Temporary Medicaid Payment Increases Coming for Primary Care Physicians

Perspectives

A VIEW OF FAMILY MEDICINE IN NEW JERSEY

VOLUME 11, ISSUE 4 • 2012

Reflections... Hurricane Sandy

Moving from Stage 1 to Stage 2 Meaningful Use

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IN THIS ISSUE

Volume 11, Issue 4 • 2012

On the Cover

Hurricane Sandy left us with a ravaged coastline and decimated communities, but family physicians remembered lessons learned from past storms and put their experiences into practice.

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I Am Going to Collect Bad Wine

IF YOU READ this column regularly you know I am a fan of "TED Talks." If this is news to you, well… I am a fan of TED Talks. And if you read this column regularly, you know that I am sometimes inspired to write about what I learn from TED Talks.

My inspiration for this column came from a talk given by Ric Elias. Mr. Elias is the CEO and co-founder of Red Ventures, a firm that helps large service companies acquire new customers online. However, that is not why he was invited to TED.

Imagine, if you will, taking off from the airport on a crisp winter afternoon. Imagine lifting into the sky above Manhattan and suddenly hearing a loud explosion and the 'clank-clank-clank-clank-clank' of a turning engine, while smoke filled the plane. Mr. Elias, in seat 1D, was the only one who could talk to the flight attendant, who said, "No problem, we probably hit some birds." The pilot began to turn the plane around. Two minutes later, three things happened: the pilot lined up the plane with the Hudson River (not the usual approach)… cut the engines (imagine being on that plane with no sound)… and then came on the radio and told everyone to brace for impact. Mr. Elias didn't need to talk to the flight attendant anymore. He could read the terror in her eyes and knew that life was over.

US Airways Flight 1549 and its historic landing on the Hudson River is well known. Mr. Elias says in his talk that he learned three things that day: The realization that life can change in an instant; that because, even though he considered himself a good person, his ego sometimes got in his way and he wasted time on things that didn't matter with people who did matter; and as he watched the water come up to meet the plane, that death wasn't scary, but it was unspeakably sad.

Facing death – facing all the things you wished you had done differently – and then surviving – can be quite an experience, freeing one from the egotism that drives so much negativity in life. It can bring one to the realization of what is truly important… children, family, and friends. The awareness that life can change in an instant prompted Mr. Elias to develop the following philosophy: "I collect bad wines. Because if the wine is ready and the person is there, I'm opening it. I no longer want to postpone anything in life."

As we enter this holiday season, I urge you to take a moment and reflect on all the things you didn't do that you wish you had. Things like reaching out to someone you've been thinking about, but just couldn't seem to find the time; mending a relationship; or going to your child's school play. Don't postpone anything in life, because it truly can all change in an instant. So, taking Mr. Elias' advice to heart, I am going to start to collect bad wines. If you are ever in the area, I invite you to stop by and lift a glass with me.

Happy Reading,

Theresa

Theresa J. Barrett, MS
Managing Editor

To see Ric Elias' TED Talk "3 things I learned while my plane crashed," go to http://www.ted.com/talks/ric_elias.html

PRESIDENT'S VIEW

A Year in Review

Salvatore Bernardo, Jr., MD

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

It has been an incredible year for the NJAFP. As we celebrate the holidays and look forward to what 2013 will bring, I thought it would be good to reflect on all of our accomplishments this past year; accomplishments that would not have been possible without your support.

Early in 2012, our Executive Vice President, Ray Saputelli, and our Government Affairs Director, Claudine Leone, testified before the Senate Health Committee on legislation regarding the state's physician workforce supply. The NJAFP provided the Committee with information specific to the workforce challenges for family medicine in New Jersey and discussed areas in which NJAFP believes New Jersey can make improvements to train and retain family physicians in the state. In addition, Claudine met with representatives from the New Jersey Department of Banking and Insurance to review health plan compliance with the Department's Health ID card regulations. Lastly, we have continued to meet with Governor Christie's health policy staff and Counsel's office to discuss the development of a multi-payer medical home pilot in New Jersey. The NJAFP has been actively educating policymakers on our efforts involving the patient-centered medical home model of care and practice transformation both in the Administration and in the Legislature.

This spring, NJAFP hosted **Collaborating for the Healthcare of New Jersey - Connecting the Silos - A One-Day Think Tank**. This brainstorming session was designed to find solutions to New Jersey's fragmented and dysfunctional healthcare system. This "invitation only" event attracted a broad spectrum of New Jersey healthcare leaders and included almost 100 participants. The outcomes from this event were captured in a monograph entitled **"Connecting the Silos - Collaborating for the Health Care of New Jersey,"** which you can download at *http://www.njafp.org/news/njafp-releases-connecting-silos*

We also published a monograph entitled **"Getting on the Right Track: Averting Disaster in the Healthcare System."** This monograph details many of the issues at the core of New Jersey's fractured and fragmented healthcare system, and offers potential solutions. This document explains why we are in crisis and how we might get out of it before New Jersey becomes a full-fledged primary care desert, unable to provide citizens with basic care at sustainable costs. It is available at *http://www.njafp.org/news/njafp-releases-getting-right-track-averting-disaster-healthcare-system*

Members of the NJAFP staff and Board of Directors continued to advocate for family physicians in New Jersey, meeting with the New Jersey Association of Health Plans and individual health plans to revisit some old issues and discuss the new generation of managed care hassle factors identified by NJAFP members. Our work with the Department of Banking and Insurance also continues in the same light that actually resulted in the Department's proposal of new regulations addressing provider contracting and provider networks.

The fact that New Jersey is not training and retaining enough family physicians remains high on NJAFP's advocacy agenda. Over the summer, NJAFP joined Senate Majority Leader Loretta Weinberg in a meeting to discuss the education, training and retention of primary care physicians in New Jersey. Senator Weinberg invited all four Deans representing UMDNJ - NJ Medical School, UMDNJ - RWJ Medical School, UMDNJ - School of Osteopathic Medicine, and Cooper Medical School of Rowan University to discuss each school's plans to address the state's shortage of primary care physicians. The NJAFP is working with Senator Weinberg to continue this dialogue with the state's medical schools to ensure there is a focused plan to address the state's primary care workforce needs. Also this summer, NJAFP and several other medical specialty societies met with Governor Christie's Counsel's Office to continue discussions on eliminating administrative hassle factors and other related practice issues that make New Jersey a distressed practice state for physicians. The goals for these meetings tie directly into Governor Christie's economic development agenda, which includes overhauling state government's regulatory system and reducing the red tape that stifles economic growth and imposes costs on businesses and citizens.

The fact that New Jersey is not training and retaining enough family physicians remains high on NJAFP's advocacy agenda.

I am proud to say that New Jersey was chosen to be one of the states to participate in The Comprehensive Primary Care Initiative (CPCI), a multi-payer initiative fostering collaboration between public and private healthcare payers to strengthen primary care. There are 73 practices involved in the program. Medicare will work with commercial and state health insurance plans and offer bonus payments to primary care physicians to better coordinate care for their patients. Primary care practices that choose to participate in this initiative will be given resources to better coordinate primary care for their Medicare patients.

It has indeed been a year of accomplishments for NJAFP. I would like to thank the members of the board, executive committee and staff for all of the support they provide to our Academy. I wish you all a healthy and happy New Year. ▲

A Call to Action to Elected Leaders

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.

Once again family physicians, along with our nation's primary care infrastructure and the patients that so depend on the high-quality, cost-effective care that family physicians provide, are all at risk, awaiting the conclusion of the annual shell game that has become known as the "Doc Fix." This year, as we all are painfully aware, the doc fix and all other negotiations in Congress are being held hostage by the sequestration policy, otherwise known as the "fiscal cliff" over which our national lawmakers are perilously close to pushing us. Hopefully, by the time many of you read this article, there will have been some action on the part of Congress to limit at least the most onerous effects of inaction that threaten our entire economy, but I suspect that any solution at this late date will be one that is rushed and as a result merely another instance of legislators kicking a can down the road hoping it becomes the next person's problem, or the next election's wedge issue. Meanwhile, family physicians face a perilous and unreasonable reduction in revenue of 26.5% on January 1 and 2% on January 2, 2013. The American Academy of Family Physicians (AAFP) estimates that these reductions are equal to $27,000 for the average family physician, and an $80,000 reduction in revenue for the average small group practice – in this case defined as a practice made up of three physicians. This does not even consider the additional revenue reduction that can be expected when commercial insurers reduce payments that are often formally or informally based on Medicare rates. In New Jersey, where family physicians and their primary care colleagues in other disciplines are already struggling with some of the lowest reimbursement rates in the country while at the same time practicing in one of the most expensive states in which to live and operate a small business, and in addition being subjected to an ever-increasing and disproportionate administrative burden compared to other medical specialties, it is not hyperbole to suggest that the crisis threatens the very foundation of our healthcare system.

In this space just three months ago, I provided an energetic and hopeful assessment of the future for family medicine. New reimbursement models were being implemented by commercial insurers, primary care physicians were seeing payments for having achieved meaningful use of electronic health records, and the CMS Comprehensive Primary Care Initiative (CPCI) was providing a window into how the federal government values primary care. Overall, I sensed a general feeling of optimism among many family physicians that I'd not experienced the last decade of working on their behalf. While I still sense long term optimism for the future, and firmly believe that there is a reason to be optimistic, I am concerned that recent events in Congress, as well as those to come, may undermine the progress that has been made toward rebuilding our fractured healthcare system, improving quality care while controlling costs, and rolling back the promise of CPCI and other reform efforts.

The pending Medicare rate reductions are so serious that the AAFP has developed a series of answers to frequently asked questions for physicians wondering what Medicare participation – or non-participation – options exist and the implications of those options to their practice. It is important to note that neither the AAFP nor the NJAFP are suggesting any particular relationship to Medicare for our members. That is a decision that each member must make for themselves based on their patient mix, practice model, financial situation, and other factors. Our goal is to provide the most complete information possible for member physicians who are reluctantly re-evaluating their Medicare participation as a result of the annual uncertainty with regard to their payment. That information is available online at *www.njafp.org/mcareoptions*.

Additionally, recent behavior by at least one commercial payer has added to the challenges faced by the primary care community.

