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Perspectives

A VIEW OF FAMILY MEDICINE IN NEW JERSEY

VOLUME 15, ISSUE 1 • 2016

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- Managing MDD
- Childhood Developmental Coordination Disorder
- Restless Legs Syndrome During Pregnancy

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Back to the Bedside

THERESA BARRETT, PHD, CMP, CAE *Managing Editor*

I was recently invited to attend a symposium entitled "Back to the Bedside." The focus of the symposium was physician education, a topic that is of much interest to me (hence the invitation). The session began with the history of physical diagnosis presented by Michael LaCombe, MD. Dr. LaCombe, a practicing cardiologist, is the associate editor for the "On Being A Doctor," "On Being A Patient," and the "Ad Libitum" sections of the *Annals of Internal Medicine*. He has also authored a vast collection of stories and essays that have been published in peer-reviewed medical journals.

Dr. LaCombe's presentation began by discussing the earliest known physician. Of course, I thought Hippocrates. I was wrong. The earliest recorded physician was Imhotep. Imhotep lived around 3,000 B.C. in Egypt. He was noted not only as a physician, but also as an architect, astronomer, scribe, and author of ancient wisdom.[1] He was one of the few commoners to be deified by the Egyptians and also by the Greeks, where he was equated with Asclepius, the Greek god of healing.[2] Sir William Osler called Imhotep "…the first figure of a physician to stand out clearly from the mists of antiquity." [3]

From Imhotep, Dr. LaCombe continued to discuss the great physicians of history and their impact on bedside teaching. He spoke of Hippocrates (450 – 380 BCE) who emphasized observation and clinical inspection and recorded his findings so others could share in his knowledge (42 case reports still exist and were the standard text disease description up until the late 1800's[4]) as well as many other great physicians who advanced medical science and medical education through bedside teaching.

I could easily write an entire thesis based on my notes from Dr. LaCombe's lecture (and maybe someday I will), but what struck me as he continued through the history of medical education was how technology has inserted itself between the physician and the patient. Dr. LaCombe stated, "One can figure things out by being at the bedside," yet this practice is falling by the wayside as diagnoses become based first on tests and then the history and physical exam.

Near the conclusion of his lecture, Dr. LaCombe cited a work by Sir Richard Hutchison, a noted Scottish physician and teacher at London Hospital and the Hospital for Sick Children in the late nineteenth and early twentieth century. He is famous for his book "Clinical Methods" (now in the twenty-second edition) as well as for his clinical sayings and a petition he wrote to physicians later in his life:[5]

From inability to let well alone
From too much zeal for the new and contempt for what is old
From putting knowledge before wisdom, science before art, and
Cleverness before common sense;
From treating patients as cases;
And from making the cure of the disease more grievous than the Endurance of the same,
Good Lord, deliver us.

This petition was written 75 years ago, when the world of medical practice was quite different from what it is today.[5] However, it remains relevant. And while the petition is directed to physicians, I believe even those of us who are not physicians can find the wisdom in Dr. Hutchison's words. I am grateful I had the opportunity to hear them.

Happy Reading,

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Reflections

ROBERT T. GORMAN, MD

As 2015 was coming to an end, I spent some time reflecting on the increasing difficulties we face in the delivery of medical care, as well as the ever growing number of regulations and external requirements. We deal with the expanding, complex medical problems of our patients, and at the same time, translate these diagnoses into new ICD-10 codes, while keeping an eye on all of the reporting requirements of the Meaningful Use Program. By the end of December, I like many of you, was feeling tired.

I have been working with my EHR for 10 years now, and I cannot imagine trying to deliver comprehensive medical care without it. There are many ways in which our lives have been made better, including our ability to keep track of medical problems, medications and potential drug interactions. Just think how much easier it is now to handle medication refills with just a few mouse clicks (remember what it was like before that?). With all of this wonderful technology, it is more important than ever to lift our faces from our computer screens, and get back to making eye contact with our patients.

When CMS Acting Administrator, Andy Slavitt announced on January 11th that Meaningful Use would end and be replaced by something better, and that technology needed to be user-centered to support physicians and not to distract us, I thought 2016 was off to a great start. Comments that appeared later in the month raised questions about exactly what would change and when.

