we will send you one of the books featured below. Additional copies of any book may be requested for an additional \$10 donation – while supplies last. (Shipping and handling charges are free!)

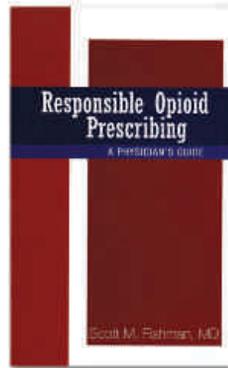
Yes, please send me the book(s) checked below.



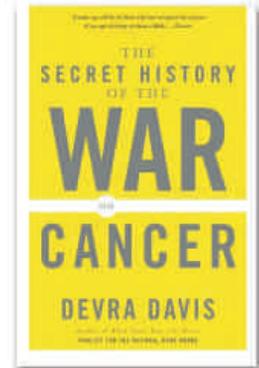
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MEMBER HIGHLIGHTS

Life is Good – Hoboken Family Physician has Found a Practice Approach that Works for Him Beth Drost

Beth Drost is the public relations specialist at Communications Solutions Group, Inc., in Jenkintown, PA.

The first thing that strikes you about Javed Islam, MD is that he is happy—happy in general, but happy in particular to be practicing family medicine in New Jersey. He is also optimistic about the future of the specialty. At a time when many family physicians are contending with declining insurance reimbursements and are concerned about what the future holds for family doctors, Javed is an anomaly. He doesn't accept insurance, his patients are of modest means, he doesn't work excessive hours, yet he is enthusiastic, successful and happy practicing as much of the scope of family medicine as he desires.

Javed is a graduate of the King Edward Medical College in Lahore, Pakistan. He completed the Family Medicine Residency program at the University of Medicine and Dentistry of New Jersey Robert Wood Johnson University Hospital/St. Peter's Hospital, in New Brunswick. During his time there, he was the Chief Resident in Family Medicine, and he was nominated Intern of the Year. After completing his residency, Javed practiced in an urgent care/family practice.

“You can't just do it for the money; you have to do it for the quality of life.”

In 2008, he established PromptMD Urgent Care Center in Hoboken, New Jersey. Open seven days a week—8 am to 8 pm, Monday through Friday and 9 am to 2 pm, weekends and holidays—for walk-ins and appointments, the center serves patients from age one and older. His ability to diagnose and treat a variety of conditions in a short amount of time led to Javed's pursuit of working in an urgent care setting. Described by his patients as “outgoing with a good sense of humor” and “a reassuring bedside manner,” Javed enjoys interacting with the diverse patient population that uses PromptMD. Despite opening its doors when the economy was at an all-time low, PromptMD has prospered.

The walk-in clinic offers a wide range of services from flu shots to strep tests, stitches, and splints. The center also evaluates and treats



patients with chronic conditions like asthma, high blood pressure, diabetes and more. An onsite laboratory, as well as x-ray and electrocardiography (EKG) equipment, enable patients to access these services at a discounted rate. Emergency, preventive and occupational services are available at the center.

PromptMD does not accept any insurance except Medicare. Payment is requested at the time of the visit, via check, credit card or flexible spending card. The office supplies a generic health insurance claim form and an itemized receipt if a patient plans to apply for reimbursement.

Guiding Javed's decision to pursue a more unconventional approach to services is his belief that, “You can't just do it for the money; you have to do it for the quality of life.” His decision not to accept insurance was prompted by his concern that insurance bureaucracy would eat into the time he spends with patients. He explains that he is very conscientious about ensuring the cost of service is reasonable. Currently, patients are charged \$90 per visit and follow-up visits are often free.

Javed is in the clinic Monday through Friday, from 9 am to 2 pm. He also works one weekend per month. This schedule allows him to spend quality time with his family and pursue his hobbies, which include cars, watches and cooking.

Javed is a diplomate of the American Academy of Family Physicians. ▲

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