Overall, I sensed a general feeling of optimism among many family physicians that I'd not experienced the last decade of working on their behalf.

Earlier this year, Aetna made headlines by implementing a program that would pay a care coordination fee to all practices who had achieved National Committee Quality Assurance (NCQA) recognition as Patient-Centered Medical Homes. Unfortunately, as of the printing of this issue, Aetna had not paid eligible practices in New Jersey either 2nd or 3rd quarter payments, and inquiries to local Aetna contacts have not produced any response beyond acknowledgement that there have been no payments. While the NJAFP, along with the rest of the healthcare community applauded Aetna for implementing this program, we are now forced to question Aetna's motives and commitment to primary care as family physicians who increased capacity and added resources based on the

continued on page 17

Perspectives:
A View of Family Medicine in New Jersey

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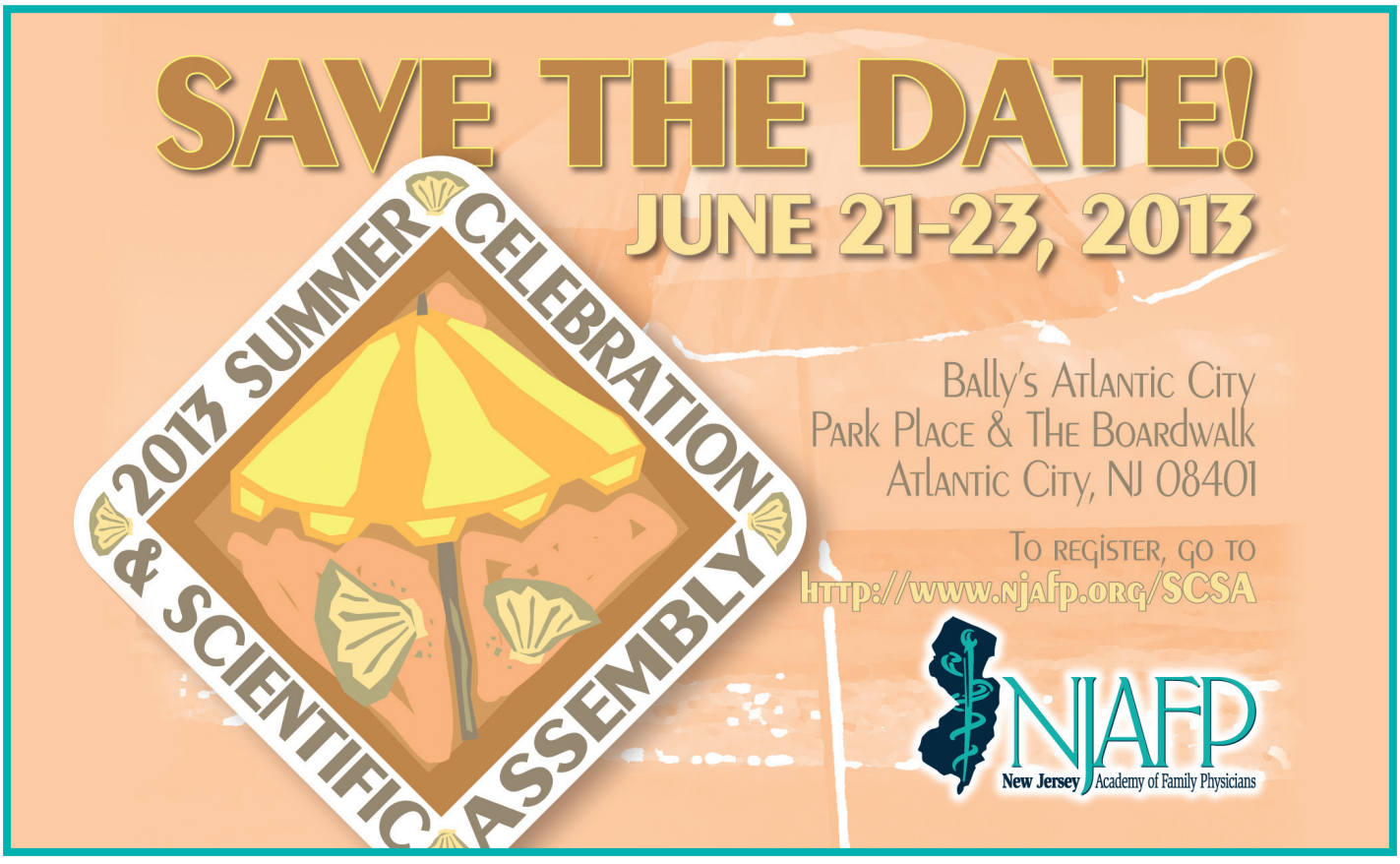

Action Required – *NJ FamilyCare Providers*

The Patient Protection and Affordable Care Act (PPACA) of 2010 is requiring that all healthcare professionals not presently enrolled as providers in the NJ FamilyCare (NJFC)/Medicaid program who provide healthcare services to Fee-For-Service (FFS) beneficiaries enroll in the program as 'non-billing' NJFC/Medicaid providers by no later than January 1, 2013.

Who is a 'non-billing' FFS provider?

When a NJFC/Medicaid FFS beneficiary (a beneficiary not enrolled in managed care) is receiving treatment, one or more healthcare professionals may be associated with his or her medical care. A healthcare professional may prescribe a NJFC/Medicaid-covered service, such as a medication; complete a physician order for the beneficiary's care; act as a referral source for a beneficiary or otherwise attend to a beneficiary's healthcare needs.

These professionals are referred to by the PPACA as 'non-billing' providers. On or after January 1, 2013, a provider billing for a service ordered, referred, or prescribed by a 'non-billing' provider not enrolled in the NJFC/Medicaid FFS Program **will be DENIED payment** by the State of New Jersey.

Who is a 'Fee-For-Service' (FFS) provider?

Fee-For-Service (FFS) providers are enrolled as NJFC/Medicaid providers and provide covered benefits to NJFC/Medicaid beneficiaries who are not enrolled in a Medicaid managed care plan (HMO). FFS providers are paid directly by Molina Medicaid Solutions, the State's fiscal agent.

Is a 'non-billing' provider eligible to receive NJFC/Medicaid FFS payments?

A 'non-billing' provider is not eligible to receive NJFC/Medicaid FFS payments. Providers requesting payments from the NJFC/Medicaid FFS program must enroll as a 'billing' provider. To request a provider enrollment application for the purpose of billing Molina Medicaid Solutions in order to request NJFC/Medicaid payments, go to www.njmmis.com (see Provider Enrollment Application) or call the Molina Medicaid Solutions Provider Enrollment Unit at (609)588-6036.

If I am currently enrolled as an active 'billing' provider, do I have to re-enroll as a 'non-billing' provider?

No. Healthcare professionals who have submitted claims to NJFC/Medicaid in the last 18 months are considered active 'billing' providers. Active 'billing' providers who also prescribe, order, refer or attend to the healthcare needs of a NJFC/Medicaid beneficiary are not required to re-enroll in the NJFC/Medicaid program as 'non-billing' providers.

Why should I enroll in the NJFC/Medicaid program as a 'non-billing' provider?

When a FFS provider is requesting a NJFC/Medicaid payment and the prescribing, ordering, referring or attending practitioner reported on the claim is not enrolled as a NJFC/Medicaid provider, the FFS provider who rendered the prescribed, ordered or referred service will not be paid by the NJFC/Medicaid program.

The National Provider Identifier (NPI) of the 'non-billing' provider must be reported by the provider rendering a service on an electronic claim, including pharmacy claims.

Is there a cost for enrolling in the NJFC/Medicaid program as a 'non-billing' provider?

There is no cost for enrolling in the NJFC/Medicaid program as a 'non-billing' provider.

I currently participate with a NJFC/Medicaid HMO as a member of its provider network. I am not a provider in the NJFC/Medicaid FFS program. Am I still required to enroll as a 'non-billing' provider if I chose to prescribe, order, or refer a service to a NJFC/Medicaid FFS beneficiary?

Yes. You are required to complete an abbreviated provider enrollment application, referred to as the Prescribing/Ordering/Referring/Attending Physician or Other Professional Application (Form FD-208) that may be found at www.njmmis.com (see Provider Enrollment Application). A 'non-billing' provider may also call Molina Medicaid Solutions Provider Enrollment Unit at (609)588-6036.

Under what circumstances is a 'non-billing' provider allowed to report to a billing provider a National Provider Identifier (NPI) other than their individually-assigned NPI?

Medical residents practicing in a hospital setting who order, refer, or prescribe the healthcare service may report the NPI of the hospital to a provider rendering a healthcare service. For services ordered, referred, or prescribed by a physician assistant, the NPI of the supervising physician must be reported to the provider rendering a healthcare service.

If I intend to participate in the NJFC/Medicaid program as a 'non-billing' provider and my NJFC/Medicaid provider number on file with the program is no longer active, do I still need to submit an enrollment application?

Yes, you will need to submit the Prescribing/Ordering/Attending Physician or Other Professional Application (FD-208 Rev. 09/19/2012) to establish 'non-billing' provider status with the NJFC/Medicaid program. Your closed provider number will be re-activated and become your 'non-billing' provider number.

If I enroll as a 'non-billing' provider, will my name or practice be listed anywhere as a NJFC/Medicaid billing provider on a state website or directory?

Your practice will not be listed on any public website as a NJFC/Medicaid billing provider. Access to a 'non-billing' provider directory will be provided only to those enrolled NJFC/Medicaid providers who need to bill the program for payment. The directory may be found through a secure portal on the State Fiscal Agent website, www.njmmis.com. The secured 'non-billing' directory will be accessible to billing providers sometime in December 2012.

If you have any further questions, please contact the Molina Medicaid Solutions Provider Enrollment Unit at (609)588-6036.