I am still encouraged that many policy makers understand the value of primary care and family physicians in particular, to a healthcare system that is more cost effective and quality-based. I believe that many of them are interested in working with us to move in the right direction, so that these objectives are met and a healthy workforce of physicians is in place. What happens after the MACRA regulations are released in the spring is not yet known, but we need to stay at the table so our voices are heard.

In February I participated in the annual Ten State meeting with other NJAFP senior leadership and staff to share our perspective with other states and AAFP leadership as we try to influence this process. Some of us will also be travelling to Washington, D.C. this spring to personally meet with members of Congress for a more up-close discussion. I would encourage any members with ideas and concerns to share them with us at the NJAFP so that when we speak, we do so as a collective voice that represents you. I would also encourage any of you who have not directly contacted your own representatives in Congress, to consider doing so during these important times when policies are being changed. The AAFP has made it quite easy for us with their Advocacy Toolkit http://grassroots.aafp.org/aafp/advocacytoolkit. Take a look at it, and click on a few links to let your elected representatives know what we need.

On the home front, the last two meetings of the NJAFP Board of Trustees have involved discussions with some of the top leadership at Horizon Blue Cross Blue Shield of New Jersey and the New Jersey Heath Care Quality Institute. Through these dialogues, we gain both an understanding of important market forces within our state and advocate for the needs of our members to be able to care for New Jersey's citizens.

I am still encouraged that many policy makers understand the value of primary care and family physicians in particular, to a healthcare system that is more cost effective and quality-based.

I have been focusing on issues that weigh us down in the practice of medicine, and I want to remind those of you who are not currently taking an active role in teaching our medical students and residents, that this is an invaluable opportunity to bring excitement and enthusiasm back into your own workday. Witnessing the exhilaration of a medical student who has just observed an interesting or challenging case, or who is amazed at the fulfillment we receive from providing longitudinal care to families, is a reward in itself. It reminds me of the extraordinary joy you experience when you return to Disney World for the 10th time, but with young children for the first time. You see the same things through fresh eyes, and their enthusiasm is contagious.

We are able to earn 20 CME credits a year through the AAFP with good reason. Teaching students can be a two-way street, where both parties benefit. Providing strong role models for young, future doctors is an important early step in strengthening the primary care base here in New Jersey. I frequently joke with my patients, explaining to them that the reason I like to teach medical students, is so that I will know who the good doctors will be when I am old (although I feel like I have been saying that for a long time now).

As we continue work to improve the environment for the practice of medicine, we should try to keep an eye on the things that bring joy to our work day; making the elusive diagnosis, hearing the wonderful family stories and appreciating that hug at the end of the visit. And then share them with a student. ▲

Robert T. Gorman, MD is President of the New Jersey Academy of Family Physicians and a practicing family physician in Verona, NJ.

The Promise of Spring

RAY SAPUTELLI, MBA, CAE

As I write, pitchers and catchers have reported. The baseball season is days away. All is right with the world. Ok those who know my sports allegiances know that not ALL is right with the world, but there is always hope in April. This time of year is a time that I look forward to like a child awaits their birthday. I love beginnings. The thought of building, imagining how close the image in my mind is to what the sweat and perseverance will deliver in the end, and the truth in the idea that in April you can still prove all the naysayers wrong is what makes this time of year so wonderful. So it's not a surprise that at this time every year I find myself not reflecting on the past, but looking toward the future for NJAFP and the wonderful family physicians that we serve.

As I look forward it isn't difficult to see what lies ahead, but what we will do with it, how we will position ourselves to take advantage of the path will make all the difference. For so long we have been waiting for payment reform. It's here. Doug Henley, Executive Vice President of the AAFP said recently "What's ahead is the most important time in the almost 40 years that I've been involved in the academy as a physician member and now as a staff leader." I think he's right. I recently asked another member of the AAFP staff with regard to MACRA implementation: "What could go wrong?" I thought I was lobbing him a softball that would allow him to talk about the upcoming presidential election. His answer surprised me. He said "Wow. So many things. We could get this metric or that measurement wrong, we could overlook…" At that moment it became clear to me that another rite of spring was ahead for me. My annual call to arms was next on my to-do list, because if this time is so very critical to the family physicians we serve, the patients they serve, and the nation's healthcare system in general, we must be forward focused.

Some of you will no doubt say that what comes next is at best a reach, because I am about to say that we need every family physician, every resident in family medicine, every medical student who has read this far to think about how they can get involved with the NJAFP. I am going to suggest that if we don't position ourselves to live in a future that WE'VE designed, we will most certainly live in one designed by people with much less understanding of what's truly important. As Michael Fleming, past-president of the AAFP was fond of saying; "If you aren't at the table, you'll be on the menu." More than that, however, I am going to ask you to think about coming to Atlantic City in June and – at least – be a part of the dialogue that will take place around the issues so crucial to family physicians in New Jersey. I'm even going to ask some of you to get more deeply involved in the leadership of the NJAFP at the committee or even board level. I can hear the chorus: "What power do we have? What difference can a state chapter of the AAFP make in issues like payment reform and the vast systemic changes that will be required?" Some of you may even question the work we've done to date. You may question our position on the issues, big and small, and wonder why we did "this" or didn't do "that." If that's you, then it's most assuredly you to whom I am focusing this plea on more than any other. It's not hyperbole to say that your academy, your specialty, your patients, and the entire healthcare system of our country have never needed you more.

If we don't position ourselves to live in a future that WE'VE designed, we will most certainly live in one designed by people with much less understanding of what's truly important.

In June the NJAFP will once again meet in Atlantic City. The House of Delegates will reconvene and discuss resolutions of importance to the membership. WHAT? What did I just write? For those of you, like me, who have nightmares at the sound of the words "House of Delegates" and "resolutions" please allow me to translate. Every June, family physicians who want to make the world a better place come together for one short day (in the grand scheme of days) and discuss issues, share thoughts and ideas, and help to set the future direction of the NJAFP – the only organization on the face of the planet whose sole mission is to serve family physicians and the patients for whom they care. The discussion this year will no doubt be focused on how we adapt to the changes that MACRA will bring; how we position ourselves to be ready for the value-based payment model that we've advocated for over the past 10-15 years; how we will learn to navigate, and help our patients navigate, things like "tiered networks" and how the academy will educate policy makers and legislators to ensure that as these new models and concepts are put into place, that they (we) get it right.

Later in this issue you will find a call for resolutions. Resolutions give focus to the discussions. You will also find a call for nominations, because after the discussions in June we need leaders who are willing to give the time to help us put the ideas into action. You will also find perhaps the most important call: the call to attendance. If you do nothing else all year to serve your specialty – and I know how precious your time is – join us on Friday, June 10 at the Sheraton in Atlantic City for the House of Delegates. Participate in the discussion and help us set the direction for what is likely the most important time in family medicine in at least the last 40 years, if not ever. It's springtime. The time of rebirth, renewal, and most of all, spring training! Shame on us if we miss the opportunity that the new season offers.. ▲

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

Interim Guidelines for Prevention of Sexual Transmission of Zika Virus – United States, 2016

AS IT IS POSSIBLE that the Zika virus, a mosquito-borne flavivirus primarily transmitted by Aedes aegypti mosquitoes,[1] can be spread through sexual transmission, the CDC has issued interim guidelines for preventing the spread of the disease through this method.[2] These guidelines are based on three cases where men developed symptomatic illness.

The CDC recommends the men who have traveled to or reside in areas where the Zika virus is active and have a partner who is pregnant, should abstain from sexual activity or use condoms during sex for the full course of the pregnancy.[2] For men with non-pregnant sex partners, the CDC also recommends abstinence or the use of condoms.

The recommendations further state that couples should take into account that most infections are asymptomatic, and should illness occur, it is usually mild with symptoms lasting from several days to a week. Hospitalization for severe disease is uncommon.[2] The risk for acquiring the Zika virus in places where it is active depends on the extent and duration of exposure to infected mosquitoes and the steps taken to prevent mosquito bites.[2] After infection, Zika virus might persist in semen when it is no longer detectable in blood.