Meningitis Outbreak Continues

AS OF DECEMBER 3, 2012 the Centers for Disease Control and Prevention (CDC) continued to receive reports of patients presenting with paraspinal/spinal infections (e.g., epidural abscess, phlegmon, discitis, vertebral osteomyelitis, or arachnoiditis at or near the site of steroid injection). These syndromes have occurred in patients with and without evidence of fungal meningitis. Because these infections are distinct from meningitis and joint infections, the CDC will report case counts to better describe types of infections being identified in patients exposed to a preservative-free methylprednisolone acetate (MPA) injection, with preservative-free MPA that definitely or likely came from one of the following three lots produced by the New England Compounding Center (NECC) [05212012@68, 06292012@26, 08102012@51]. To date there have been 38 cases of fungal infections linked to steroid injection (Table 1) that have occurred in New Jersey. For additional information please visit the CDC website at *http://www.cdc.gov/hai/outbreaks/meningitis-map.html*

Table 1

State	Total Case Counts	Meningitis (with or without other infection)*	Stroke without Lumbar Puncture only	Paraspinal/ Spinal Infection only	Peripheral Joint Infection only	Death
New Jersey	38	36	0	2	0	0

Additional information on this issue can be found on the Food and Drug Administration (FDA) website in the article entitled *FDA Reports Voluntary Recall of All Ameridose Drug Products* (October 31, 2012) available at *http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm326361.htm*

New Jersey Medicaid Reminder

The Centers for Medicare and Medicaid Services (CMS) mandate for ICD-10 Diagnosis and Surgical code implementation is quickly approaching. This mandate requires all providers to transition to the new ICD-10 codes and exclusively use only these new codes for the date of service beginning October 1, 2014. New Jersey Medicaid will open up their testing window for all providers as of January 1, 2014 and remain open for the full period until the compliance date of October 1, 2014. For all updates concerning these new codes and the federally mandated compliance date please visit our Medicaid website at *http://www.njmmis.com/headlines.aspx* and look for "Web Announcement: ICD-10 is coming, will you be compliant?"

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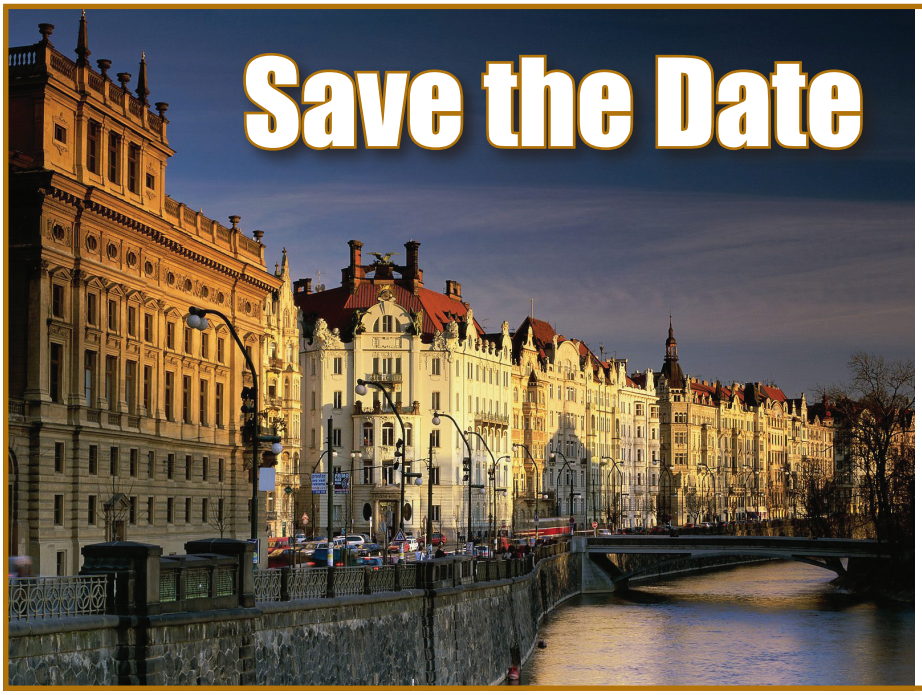

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NEW
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CLINICAL VIEW

CME

New Screening Guidelines for Hepatitis C

Joseph P. Wiedemer, MD and Theresa J. Barrett, MS

Dr. Wiedemer is the Director of the Mountainside Family Medicine Residency Program in Verona. Ms. Barrett is the Deputy Executive Vice President for the NJAFP.

Introduction

Hepatitis C is a very slow progressing disease, and the risk of serious infection increases with time. It is the most common chronic blood borne infection in the United States.[1] In 1998 the Centers for Disease Control and Prevention published *The National Hepatitis C Prevention Strategy* in order to identify those individuals at highest risk for the disease, reduce the incidence of acute hepatitis C in the U.S., and reduce the burden of disease from chronic hepatitis C virus infections (HCV).[1]

Who is at Risk?

It is estimated that over 3.2 million people nationwide are infected with HCV.[2] Of those, 75% have chronic HCV infection, and most likely became infected 20 to 40 years ago, before HCV was discovered.[3,4] These numbers may actually be higher when those who are homeless, prisoners, or illegal immigrants are taken into consideration.[5]

Those who are at risk for HCV include anyone who ever injected illegal drugs, even if they only injected once many years ago. Other people at risk are recipients of clotting-factor concentrates made before 1987; those who received blood transfusions or solid-organ transplants before 1992; anyone who ever received long-term hemodialysis treatment; persons who have known exposures to HCV (i.e., healthcare workers); anyone with HIV; patients who have signs or symptoms of liver disease; and children born to HCV-positive mothers.[6] Approximately 75% of people infected with HCV are unaware of it, remain a transmission source and are at risk for HCV related chronic diseases.[6,7]

Studies have shown that those adults born between 1945 and 1965, "the baby boom generation," will have the highest lifetime risk of acquiring HCV.[3] Most of those who are infected with HCV are only now reaching the age where complications from liver disease may start to develop. The CDC estimates that 2.7 - 3.9 million persons who have HCV infection are unaware it and do not receive care and treatment. Although persons born during 1945 - 1965 comprise an estimated 27% of the population, they account for approximately three fourths of all HCV infections in the United States, 73% of HCV-associated mortality, and are at greatest risk for hepatocellular carcinoma and other HCV-related liver disease.[8] Several studies have predicted a rise in HCV-related morbidity and mortality rates as the population continues to age.[4,9,10]

Overview of Hepatitis C

There are eleven different genotypes (genetic makeup of the virus) for Hepatitis C.[11] Of these, genotype 1 is the most common in the United States. It is also the most difficult to treat, with only 50% of whites and 30% of African Americans responding to treatment.[12] Only 15% to 30% of people who contract HCV will develop clinically recognizable symptoms, such as jaundice, malaise, and influenza-like symptoms.[13] The majority of those with acute HCV will progress to chronic HCV, though women and children have higher spontaneous clearance rates.[14] Those who progress to chronic disease are often asymptomatic prior to developing cirrhosis.[14]

Minorities and HCV

African Americans have higher prevalence of Hepatitis C than persons of any other racial group in the United States, and experience greater complications.[15] Though African Americans represent 12% of the U.S. population, it is estimated that they represent greater than 22% of the estimated number of Americans with HCV infection.[16]

As with whites, the main mode of transmission is intravenous drug use followed by receipt of a contaminated blood transfusion.[17] African Americans also have a higher prevalence of genotype 1, but the reason for this is still unknown.[15] Chronic liver disease, often Hepatitis C-related, is a leading cause of death among African Americans ages 45 to 64, yet too few African Americans at risk get tested.[16]

The Importance of Screening

There are many benefits to screening patients for HCV. Early identification of the disease can facilitate virologic suppression, as treatment earlier in the course of the disease is associated with better efficacy.[18,19] Early diagnosis coupled with lifestyle modification and patient education can reduce the risk of transmission to other individuals and increase adherence to therapy,[20,21] and routine screening will lead to a fuller understanding of HCV prevalence in individual communities, allowing resources to be focused where they are most needed.[22]

Most primary care physicians do not screen patients for HCV.[23,24] This is an unfortunate trend as the earlier those with HCV are identified, the earlier they can receive treatment and the better their outcomes. One contributing factor to the lack of screening is the relatively low awareness of HCV among healthcare providers and the public, especially within specific high-risk groups.[6] It has been shown people who are unaware they have HCV engage in more risk taking behaviors than those who do know their status,[25] thereby contributing to the spread of the virus.

While screening for HCV is currently done on risk basis, Rien et al.[3] theorized that by expanding screening recommendations to those born from 1945 to 1965, the group with the highest prevalence of HCV, more undiagnosed patients would be identified, lowering the burden of disease. Rien's model also showed that this one-time screening was cost-effective, reducing the burden on the healthcare system.

Screening, Shared Decision Making and Patient-Centered Care

The family physician is the patient's entry into the healthcare system. As such, they are in the perfect position to screen and counsel patients regarding HCV. Using the model of the patient-centered medical home,[26] family

physicians can provide coordinated care focused on the individual patient, resulting in improved screening services and improved interpersonal communication between the healthcare team and the patient.[27,28] Ferrante et al.[29] found that the relationship-centered aspects of the PCMH were more highly correlated with preventive services delivery, including enhanced screening services, in community primary care practices.

Patients today increasingly expect their physician to help them understand the complex risks and benefits regarding therapeutic options and how those decisions will affect their lives.[30] Shared decision-making and clinical decision aids can help both the physician and the patient make the choice that is the right one for the patient.[30] A Cochrane Review on the use of decision aids found that they resulted in greater knowledge, lower decisional conflict, reduced the number of people who were passive about decision making as well as the number of people who remained undecided post-intervention.[31] Shared decision-making has also been shown to improve adherence to therapy.[32,33]

Treatment of HCV

Standard combination therapy with pegylated interferon–ribavirin has a high incidence of side-effects and less than 50% sustained viral response. Patients with minimal fibrosis or normal alanine aminotransferase levels are usually not offered treatment and asymptomatic patients often drop out of treatment because the side effects are too difficult to handle and the course of treatment is long.[34] It is estimated that only 10% to 20% of known HCV infected patients accept standard therapy and complete the full course.[6]

Comorbidities and HCV

Depression of variable severity, along with suicidal ideation, is a common reason for discontinuation of HCV therapy.[5,15,35] Even with new treatments available for HCV, pegylated interferon is anticipated to remain an integral part of treatment, therefore screening for depression by the family physician prior to starting HCV therapy is crucial and could improve treatment outcomes.[5]

Family physicians can play a key role in reducing the morbidity and mortality of other comorbidities such as insulin resistance, metabolic syndrome, cardiovascular diseases, and anemia.[36] These comorbidities affect the response to antiviral therapy thereby reducing compliance and adherence to therapy.[37] Excess alcohol intake, HIV and hepatitis B can also influence the course of HCV and the response to antiviral therapy, as does schistosomiasis, iron overload, and excessive smoking.[36,37]

Studies have shown that viral protease inhibitors, when used in conjunction with standard therapy, shorten treatment duration and significantly increase treatment success in persons infected with genotype 1.[38,39] While triple therapy won't reduce the adverse effects of treatment, it shortens the course of treatment and increases efficacy by up to 70%.[34] Liu and associates[40] showed that using protease inhibitors as part of a triple therapy plan, targeted to those most likely to benefit from treatment, improved health outcomes compared to the standard two drug therapy.