Testing has been recommended to diagnose the Zika virus in pregnant women and other groups.[3] Testing of men to assess risk for sexual transmission is not recommended as knowledge of the incidence and duration of shedding in the male genitourinary tract is limited to a single case report in which the Zika virus persisted longer than in blood.[4]

As more is learned about the virus recommendations to prevent sexual transmission of the Zika virus will be updated. The full guideline can be accessed at http://www.cdc.gov/mmwr/volumes/65/wr/mm6505e1.htm

Additional information on the Zika virus can also be found on the New Jersey Department of Health website at http://www.nj.gov/health/cd/zika/index.shtml

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USPSTF UPDATED RECOMMENDATION ON DEPRESSION SCREENING

THE UNITED STATES PREVENTIVE SERVICES TASK FORCE released their final recommendation statement on screening for depression in adults.[1] USPSTF stated that there is "convincing evidence that screening improves the accurate identification of adult patients with depression in primary care settings, including pregnant and postpartum women."[1]

Recommendation Summary[1]

Population: General adult population, including pregnant and postpartum women

Recommendation: Screen for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.

Grade: B – there is high certainty that the net benefit is moderate or there is moderate certainty the net benefit is moderate to substantial.

More information can be found in the January 26, 2016 edition of JAMA available at http://jama.jamanetwork.com/article.aspx?articleid=2484345

Depression in New Jersey

According to the New Jersey Department of Health, 10 to 20% of women develop a mood disorder during their pregnancy and up to one year after delivery of their child.[2] The NJDOH website provides information and resources on Perinatal Mood Disorders (PMD) for both patients and physicians. Visit http://www.state.nj.us/health/fhs/postpartumdepression/ for more information.

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2016 IMMUNIZATION SCHEDULES AVAILABLE

The Advisory Committee on Immunization Practices (ACIP) has released the 2016 Immunization Schedules for Children and Adults. Each year the schedules are reviewed to reflect current recommendations for Food and Drug Administration-licensed vaccines. The 2016 schedules contain several changes from the 2015 schedules. Immunization schedules are approved by ACIP, the American Academy of Family Physicians, the American Academy of Pediatrics, and the American College of Obstetricians and Gynecologists.

The most current immunization schedules can be found on the Vaccines and Immunizations pages of CDC's website (http://www.cdc.gov/vaccines/schedules). Family physicians should be aware that changes in the recommendations for specific vaccines can occur at any time between the annual updates. When this occurs, updates are posted on the ACIP Vaccine Recommendations page at http://www.cdc.gov/vaccines/hcp/acip-recs/.

Perspectives

A View of Family Medicine in New Jersey

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CME Depression

THERESA J. BARRETT, PHD

Dr. Barrett has no relevant financial conflict regarding this topic.

Learning Objective

- Discuss the management of major depressive disorder in patients with MDD

Introduction

It is difficult for those who have never experienced major depressive disorder (MDD) to understand the level of distress it causes for both the patient and their families. The emotional and psychological weight affects the entire physiology of the patient. Depression not only impacts quality of life, it is also an independent risk factor for all-cause mortality,[1] mortality from diabetes,[2] and contributes to adverse outcomes in acute coronary syndrome, congestive heart failure, isolated systolic hypertension, and myocardial infarction. [3, 4]

It has been shown that most patients with MDD are seen in primary care offices, yet few patients will discuss their symptoms with their physician.[5,6] Instead, they will present with somatic symptoms such as chronic pain or headache.[5] According to the Behavioral Risk Factor Surveillance System (BRFSS) at some point in their lives 22.7 million adults in the United States have been told they have depression.[7] According to the results of the 2013 New Jersey Behavioral Risk Factor Survey, 13.9% of New Jersey adults have been told by their physician that they have depression.[8] Women are more likely to have depression than men, as were adults 18 to 24 when compared to adults age 55 or older.[7] Depression is also common postpartum, affecting not only the mother but the child as well.[9]

United States Preventive Services Task Force Guidelines

Because of the prevalence of MDD and its impact on the population, the US Preventive Service Task Force (USPSTF) has updated its recommendations for depression screening in adults.[9] USPSTF recommendations are based on the evidence for both the harms and benefits of a treatment or service and an assessment of the balance between the two.[9]

The 2009 USPSTF recommended screening for depression in clinical practices that had systems in place to ensure accurate diagnosis, effective treatment, and follow-up.[10] USPSTF also instructed physicians not to screen when staff-assisted depression care supports were not in place.[10] In the intervening years awareness of the importance of integrating mental health into primary care grew and the USPSTF recognized that support is more widely available. Based on this trend, USPSTF stated that selective screening is no longer recommended as it no longer represents current clinical practice.[11,12,13]

The 2016 USPSTF recommendation statement for depression screening in adults advises "… screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up."[9] The USPSTF considers "adequate systems" a depression care manager who is responsible for patient screening, and if the screening is positive for depression, for ensuring appropriate diagnosis and treatment using evidence-based stepped care or referrals to specialty care when necessary.[9]

Screening

Several screening tools are available for use in primary care. Two tools that are easy to use in family medicine are the Patient Health Questionnaire-2 (PHQ-2) and the Patient Health Questionnaire-9 (PHQ-9). The PHQ-2 asks two questions related to the frequency of depressed mood or anhedonia in the past two weeks.[14] PHQ-2 has been shown to be as effective in ruling out depression as longer scales such as the Zung Depression Scale or the Beck Depression Inventory.[15] If the patient has a positive screening with the PHQ-2, the PHQ-9 is used for confirmation.[16] The PHQ-9 can, and frequently is, used alone because it is valid, takes 2-5 minutes to complete, and has demonstrated 61% sensitivity and 94% specificity for mood disorders in adults.[17]

Older depressed adults may present with primarily somatic symptoms rather than the articulated sadness seen in younger adults. As a result several screening instruments, such as the 15-item Geriatric Depression Scale, have been developed specifically for this population, though shorter forms have been shown to be equally effective.[18] The American Geriatrics Society recommends the PHQ-2 as an initial screening tool and, if positive, follow-up with the 15-item Geriatric Depression Scale or the PHQ-9.[19]

Diagnosis

When a patient does screen positive for depression, the diagnosis should be confirmed by following the DSM-5 criteria for MDD. According to the DSM-5, a diagnosis of MDD is warranted when a patient reports a depressed mood or anhedonia, plus four or more of the following symptoms:[20]

- Significant weight loss (when not dieting) or weight gain (+/- 5 percent of body weight in a month) or a marked increase *or* decrease in appetite nearly every day
- Excessive sleepiness *or* insomnia
- Agitation and restlessness
- Fatigue
- Feelings of worthlessness or excessive and inappropriate guilt nearly every day
- Diminished ability to think, concentrate, or make decisions
- Recurrent thoughts of death or suicide

Symptoms must be present most of the day, nearly every day, during a two-week period. In addition, the symptoms must cause clinically significant distress or impairment in social, occupational, or other important functioning areas, and should not be attributable to other medical conditions or the effects of substance use or abuse.[20]

Treatment Stages

MDD is typically episodic with a progression of symptoms from sub-clinical to patently dysfunctional.[20] The progression of treatment can be divided into three phases: 1) the acute phase, which lasts at least 6 weeks and until the patient has attained an acceptable treatment response; 2) the continuation phase, which usually lasts 4 to 9 months; 3) and the maintenance phase, which lasts a year or more.[21] Patients may partially respond to treatment or they may fully respond to the point of remission, however, relapse may occur prior to or after remission.

If the patient remains in remission for a significant period, defined as at least 2 to 4 months, they can be deemed recovered. Relapse is a return to the index episode. A relapse is diagnosed when symptoms return after a response to treatment but before the patient has advanced to recovery. A relapse or new episode of depression must be considered when recovery does occur and then the patient's symptoms return.

Patient-Centered Management of MDD

For successful treatment of patients with MDD,

it is important that they have an ongoing relationship with a personal physician and access to a practice team that takes responsibility for ongoing, coordinated patient care. Studies that have been conducted on the effect of treating depressed patients using a patient-centric model have been encouraging. In the PRISMe (Primary Care Research in Substance Abuse and Mental Health for the Elderly) study, researcher found that older patients were more likely to accept treatment for mental health issues when it was offered in primary care rather than in mental health/substance abuse clinics.[22] The Nurse Telehealth trial, which compared usual care, telehealth care, and telehealth care plus peer support, found that telehealth care improved both mental functioning and patient satisfaction.[23] Researchers concluded that patient-centered telehealth care fosters a therapeutic relationship that not only improves clinical outcomes and patient satisfaction but fits into a primary care settings.[23] Two trials in mixed aged populations showed that collaborative care can reduce depression over a span of 2-5 years.[24] And the IMPACT study found that a tailored collaborative care actively engages older adults in treatment for depression and delivers substantial and persistent long-term benefits including less depression, better physical functioning and an enhanced quality of life.[25]