Alter and Liang[34] posited that as treatments for HCV continue to improve, the question will not be who to treat, but how to identify those with HCV who are unaware of their infection. Most people who are infected are not addicted to drugs, but experimented with them when they were younger. Those long ago experiences don't register as a risk factor for HCV, nor are they seen as a reason to seek screening.

The Centers for Disease and Prevention (CDC) has developed a series of fact sheets for physicians to use with their patients in explaining hepatitis C. All fact sheets are available for download in either color or black and white from *http://www.cdc.gov/hepatitis/C/PatientEduC.htm*

- **Hepatitis C** – *General Information Fact Sheet (also available in Spanish)*
- **Hepatitis C** – *Information about Testing*
- **Living With Chronic Hepatitis C**
- **Hepatitis Fact Sheet for Gay and Bisexual Men**

Summary

HCV progresses slowly and the risk of serious complications for those unaware they are infected progresses with the passage of time.[4] Unless there is a change in identifying those at risk and getting them into treatment, the death rate from HCV is expected to increase to 35,000 annually by 2030.[41] Providing education to family physicians to increase their knowledge and competency in HCV screening and treatment is a key to identifying those patients from the baby boom generation who are HCV positive and getting them into treatment to improve patient outcomes and reduce the burden on the healthcare system. ▲

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CME QUIZ

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

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

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

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

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

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

Name:_____ AAFP Membership Number:_____

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Email Address: _____

Phone: _____ Fax: _____

New Screening Guidelines for Hepatitis C

1. Which of the following people are at risk for hepatitis C? a) anyone with HIV; b) anyone who injected illegal drugs; c) anyone who received donated blood or organs before 1992; d) recipients of clotting-factor concentrates made before 1987; e) all of the above.

2. Before prescribing treatment for a patient with hepatitis C virus (HCV), which factors should you consider? a) alanine aminotransferase levels; b) depression; c) severity of fibrosis; d) suicidal ideation; e) all of the above.

3. Which class of agent is most effective for treating patients with HCV? a) anticoagulant; b) antiplatelet; c) anti-inflammatory; d) antiviral.

4. Standard combination therapy for HCV includes pegylated interferon and which of the following medications? a) ramelteon ; b) ribavirin; c) rivaroxaban; d) ranolazine; e) reteplase

5. Patients tend to discontinue HCV therapy for which of the following reasons? a) side effects are too difficult to manage; b) length of treatment; c) onset of depression; d) a and c only; e) b and c only; f) a, b, and c.

6. True or False. Hepatitis C is the most common chronic blood borne infection in the United States.

7. True or False. The majority of people infected with hepatitis C virus (HCV) are aware of it.

8. True or False. It is estimated that only 10% to 20% of known HCV infected patients accept standard therapy and complete the full course.

9. True or False. Studies have predicted an increase in HCV-related morbidity and mortality rates as the population continues to age.

10. True or False. Research shows when therapy is targeted to those patients who are most likely to benefit from treatment, use of protease inhibitors as part of a triple therapy plan improves health outcomes compared to the standard two drug therapy.

ANSWERS ON PAGE 17

Primary Care Payments for Coordination of Care Post-Discharge

Susan B. Orr, Esq.

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

The 2013 Medicare Physician Fee Schedule includes payment to physicians to coordinate a patient's care following a patient's discharge from an acute care hospital, psychiatric hospital, long term care hospital, skilled nursing facility and inpatient rehabilitation facility. Physicians will, for the first time, receive a payment separate from the E/M Codes to help a patient transition back into the community following a discharge. Two new Transitional Care Management (TCM) procedure codes are being introduced that recognize the additional resources community physicians must utilize on behalf of patients as they monitor patients in the 30 days following a discharge.

The two new TCM payment codes are as follows:

- **99495 Transitional Care Management Services with the following required elements:**
  - Communication (direct contact/face-to-face, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge;
  - Medical decision-making of **at least moderate complexity** during the service period; and
  - Face-to-face visit, within **14 calendar days** of discharge (to be billed separately using an E/M code).
- **99496 Transitional Care Management Services with the following required elements:**
  - Communication (direct contact/face-to-face, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge;
  - Medical decision-making of **high complexity** during the service period;
  - Face-to-face visit, within **7 calendar days** of discharge (to be billed separately using an E/M Code).

The post-discharge TCM service includes non-face-to-face care management services furnished by either a clinical staff member or an office-based case manager under the supervision of the physician. The non-face-to-face services provided by clinical staff or case managers include:

- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
- Communication with home health agencies and other community services utilized by the patient
- Patient and/or family caregiver education to support self-management, independent living and activities of daily life
- Assessment and support for treatment regimen adherence and medication management
- Identification of available community and health resources
- Facilitating access to care and services needed by the patient and/or family

Non-face-to-face services that can be provided by the physician include:

- Obtaining and reviewing the discharge information
- Reviewing the need for follow-up on pending diagnostic tests and treatment
- Interaction with other qualified health-care professionals who will assume or resume care of the patient's system-specific problems
- Education of patient, family, guardian and/or caregiver
- Establishment or reestablishment of referrals and arranging for needed community resources
- Assistance in scheduling any required follow-up with community providers and services

Based on the level of medical decision-making complexity, the patient must be seen by the physician either within 14 days of discharge for moderate complexity and within 7 days of discharge for high complexity for which the physician can bill Medicare with an E/M code. Medical decision-making is defined by the E/M Services Guidelines, and the medical decision-making over the service period reported is used to define the medical decision-making of the TCM services. Medication reconciliation and management must occur no later than the date of the face-to-face visit (i.e., within 7 or 14 days after discharge). TCM services are to be billed only once per patient within 30 days of discharge and only at the end of the 30-day period. Even if another hospital discharge occurs within the 30-day period following the original discharge date for which TCM services are billed, another TCM service may not be reported by the same physician or group for any subsequent discharge(s) within the same 30-day period.

The TCM codes are to be used only for patients transitioning from an inpatient setting to a patient's community setting (i.e., home, domiciliary, rest home or assisted living), and not when the patient is transitioning to another inpatient facility such as a skilled nursing facility. TCM services can be provided to both established and new patients.

Payment will be made to only one provider of TCM services. Although primary care providers are the likely choice for providing TCM services, cardiologists, oncologists or other specialists are not precluded from providing the services, as well. Note, however, payment will be made to that provider whose claim is received first by Medicare. Non-physician qualified healthcare professionals such as NPs, PAs, CNSs, and certified nurse midwives may also bill the new TCM codes.

The new TCM codes acknowledge the importance of transitional care services and the role of community physicians. Educate your staff now to enable your practice to appropriately treat your patients and effectively utilize these codes when they become effective January 2, 2013.

For more information, contact Susan B. Orr, Esq. at Tsoules, Sweeney, Martin & Orr, LLC at (610) 423-4200 or send an email to sorr@tshealthlaw.com.

Reflections of Hurricane Sandy

NJAFP WANTS TO RECOGNIZE the efforts of all of our members in going above and beyond to provide care to their patients at the same time they were experiencing the effects of Hurricane Sandy. Thank you for being family physicians.

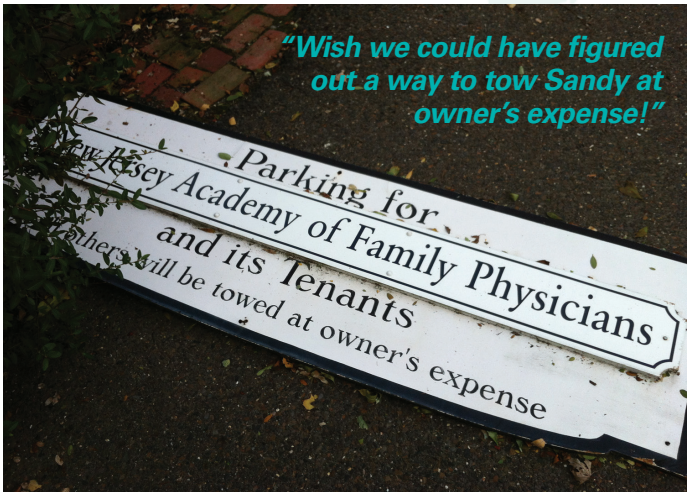
"…if you have exam rooms with outside windows and sunlight, it is worth going to the office. People show up and you can help many of them."

"We keep paper notes--have to ask more history questions like they are new patients since we can't access their charts. The patients think it is great."

"We were able to send out an e-mail blast that we would see walk-ins today during daylight hours. We did not do that last year after the Halloween snow storm and lost 3.5 days in the office and heard from our patients afterward that many drove by the closed office looking for us. We will do this every day until we get power and phones back."

"Our office…is still without power, but a local allergist has some space for us to use, so we are able to see some patients at his office."

"We have seen 25 patients today in exam rooms with windows for light. I feel like an old fashioned country doc."