It is possible to integrate mental health professionals into family medicine practices. One method of doing so is to hire either a full or part-time psychiatric nurse practitioner who can provide counseling services manage prescriptions for antidepressant medications. Forming relationships with other types of mental health workers such as mental health social workers, psychologists, or counselors with specific training in psychotherapeutic approaches known to be effective for MDD (e.g., CBT and IPT) is another option. Sometimes it is possible for a single mental health professional to be shared between primary care practices. One family physician reported that integrating mental health services into his practice resulted in patients being more likely to show up to appointments for therapy because of a perceived lack of stigma around visiting a doctor's office as opposed to a mental health facility.[26]

Conclusion

Primary care clinicians manage a large percentage of patients with MDD. With the change in the USPSTF guidelines for the screening of depression, family physicians can take this opportunity to identify and treat MDD to improve clinical outcomes and quality of life of their patients with MDD.

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Theresa J. Barrett, PhD is the Managing Editor of *Perspectives: A View of Family Medicine in New Jersey* and the Deputy Executive Vice President of the New Jersey Academy of Family Physicians.

Cardiovascular Controversies

The goal of this NJAFP on line program, **"Cardiovascular Controversies"** is to increase knowledge of the new ACC/AHA cholesterol guidelines; raise awareness of the persistence of cardiovascular risk, especially in patients who have familial hypercholesterolemia or who are statin intolerant; and introduce new/emerging research and mechanisms of action for lipid lowering therapies to improve the care of patients with dyslipidemia.

Program 1: **Cardiovascular Controversies: Exploring the ACC and AHA Guidelines on the Treatment of Blood Cholesterol**
Host: *Brian P. McDonough, MD, FAAFP*
Guest: *Seth Martin, MD*
The American College of Cardiology and American Heart Association recently published new guidelines for risk assessment for cardiovascular disease and cholesterol treatment focusing on the assessment of an individual's aggregate cardiovascular risk and providing treatment for those at the greatest risk overall with more aggressive therapy. Many of the recommendations represent a paradigm shift which will have implications on the way primary care physicians treat their patients.

Program 2: **Cardiovascular Controversies: A World Apart –The High Risk Patient**
Host: *Brian P. McDonough, MD, FAAFP*
Guest: *Peter Jones, MD*
Familial hypercholesterolemia is a group of inherited disorders that result in very high cholesterol levels and associated increased risk for cardiovascular disease. Other patients at a high risk for cardiovascular disease are those patients who are statin intolerant. Join Dr. Brian McDonough and Dr. Peter Howard Jones as they discuss the care of patients who fall into these high-risk categories.

Access programs at https://reachmd.com/cme/new-jersey-academy-of-family-physicians/

Program 3: **Cardiovascular Controversies: Emerging Therapies for Lowering Cardiovascular Risk**
Host: *Brian P. McDonough, MD, FAAFP*
Guest: *Carl Orringer, MD, FACC, FNLA*
Statins are efficacious in lowering LDL-C and in reducing cardiovascular events. However, there are patients who do not respond well to statin therapy or cannot tolerate statin therapy due to side effects. There are a number of new agents that are newly approved or in late stage development that are attempting to address these issues. Join Dr. Brian McDonough and, Dr. Carl Orringer as they discuss these new and emerging therapies and what it might mean for your patients.

CME Developmental Coordination Disorder and Sensory Processing Issues in Children

BOBBIE VERGO, OTD, OTR/L AND EMMY LUSTIG, BA

Bobbie Vergo received her clinical doctorate in occupational therapy from Washington University School of Medicine in St. Louis, School of Occupational Therapy. She has a research background in executive function and mental health, and she has worked in pediatrics for five years and currently works at Pathways Center in Glenview, IL.

Emmy Lustig is a Communications Associate at Pathways.org in Chicago, IL. Her work primarily focuses on researching and writing about children's developmental delays.

The authors have no relevant financial conflicts to disclose.

Learning objectives:

- Describe Developmental Coordination Disorder
- Discuss the impact of Developmental Coordination Disorder on child development

Developmental Coordination Disorder (DCD) is a common diagnosis for children with motor skill and sensory processing difficulties in the absence of other conditions and learning issues. This disorder affects 5-6% of school-aged children and is more commonly diagnosed in boys.[1]

Children with DCD have trouble with both fine and gross motor movements. Very often, parents may describe their child having these motor difficulties:

- Clumsiness - child frequently bumps into other objects or people, trips, and drops things
- Difficulty walking, standing or balancing
- Problems playing sports or riding a bicycle
- Difficulty with daily living activities - getting dressed, feeding themselves, tying shoes
- Poor posture
- Messy handwriting
- Difficulty learning and applying new motor skills[2]

Sometimes, there is a sensory component to the disorder. Children with sensory processing/integration differences can have trouble integrating all the information received from their senses to produce coordinated motor movements and perform everyday activities.[3] If a child is over reactive to sensory information, they are more sensitive to sensory stimuli than their typically developing peers. Warning signs for over reactive children may include:

- Avoids sensory environments with loud noises and too many bright colors
- Seems fearful or very distracted
- Avoids being touched or engaging in activities with lots of tactile input[4]

Children who are under-reactive to sensory information have difficulty perceiving sensory stimuli, which can also affect their behavior and ability to perform daily activities. Warning signs for under-reactive children may include:

- Difficulty discriminating odors and tastes
- Using too much force when picking up objects
- Being unaware to pain caused by cuts and bruises
- Engages in sensory seeking behaviors - rough housing or activities with lots of motion such as swinging[4]

Studies show children who have DCD with a sensory component can have difficulty receiving, processing and integrating visual and vestibular feedback, which contribute to our sense of balance. In one study, children with DCD and typically developing children were asked to stand on their non-preferred leg so researchers could evaluate their balance abilities. The children with DCD showed poorer postural control and were less able to adjust to changes in posture due to slower hamstring muscle contraction and differences in processing sensory information. Balancing requires the use of multiple sensory systems, as well as proper muscle responses and movement strategies. As a way of compensating for differences in muscle contraction, visual, and vestibular feedback, the DCD group swayed their hips to maintain their balance instead of using their legs and ankles to stabilize themselves.[3]

Differences in sensory processing and motor skill difficulties can extend to children's everyday activities and affect their ability to learn new motor movements needed for playing on a playground, participating in sports, or engaging in daily self-care.[5] Activities that require making multiple movements at once and using different senses to coordinate movements can be difficult for children with DCD. To view a checklist to help identify sensory areas of concern, see the Sensory Motor Checklist on the Pathway.org website. Parents can use this to track their concerns and discuss them with their healthcare professional.

Physical and occupational therapy are two common forms of treatment used to help children improve their motor skills. Treatment approaches vary depending on the child's motor abilities and whether there is a sensory component to their diagnosis. Physical therapists may work with children to build muscle strength needed for improving balance and motor movements. One study found that a strength training program also helped a young child process their proprioceptive sense, body position sense, which improved their motor skills and confidence.[1] Common occupational therapy treatments for DCD include taking more of a task specific and cognitive approach to focus on the child's motor learning.[1] Cognitive approaches to therapy may provide children opportunities to practice holding their attention and using working memory to improve their problem solving and motor task strategy. A child's treatment plan varies depending on their needs, and therapists can decide which approach would be the most beneficial.[6]

Medical professionals can ask parents or caregivers additional questions about a child's everyday behaviors and activities to help diagnose DCD. If parents have concerns about their child's sensory processing/integration, most pediatric physical and occupational therapy clinics offer free screenings. An early referral and early intervention can help children reach their fullest potential.

About Pathways.org

Pathways.org is a national not-for-profit dedicated to maximizing children's development by providing free tools and resources for medical professionals and families. Medical professionals can contact Pathways.org to receive free supplemental materials to give away at well child visits and parent classes.