Hurricane Sandy had a profound impact upon our community, both on a professional level, and for many of us, on a personal level as well. It will be years before New Jersey has fully recovered. Many areas of the state have been altered to the point where they will never be able to come back to their original configurations. Families have lost everything they had, and in some cases don't have the right insurance to cover the damages. The full financial and emotional toll that Sandy has extracted from the residents of New Jersey and New York is still to be felt and recovery efforts will go on for quite some time. Please, if you are able, donate to the relief efforts to help your community, friends, and colleagues get back on their feet. There are many ways that you can donate:

Hurricane Sandy New Jersey Relief Fund

Relief fund established by New Jersey Governor, Chris Christie, and First Lady, Mary Pat Christie, to aid, comfort and rebuild New Jersey. Of the money donated to the Relief Fund, 100% will go towards immediate relief efforts to those affected by Hurricane Sandy in addition to the long term recovery efforts across the state. The purpose of the Relief Fund is to assist in the rebuilding of communities devastated by Hurricane Sandy and help in those areas where insurance, the Red Cross, or FEMA do not cover. The Relief Fund is New Jersey specific – the money raised will go directly to New Jerseyans and their communities.
www.sandynjrelieffund.org

The American Red Cross

The Red Cross continues to focus on reaching as many people as possible who need help. Getting supplies, meals, and water into affected areas is the top priority. Financial donations make the greatest and most immediate impact, helping the Red Cross provide shelter, food, emotional support and other assistance to those affected by disasters like Hurricane Sandy.
www.redcross.org/hurricane-sandy

Restore the Shore

Restore The Shore Projects is an initiative to assist in disaster relief for Hurricane Sandy victims. Their main goal is to work quickly to provide relief and deliver it right into the hands of victims and restore their lives back to normal.
Editor's note: do your homework on this one; there are a lot of options to donate and a lot of sites.
www.facebook.com/restoretheshoreprojects
www.cowerking.com

If you want to volunteer to help with the relief efforts, call ***1-800-JERSEY-7*** (1-800-537-7397) or email ***Feedback@sos.state.nj.us***

To make a bulk contribution of goods, call ***1-855-NJ-DONATE*** (1-855-653-6628). If you wish to donate food, please contact the Community Food Bank of New Jersey at ***908-355-3663***, ***email@njfoodbank.org*** or ***www.njfoodbank.org***

To donate clothing, please contact Goodwill at either Goodwill Industries of Greater New York and Northern New Jersey, Inc.; 718-728-5400, ***www.goodwillny.org*** or Goodwill Industries of Southern New Jersey and Philadelphia, Inc. ***856-439-0200***, ***www.goodwillnj.org***

You can also check out the White House Blog, where there is information and updates on the recovery efforts.
http://www.whitehouse.gov/blog/2012/10/31/how-help-victims-hurricane-sandy

2013-2014 Call for Nominees for the Board of Trustees

Nominations are being sought for the Board of Trustees for the 2013-2014 year. Member involvement is key to the success of the NJAFP. There are eight board positions open for the 2013-2014 year:

- **Three Board of Trustee positions:** *three-year term: 2013 through 2016*
- **One Resident Trustee:** *two-year term: 2013-2015*
- **Two Student Trustees:** *two-year terms*
- **One AAFP Delegate:** *two-year term*
- **One AAFP Alternate Delegate:** *two-year term*

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

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

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

Members in the News…

Al Tallia, MD *(New Brunswick)*, **Claudine Leone, Esq.**, *(Trenton)*, and the NJAFP were featured in an article in *NJ Spotlight* entitled "NJ Doctors Turn to Medical Schools to Help Close Family-Practice Gap." The article focused on the efforts of the NJAFP and New Jersey medical schools to bring more students into family medicine. The article appeared in the November 27, 2012 edition. **Claudine Leone, Esq.**, was quoted in an article in *NJ Spotlight* regarding a bill that would allow advance practice nurses to prescribe without a consulting physician. Ms. Leone stated that the "bill is a step backward from the increasing emphasis on patient-centered medical homes. Under the PCMH model, healthcare providers collaborate closely to deliver care." This article appeared on the November 26, 2012 edition. Ms. Leone was also quoted in a November 16, 2012 article on Medicare Coverage in New Jersey. To view both articles, visit *www.njspotlight.com/healthcare*

Robert Eidus, MD, MBA *(Cranford)* and **Robert Brenner, MD** *(Short Hills)*, were featured in a *NJ Spotlight* article regarding the effects of impending cuts to Medicare reimbursements and its effect on primary care and family medicine in New Jersey. To read the complete article, visit *www.njspotlight.com/healthcare*

Tom McCarrick, MD *(Verona)* and **Mary Campagnolo, MD** (AAFP Alternate Delegate and President of the NJ Medical Society) *(Lumberton)* were quoted in an article entitled "Insurers Latest to Champion Medical Homes" in *American Medical News*. Read the full article at *http://www.ama-assn.org/amednews/2012/10/01/bil21001.htm*

Now More Than Ever...
The NJAFP Needs Your Voice

NJAFP has worked hard to raise awareness of the importance of family medicine and primary care in the state of New Jersey. Local publications reflect NJAFP's voice on issues such as Medicare, PCMH, and the importance of supporting medical students in choosing family medicine. We need all members to help keep this force going, both within the state and nationally. Share your insights and let us know what you think NJAFP leadership can do to improve family medicine in New Jersey.

One of the easiest ways to do this is to write a resolution for the House of Delegates. Don't be discouraged by the formality of a resolution. Help is available. Just contact the NJAFP office for assistance. Resolutions are due in the NJAFP office by May 13, 2013. Check the NJAFP website under the membership tab (*www.njafp.org*) for more details.

Congratulations to…

Robert Eidus, MD, MBA who was recently named to the AAFP Commission on Quality and Practice. Dr. Eidus will serve a three-year term on this commission.

Congratulations to the following NJAFP members who were listed as Top Doctors 2012 by *US News and World Report*. These physicians are considered to be in the top 10% in their region. *(http://health.usnews.com/top-doctors)*

David Bauman, MD . . . . . Woodstown, NJ
Mary Bello, MD . . . . . Mahwah, NJ
Salvatore Bernardo, MD . . . . . Freehold, NJ
Mary Campagnolo, MD . . . . . Lumberton, NJ
Myung Chung, MD . . . . . Morristown, NJ
Richard Cirello, MD . . . . . Verona, NJ
Richard Corson, MD . . . . . Hillsborough, NJ
Anthony Frisoli, MD . . . . . Martinsville, NJ
Joel Fuhrman, MD . . . . . Flemington, NJ
Robert Gorman, MD . . . . . Verona, NJ
Harvey Gross, MD . . . . . Englewood, NJ
Elbridge Holland, Jr., MD . . . . . Chatham, NJ
Ohan Karatoprak, MD . . . . . Fort Lee, NJ
Martha Lansing, MD . . . . . Trenton, NJ
George Leipsner, MD . . . . . Maywood, NJ
John Metz, MD . . . . . Edison, NJ
Dennis Novak, MD . . . . . Forked River, NJ
Anne Picciano, MD . . . . . Edison, NJ
Richard Podell, MD . . . . . Summit, NJ
Craig Quigley, MD . . . . . Carneys Point, NJ
Everett Schlam, MD . . . . . Verona, NJ
Rebecca Steckel, MD . . . . . Somerset, NJ
David Swee, MD . . . . . New Brunswick, NJ
John Tabachnick, MD . . . . . Westfield, NJ
Al Tallia, MD . . . . . New Brunswick, NJ
Peter Tierney, MD . . . . . Plainsboro, NJ
Robin Winter, MD . . . . . Edison, NJ
David Zalut, MD . . . . . Voorhees, NJ
Thomas Ziering, MD . . . . . Bernardsville, NJ

Dates to Remember

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

– – –

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

– – –

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

– – –

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

Call for Family Physician of the Year

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

Please consider family physicians you know who would represent New Jersey as the "best of the best." The physician selected will be recognized in the public relations efforts of the NJAFP, and will be forwarded as the New Jersey nominee for the prestigious AAFP Family Physician of the Year Award. For more information, visit *www.njafp.org/SCSA.*

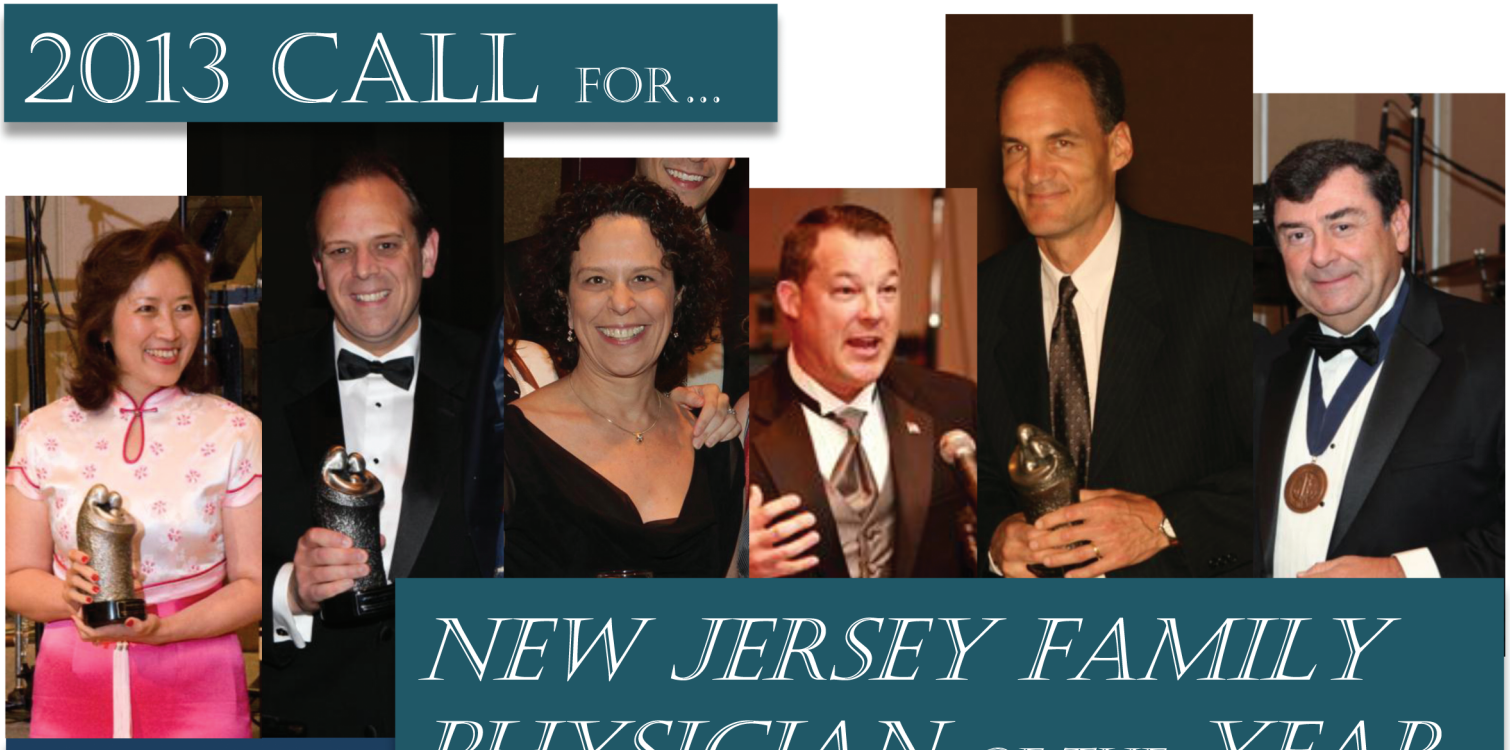
Save the Date

2013 Summer Celebration and Scientific Assembly

Plans are underway for the 2013 Summer Celebration & Scientific Assembly. We've heard you loud and clear… you want something new, something different, something exciting. Well, this year's education committee is working hard to bring you just that.

If you miss the 2013 Summer Celebration & Scientific Assembly, you're going to miss a lot... like "Breast Cancer and the Environment," "Drug Recognition – Cop's Stuff for Family Physicians," "Acupuncture and its Role in Family Medicine," "Dead on Arrival: Heart Disease in Women," and lots more. Visit *www.njafp.org/SCSA*. Details will be posted as they become available.

2013 CALL FOR...



NEW JERSEY FAMILY PHYSICIAN OF THE YEAR

The **Family Physician of the Year Award** provides a means for recognition of individuals who embody the principles of the family physician of excellence. It is the Academy's most prestigious award. The Selection Committee is making its first call for nominees for this award for 2013. Please consider family physicians you know who would represent New Jersey as the "best of the best."

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

GUIDELINES FOR SELECTION

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

TO NOMINATE A FAMILY PHYSICIAN

Members wishing to place a candidate in nomination should submit the following materials to: **NJAFP Selection Committee, 224 West State St. Trenton, NJ 08608**

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

Nominations must be received NO LATER than

APRIL 30, 2013

NJAFP New Jersey Academy of Family Physicians

Temporary Medicaid Payment Increases Coming for Primary Care Physicians

Claudine Leone, Esq.

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

The Centers for Medicare & Medicaid Services (CMS) released its final rule on November 1, 2012 that sets Medicaid payments for primary care services at 100% of Medicare rates for calendar years 2013 and 2014. States will receive an additional $11 billion from the federal government during this period to administer the enhanced pay rates. These enhanced payment rates for 2013 and 2014 were authorized by the Affordable Care Act's (ACA) temporary pay parity provision.

The CMS rule provides:

- Eligible physicians must have a specialty designation of family medicine, general internal medicine, pediatrics or a related subspecialty.
- At least 60% of codes eligible physicians submit to Medicaid in 2012 must be for primary care services, or the physicians must be board certified in their specialties.
- Midlevel practitioners, such as physician assistants and nurse practitioners, may be eligible for the enhanced payments, provided they are supervised by physicians who also qualify for the increase.
- States will receive 100% federal funding for the difference between the Medicaid state plan payment amount for selected evaluation and management services as of July 1, 2009, and the Medicare rates in effect for calendar years 2013 and 2014.
- The Medicaid payment ceiling for children's vaccine administration will be raised.
- The increases will not apply to federally qualified health centers and rural health clinics.
- The estimated federal cost of the pay boosts is $5.5 billion a year for each of the two years.

Nationally, Medicaid's average payment rate for physicians' services is 66% of what Medicare pays. In New Jersey, Medicaid payments to physicians were at 37% of Medicare for 2011 – one of the country's lowest ranked states for payment. New Jersey is also ranked the lowest state in terms of physicians accepting new Medicaid patients – at 40%. The ACA's goal with the provision to set primary care fee schedules on par with Medicare is to improve access to care for Medicaid patients in New Jersey that is, if New Jersey's primary care physicians take the bait.

Primary care physicians must decide whether their practices will participate in Medicaid or accept new Medicaid patients under such a short-term improved payment schedule. It is, however, certain that the states, including New Jersey, will be unable to maintain these rates beyond the two years and access to care problems will resurface unless a permanent funding solution is found. As NJAFP has advocated through the years to the NJ Medicaid program, even maintaining a reasonable bump post-2014 from the current rates in New Jersey may likely make a difference in primary care practices' ability to participate in Medicaid.

The CMS rule recognizes this and has requested data to evaluate the impact of the temporary primary care pay bump. In the event that raising payment rates corresponds to an increase in physician participation in Medicaid, there may be opportunity for CMS to pursue extension of the par payments.

How Does the ACA's Medicaid Expansion Fit in?

With the U.S. Supreme Court's upholding of the ACA, the federal government and the states have focused on its implementation. The court upheld the law's expansion of Medicaid eligibility, but it invalidated a provision requiring states to accept the expansion or forfeit all federal

Measuring Who's Accepting New Medicaid Patients[1]

A recent survey found that 96% of office-based physicians accepted new patients in 2011, but fewer were taking on new Medicaid patients compared with patients with other types of insurance coverage. Midwestern states were more likely than Northeastern states to take on new Medicaid patients, although a few New England states had higher-than-average acceptance rates. The national average for acceptance was 69.4%.

Highest Acceptance Rates:		Lowest Acceptance Rates:	
Wyoming	99.3%	New Jersey	40.4%
Minnesota	96.3%	California	57.1%
North Dakota	94.6%	Florida	59.1%
South Dakota	94.1%	Connecticut	60.7%
Wisconsin	93.0%	Tennessee	61.4%

Reference

1. Decker, S. In 2011 Nearly One-Third of Physicians Said They Would Not Accept New Medicaid Patients, But Rising Fees May Help. *Health Affairs.* 2012;31(8):1673-1679.

Medicaid funding. That effectively gives states an opportunity to opt out of the expansion while maintaining their current Medicaid programs.

The ACA authorizes states to cover individuals up to 133% of the federal poverty line if it decides to expand its Medicaid program fully in 2014. For states that decide not to participate, those above 100% of poverty potentially still could qualify for federal subsidies to buy private coverage through the law's health insurance exchanges. States that refuse the expansion will give up the federal funding designated to pay for the new coverage.

The Rutgers Center on State Health Policy estimates that Medicaid expansion in New Jersey would provide health coverage for 234,000, although some of these residents are already eligible for Medicaid but haven't enrolled. An additional 360,000 people might be able to get group health insurance through the health insurance exchanges, bringing about 800,000 people under coverage in New Jersey.

New Jersey did opt to expand Medicaid eligibility 3 years ahead of 2014 to nearly 70,000 childless adults through a Section 1115 waiver authorized under the ACA and approved by CMS in April 2011. The waiver allowed the state to extend a package of essential Medicaid benefits to low-income residents aged 19 to 64, who are not eligible for traditional Medicaid.

Governor Christie has expressed his skepticism about expanding the Medicaid program in New Jersey further. Without a specific deadline for the states to make a decision on expansion, New Jersey remains listed as a state "leaning no" on the expansion. Regardless of New Jersey's decision on expansion, the ACA's enhanced payment rates for primary care services remains on schedule for calendar years 2013 and 2014. ▲

A Call to Action

continued from page 3

expectation of the promised care coordination fees are now dealing with a potential double-blow of not receiving these promised payments while at the same time facing the Medicare fee reductions in just a few days.

As we enter the Holiday season, and look forward to the annual promise of a new year, the NJAFP calls on our elected officials in Washington, DC and in Trenton to meet their obligation to their constituents to both find thoughtful and sustainable solutions to the pending financial issues that threaten all of us. It is crucial that party and political agendas take a back-seat to the needs of the people that are at risk. As it seems is always the case, those most injured by inaction – or knee-jerk, last minute solutions – will likely be the most vulnerable: the elderly, those with chronic illness, and the underserved. In addition, we call on all stakeholders in the healthcare system, including our state lawmakers, to ensure that our primary care infrastructure is properly valued and capable of providing the care so needed by the citizens of the Garden State. We further insist that payers who take advantage of the positive publicity that they gain from implementing programs that support primary care then follow through and keep the promises that they make.

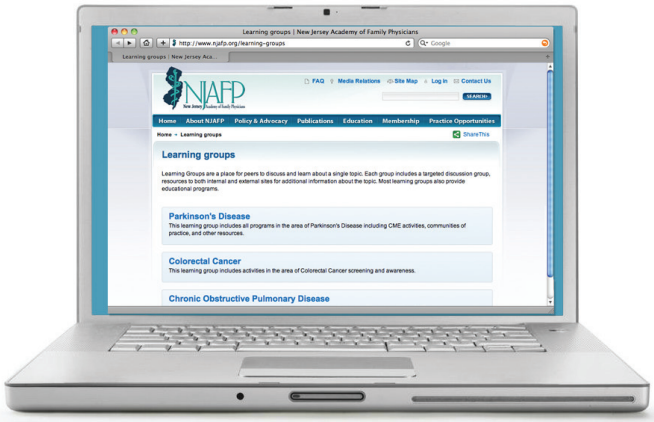
On behalf of the entire staff and physician leadership of the NJAFP, I wish you Happy Holidays and a healthy, peaceful, and prosperous New Year. On a personal note, I am blessed to work on behalf of family physicians and to know so many of you personally. I look forward to another year of fighting your fight, working each day to improve your practice environment and your ability to continue to provide comprehensive, high-quality, cost-effective care to your patients. ▲

CME

NJAFP offers CME online

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

Visit **www.njafp.org** and click on the education tab.



CME TEST ANWSERS: 1) E; 2) E; 3) D; 4) B; 5) F; 6) True; 7) False; 8) True; 9) True; 10) True

HI-TECH VIEW

Moving from Stage 1 to Stage 2 Meaningful Use – What Providers Need to Know:

An Interview with Bala Thirumalainambi

Bill O'Byrne

Bill O'Byrne is the Executive Director of NJ-HITEC, New Jersey's Regional Extension Center.

NJ-HITEC's *Meaningful Use Director, Bala Thirumalainambi, is a nationally recognized subject matter expert on Meaningful Use (MU). Thirumalainambi leads a NJ-HITEC team that assists providers in the fulfillment of MU requirements so they can receive their federal incentives. In late August, the Centers for Medicare and Medicaid Services (CMS) released its Final Rule specifying Stage 2 Meaningful Use criteria that eligible professionals, hospitals, and critical access hospitals must meet to continue to participate in Medical Electronic Health Record (EHR) Incentive Programs. In an interview with Thirumalainambi, he explains what providers need to know about the next stage of Meaningful Use.*

O'Byrne: **Explain the differences between Stage 1 and Stage 2 Meaningful Use Measures based on the new CMS Stage 2 Meaningful Use Final Rule.**

Thirumalainambi: In Stage 1 MU, providers have to meet 15 Core Measures and five out of 10 Menu Measures. In Stage 2, providers have to meet 17 Core Measures and three of five Menu Measures. Many of the Stage 1 Menu Measures moved to the Stage 2 Core Measures. The total remains 20, but the major difference is that a number of Stage 1 Core Measures have been combined in Stage 2 and for a good reason. The Clinical Quality Measure requirement in Stage 1 Core list is a separate requirement in Stage 2, in other words, it is not a Core or Menu requirement. Moreover, the providers will have to report this electronically to meet this measure in 2014.

Stage 1 MU focuses on data collection and Stage 2 MU is all about interoperability, that is, systems communicating between each other. Stage 2 MU is positioned as a use case as opposed to Stage 1 MU, which is more about meeting particular measures. In fact, three of the five Stage 2 Menu Measures relate to providers connecting their EHR system to registries. Unlike Stage 1, when providers could exclude themselves from specific Menu Measures, Stage 2 does not count the exclusions as meeting these measures. The good news is that if a provider is connected to a Health Information Exchange (HIE), which connects to public health registries, then this provider will meet all of the public health requirements that the HIE is connected to, provided the HIE is connected to the registries using the prescribed standards. NJ-HITEC is working with several HIEs in the state and also has capabilities to facilitate the electronic exchange requirement for Stage 2.

O'Byrne: **Have any of the core requirements from Stage 1 Meaningful Use changed in Stage 2 Meaningful Use?**

Thirumalainambi: There were some interesting changes to Stage 1 MU based on the new Final Rule for Stage 2. Consequently, if you are planning to achieve Stage 1 MU in 2013, it's going to look a little different from what it used to look like. First, CMS removed the HIE core requirement. Second, the vital sign core requirement has changed as well. Instead of requiring physicians to record height, weight, and blood pressure, they can record height and weight or blood pressure or both based on their preference. Moreover, providers can request exclusions for one or both categories if this information doesn't fit for the practice.

In addition, the child's age at which pediatricians are required to record height, weight, and blood pressure has been raised from age two to age three, which is more in line with current medical practice. These are not all of the changes, but some of the key differences for providers. Overall, it seems that CMS listened to the feedback it received during the comment period and implemented the new rules accordingly. All of the changes take effect on January 1, 2013 for Stage 1 and are also applicable to Stage 2 that begins on January 1, 2014.

O'Byrne: **Does the Stage 2 Meaningful Use Final Rule affect the current EHR systems that the providers have or will be integrating into their practices?**

Thirumalainambi: Providers also need to know that they must be using a 2014 Office of the National Coordinator (ONC) certified version of an Electronic Health Record (EHR) system, regardless of whether they are in Stage 1 or Stage 2 starting in 2014. One of the reasons CMS is beginning Stage 2 MU in 2014 is because it is going to take time for the EHR vendors to understand, adapt, and develop their software to meet the federal government's standards. It is also a welcome change for the providers as well, because they will have to install and learn how to effectively implement the updated software.

Consequently, based upon this key change, NJ-HITEC is strongly urging all providers to get in the queue for their vendor software upgrade. Initially it was thought that providers would have to demonstrate Stage 2 MU for one year; however, the Final Rule requires providers to demonstrate MU for only 90 days, similar to Stage 1 MU. The reason for the 90-day ruling is because it gives providers more time to understand how the new software works and how to effectively implement the software to meet the federal requirements to attain their third, and possibly their fourth, incentive payment.

O'Byrne: **Based on what you have explained, it's clear that providers need to be working closely with their vendors to make Stage 2 MU happen.**

Thirumalainambi: That is correct. The providers have to push their vendors a little to ensure that they will receive the upgrade in a timely manner. The majority of vendors are on track because the ONC has released the draft standards for EHR certification through the National Institute of Standards and Technology. Currently these standards are in the comment phase. Once the comment period closes, the final standards will be documented and released. Once that happens, the vendors will know the procedures they have to follow and the functionality that their software must contain to become ONC certified. The vendors will not be shy about telling the providers that their software upgrades are ONC certified and ready for implementation.

O'Byrne: **How are Stage 2 Meaningful Use requirements going to fit into a provider's current workflow?**

Thirumalainambi: The Medicare providers, who started in 2011 and have attested to the 90-day MU period and completed a full year of Stage 1 MU in 2012, will be doing a subsequent year of Stage 1 MU in 2013. But keep in mind the HIE core requirement and vital sign changes will also go into effect for those providers on January 1, 2013.

In 2014, providers will begin working on the Stage 2 MU standards beginning with the 90-day period, followed by a full year of Stage 2 MU in 2015. Stage 3 MU should begin in 2016 and those standards are currently under development.

Medicaid providers have a longer time frame to meet the federal requirements, from 2011 through 2021, which includes all three stages of MU. These providers have to demonstrate six years of MU within this time period to receive the maximum federal incentive. However, the six years do not have to be consecutive.

O'Byrne: **We know that in order to receive the full Medicare incentive payment, providers had to begin the 90-day reporting period for Stage 1 MU on an ONC certified EHR system by October 3, 2012, but will providers be penalized when billing for Medicare reimbursement if they fail to implement a certified EHR system?**

Thirumalainambi: In addition to the lower incentive payments if providers failed to meet the October 3, 2012 deadline, Medicare has already established a schedule of penalties for those providers who are not meeting the Stage 1 MU criteria beginning in 2014 (providers should attest before October 1, 2014). For those providers who have a large contingency of Medicare patients, these penalties will add up quickly in lost revenue to the provider. The penalties are based on when providers plan to demonstrate MU and will increase from 1% to 5%. ▲

For more information on Stage 1 and Stage 2 Meaningful Use requirements as well as PCMH, please call NJ-HITEC at (973) 642-4055, send an email to info@njhitec.org, or visit us at www.njhitec.org.

MY VIEW

SOI IS COMING! SOI IS COMING!

Jeffrey A. Zlotnick, MD, CAQ

Jeffrey A. Zlotnick, MD ("Z") is a past president of the NJAFP and Medical Consultant to Special Olympics New Jersey MedFest program. He lives in Easton, PA.

I was not in Philadelphia for the AAFP national meeting because I was invited to a conference for Special Olympics in Louisville, KY. The conference was described as a "Train the Trainers" session for starting a MedFest program. New Jersey already has a MedFest program, which we have been successfully running for almost 10 years. I have been known to comment (tongue in cheek) that Special Olympics International (SOI) has never recognized what we have put together… well, seems I was wrong. SOI is very aware of what we are doing and they invited me to the conference to present on NJ MedFest.

The Louisville conference focused on the MedFest conducted by the Kentucky Special Olympics chapter. Dr. Matthew Holder, Medical Director, and the Kentucky chapter did an incredible job, certifying about 300 athletes! The conference participants observed the Kentucky MedFest in order to take best practices back to their own states. In addition, I discussed how we produce MedFest in New Jersey and shared some ideas that have been successful for us.

As a result of the conference, there will be modifications to the MedFest program, the first significant one being the change to the athlete patient form. SOI will now require a much more detailed athlete history, including a comprehensive list of medications. NJAFP previously recommended this change; however, Special Olympics New Jersey (SONJ) was concerned that some information might actually hinder athletes from competing. Ultimately, it was determined that the more information a coach had on his or her athletes (medical history and medicines), the better the care that could be provided in the field should something occur. The MedFest motto is "NOBODY fails!" SOI agreed that a more thorough medical history would enhance the athlete's safety and in no way remove them from being able to participate in some capacity.

Special Olympics International agreed that a more thorough medical history would enhance the athlete's safety and in no way remove them from being able to participate in some capacity.

Dr. Z (L) and Dr. Seth Keller (R) of Special Olympics International

Another change will be to the station exam system. SOI prefers the practitioner or physician to do the entire physical examination, rather than using different providers at each station, as we do in New Jersey. After some discussion, a compromise was reached. It was decided to continue using stations for Intake/History and Vitals, and combine the HEENT (Head, Eyes, Ears, Nose and Throat), Heart/Lung, & Abdominal Exam stations. New Jersey will also continue using the volunteers from the Athletic Trainers Association to do the orthopedic evaluations in the musculoskeletal exam station.

Finally, there will be a better tie-in to the Healthy Athletes Program. Athletes found to have medical issues in the main areas covered in the program (vision, hearing, oral health, healthy lifestyles, general fitness, podiatry) will be referred for further evaluation. We will be working with SONJ on how to make those referrals more effective.

One of the unique attributes of the New Jersey program is how we move the athletes through the stations in small groups of 3 to 5. It is evident that being able to observe their fellow group members alleviates the anxiety some athletes experience when being examined alone. Dr. Holder expressed interest in this successful tactic and will be passing it along to other MedFest programs.

Another unique attribute of the NJ program is that it is also a teaching program for the state's Family Medicine residency programs. SONJ's MedFest program fulfills some of the core requirements for residents by providing them the experience of working within the special needs population, while performing a community service, and offering sports medicine training. Two of the participants at the Kentucky conference were residents looking for a way to get

Special Olympics

Exam Stations: Kentucky Special Olympics MedFest

their residency programs to participate. We were able to provide them with a training model, to the mutual benefit of the Family Medicine residencies and Special Olympics.

It is also important to mention that in preparation of MedFest, New Jersey offers an online training program: "Pre-participation Exam in the General and Special Needs Populations." Volunteers new to MedFest must first view this CME accredited program before participating in a live event. As an additional teaching tool, we will also be developing a video demonstrating the physical exam for a Special Olympics athlete. Through these educational programs, we hope to be able to answer the lingering questions of "how much is too much, and how much is too little," and understand that "normal" is a relative term anywhere it may be used.

Many athletes have medical problems and physical disabilities, yet the goal is to have 100% participation. MedFest documents what an athlete's barriers are so Special Olympics can create an "Adaptive Sports Program" that can provide the athlete the ability to participate in their own unique capacity. In New Jersey, "NOBODY fails!!"

It is exciting to have this opportunity to demonstrate to other state Special Olympic chapters what we have accomplished with our program in NJ and have it serve as a model for others to follow!

Now for the really big news... the 2014 National Games will be held in Princeton, New Jersey, June 13 - 21, 2014, and the New Jersey MedFest program is going to be a very big part of it!

SPECIAL PROJECTS VIEW

Summer 2012
Tar Wars is Presented in India!

Shruti Nadkarni

Shruti Nadkarni is a freshman at Kean University/Drexel University's College of Medicine's BS/MD Program. Ms. Nadkarni was the recipient of the 2010 Tar Wars Star Award for presenting "Tar Wars with a Twist" as a young adult in peer-to-peer learning groups.

'TAR WARS WITH A TWIST' is the AAFP's national program that teaches a tobacco-free message to 4th and 5th graders in peer-to-peer learning groups. Under the guidance of the AAFP and NJAFP, I adapted this program from the original Tar Wars program during my sophomore year of high school after learning statistics of adolescent smokers had skyrocketed during the past decade. I started my outreach by teaching young children in my school district about the harmful effects of smoking. Tar Wars with a Twist is also presented in other states by young volunteers who have adapted the program for their communities.

Last summer, I researched statistics about tobacco usage worldwide and realized that the misuse of tobacco products is a universal problem around the globe. I became interested in spreading the anti-smoking message not only on a state/national level, but also internationally.

In August 2012, I traveled with my family to India, one of the most densely populated third-world countries, second only to China. India has a huge problem dealing with the explosive growth of tobacco usage among young adults.[1] Based on my research, I had found that a very common tobacco product in India is called "beedi." It looks like a cigarette but it is a slightly different shape and size and is unfiltered.

Being a Girl Scout and a Gold-Award Girl Scout Recipient, I decided to visit Sangam World Centre (Girl Scout Center), which is located in the city of Pune in Maharashtra State to do my presentation. I decided to present a modified version of 'Tar Wars with a Twist,' customized to an international audience. I presented to a group of international, young adult Girl Scouts and Girl Guides.

During the presentation, I asked about tobacco use in their respective countries. I learned that some had traveled to India from as far as Kenya, Australia, and South Korea. One girl was from the U.S. We discussed the harmful effects of tobacco. To demonstrate this we performed the 'straw experiment.' This exercise illustrates the difference between a smoker's lung and a non-smoker's lung. We talked about the differences in common tobacco products in different countries.

At the conclusion of the program, I explained about the poster and video contest that we run in the U.S., where interested participants have the opportunity to draw a poster or make a video creatively depicting what they learned. If they wish to present the program in their own communities, I suggested that they may also consider a similar contest for their students.

The Tar Wars with a Twist program was very well received and many of the Girl Scouts and Girl Guides expressed an interest in implementing similar programs in their home countries. I was pleased to have the opportunity to present this tobacco awareness program to an international audience, hopefully inspiring them in turn to teach the important Tar Wars message to children in their own communities.

Although I realize this is only one small step towards building a global smoke-free society, I would like to do my part to continue to spread the anti-smoking message throughout the U.S. and the world.

For more information about 'Tar Wars with a Twist' go to www.tarwars.org.

Reference

1. Perry, C, Stigler, M, Arora, M, et al. Preventing tobacco use among young people in India: Project MYTRI. *American Journal of Public Health*. 2009;99(5):899-905.

Study Finds Many Health Insurance Plans Fall Short in Covering Tobacco Cessation Treatments Mandated by Health Reform Law

Many health insurance plans are failing to provide coverage mandated by the health care reform law for treatments to help smokers and other tobacco users quit, according to a study of insurance contracts by Georgetown University researchers conducted for the Campaign for Tobacco-Free Kids.

The Affordable Care Act (ACA) requires all new private health insurance plans to cover preventive health services recommended with an A or B grade by the U.S. Preventive Services Task Force (USPSTF), with no cost-sharing such as co-pays. These recommendations include tobacco cessation treatments, which received an A grade. The USPSTF recommends that clinicians ask adults about tobacco use and provide cessation interventions for tobacco users. It found that more or longer counseling sessions improve quit rates and combining counseling with medication is more effective for treating tobacco dependence than either therapy used alone.

To determine how the cessation coverage requirement is being implemented, insurance experts at the Georgetown University Health Policy Institute analyzed 39 health insurance plans sold in six states, including individual, small group, federal employee and state employee plans. The study was commissioned by the Campaign for Tobacco-Free Kids with funding from Pfizer, Inc.

The researchers found that many policies are rife with confusing and conflicting language that could leave consumers uncertain if tobacco cessation treatments are covered and discourage them from seeking these treatments. It also found that many policies included gaps in coverage for cessation counseling and medication and cost-sharing requirements that appear to conflict with the law.

"Absent detailed guidance, huge variations in benefits will continue to be a problem, and tobacco users' access to tobacco treatment will continue to be limited. Finally, absent additional steps by federal or state regulators, the promise of reducing tobacco use – saving lives and saving health care resources – will not be realized fully," the report concludes.

The study can be found at *http://tfk.org/coveragereport/*

Inspiration

During the holiday season, it is easy to get caught up in the frazzled, crazed pace that we all seem to fall into. We worry if our efforts will even be recognized. What if the sweater doesn't fit? Or worse, they hate it. They already have that book—and by the way they use a Kindle now… who knew?

Do you want to make a positive impact that will be appreciated? Please take a moment and consider making a contribution to support the vision of the NJAFP Foundation. You can make a donation to recognize someone special, perhaps honoring their commitment to health care, or maybe their commitment to *your* health care. Consider the ways your contribution will be used to enhance the vision of the NJAFP Foundation.

New Jersey Academy of Family Physicians Foundation Vision

- Increase interest in family medicine among medical students and college students through its scholarship and grant programs
- Assist men and women in entering the practice of family medicine in New Jersey through preceptor programs and resident repayment programs
- Enhance the specialty through encouragement and support of research by medical students and family physicians ▲

"No one has ever become poor by giving."
– Anne Frank

"Give when asked, even be it a little."
– Siddhartha Gautama

"When you learn, teach. When you get, give."
– Maya Angelou

"It is in giving that we receive."
– Saint Francis of Assisi

"To give without any reward, or any notice, has a special quality of its own."
– Anne Morrow Lindbergh

Thank you for your generosity!

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Joseph P. Wiedemer, MD is a Trustee of the NJAFP and is the Director of the Mountainside Family Medicine Residency Program in Verona. He has been an Academy member since 1995. He resides with his family in Ringoes, NJ.

TEAMWORK

Joseph P. Wiedemer, MD

No one in my immediate family is a physician; however, when I was a child I knew that I wanted to be a family doctor. My own family doctor inspired me. I remember his office having a large wooden desk and a skeleton in the corner. He was in solo practice. I don't think he had a nurse, but he had a "receptionist" who did nursing. He was warm, calm, and reassuring. I used to think that one day I would be in a four-provider practice in a small town. Expectations and opportunities have a funny way of not working out the way we imagined they would.

After completing my own residency, I joined another residency program as a clinician. I later became faculty, then had the opportunity to become the Associate Director and then Interim-Director. About 90 days ago I became Program Director at another residency program in New Jersey. I love where I am, and this new position opens up many opportunities that I never even envisioned for myself.

Throughout my medical training I became very independent and fairly self-sufficient, as I think most of us did. Now in my new position, I look at office designs to help people work together to be more efficient. I read about team building and I plan huddles. There is nothing in my current world that resembles the world of my childhood family doctor. Our new, patient-centered medical homes are designed around team-based care, care coordination and quality improvement.

I have had the opportunity to see some of this new approach to family medicine in action. I recently donned my stethoscope to see a patient. I knocked on the exam room door and opened it to see a 54-year-old man leaning over the exam table in an awkward position with one hand on his back.

"Hi!" I introduced myself. "What's going on?"

"I hurt my back. I hurt it last year and then last week it flared and keeps getting worse each day," he replied.

"What did you do last year?" I ask.

"I strained it. I didn't have a disc or anything," he sighs.

"What did you do to deserve this now?" I ask.

"Nothing. I gave up biking and playing the drums because of my back. Since then my belly has gotten bigger and now my back hurts," he rolls out in one breath.

"You pretty much summed up why you are here today," I answer smiling.

"I just don't know what to do!" he blurts out with a tone of frustration.

I examined him, found no signs of a herniated disc, but I did feel muscular spasm along his lumbar spine.

"I think you are going to be fine. You're right – you need to get back to being more active. It's going to take some time though." I taught him some back stretching and strengthening exercises and referred him for physical therapy.

My nurse knocks at the door and pokes her head in, "Do you want a flu vaccine? I see that you have not had it yet this year."

I'm excited to teach new family physicians. I hope to have many of them stay in NJ. We need them.

"Yes, that would be great. Will it help my back?" he smiles.

"No, but it will keep you healthier," she answers.

I walked out of the room and one of my front staff met me.

"I don't think he's had a physical exam. Do you want me to set that up? He usually sees Dr. S," she informs me.

"Thanks, that's great," I answer.

It came together as a bit of team-based care. I'm proud of my staff for picking up on the care pieces that I missed.

I hope to begin seeing patients more regularly now that I am getting settled into my new role. I'm happy to start again, and it gives me an appreciation for issues that the residents and faculty face in caring for our patients. The challenges that we face are broad as we create a new model of care for our residents and for our patients. They will grow in an environment of collaboration and not isolation. It is an exciting time. I am excited to lead this group to develop the skills needed to practice in the 21st century. The road ahead has many bumps and curves in it as we wrestle with the acronym soup of ACOs, ACA, PCMH and MU.

I believe we can make a better healthcare system. We can't do it alone, and it will be challenging. I am excited about the new opportunities before us. I'm excited to teach new family physicians. I hope to have many of them stay in New Jersey. We need them. I plan to prepare them to practice across the state in state-of-the-art practices. I know many of you are looking for their help, and you will be happy to have them.

As always, I look forward to your comments.

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