View our Sensory Integration/Processing Brochure to provide parents with information on how children use their senses and warning signs of a sensory processing/integration issue. For a free package of brochure to give away to families, please email friends@pathways.org.

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CME Diagnosis and Treatment of Restless Legs Syndrome (RLS) During Pregnancy

JONATHAN P. HINTZE, MD AND SHALINI PARUTHI, MD

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Shalini Paruthi, MD, is the co-director of the Sleep Medicine and Research Center at St. Luke's Hospital and an adjunct Associate Professor at Saint Louis University School of Medicine. She evaluates and treats patients of all ages with sleep problems. She is a member of and a spokesperson for the American Academy of Sleep Medicine. She completed her Internal Medicine residency and Sleep Medicine fellowship at the University of Michigan.

The authors have indicated that they have no relevant financial conflict regarding this topic.

Learning objectives:

- Diagnose restless leg syndrome in pregnancy
- Describe the impact of ferritin on restless leg syndrome in pregnancy

Case: A 31-year-old healthy female, 28 weeks into her third pregnancy sees her doctor to discuss her sleep. She complains of difficulty falling asleep and waking up multiple times throughout the night. She says she "just can't get comfortable" and is tossing and turning all night because her legs "won't sit still." Upon further questioning, she confirms that her legs feel worse particularly at night, and feel better when she gets up and walks around. Her pregnancy is otherwise uncomplicated and her only daily medication is a prenatal vitamin, though she has started trying over the counter benadryl at night without improvement in her sleep. She never had this problem with her other pregnancies. Her physical exam, including a detailed exam of her lower extremities, is unremarkable.

Restless legs syndrome (RLS) is a common sleep disorder that increases in prevalence during pregnancy. It is estimated to affect approximately 25% of all pregnancies with a peak in the third trimester.[1-4] It is the third most common reason for insomnia during pregnancy,[5] and as seen in our patient, the risk of developing RLS increases with each pregnancy and may not have been present in prior pregnancies.[6,7] It is a clinical diagnosis which is made if the following criteria are met: (1) An urge to move the legs, usually associated with an unpleasant sensation in the legs, (2) this urge is worse with rest or inactivity (i.e. lying down), (3) it is relieved at least partially with movement (e.g. walking or stretching), (4) and is worse in the evenings or at night. Additionally, symptoms cannot be explained by another condition (leg cramps or venous stasis, for example) and the symptoms must cause sleep disturbance, distress, or some impairment of function, whether mental, physical, social, or others.[8] This patient clearly meets criteria for the diagnosis of RLS. As she describes, the sleep disturbance commonly observed in RLS is at sleep onset and may impact sleep maintenance as well. [2,3,9-12]

Although the pathophysiology of RLS in pregnancy is still under investigation, in the general population there is evidence that genetics, the central dopamine system, and iron all play roles in the syndrome.[13-17] The role of iron is of particular interest during pregnancy, as many women develop iron deficiency during this time.[18] Specifically, iron is a known co-factor for the enzyme tyrosine hydroxylase, which is a rate-limiting reaction of dopamine production and has been hypothesized as a connection between low iron status and RLS.[15] Therefore, it is not surprising the same population who is at a higher risk of iron deficiency is at a higher risk of developing RLS.

Recently, the International RLS Study Group (IRLSSG) published clinical guidelines for the diagnosis and treatment of RLS during pregnancy.[19] The first step is to accurately diagnose RLS with the above criteria, and assess severity and possible comorbid depression.[20] Next, assessing iron status should be done by checking a serum ferritin, and this may also include a hemoglobin, iron, TIBC, and percent transferrin saturation as deemed appropriate. It is notable that ferritin is an acute phase reactant and may be elevated if there is a concurrent illness or chronic inflammation, making additional iron studies more useful. Ferritin levels below 75 mcg/L should be treated with oral iron supplementation of 65 mg elemental iron 1-2 times daily,[21] and advising patients to take vitamin C together with iron can improve absorption.[22] Repeat ferritin levels should be checked after 6-12 weeks to monitor a response. If there is a failure of response to oral iron and ferritin remains below 30 mcg/L, intravenous iron can be considered though is rarely needed.[23,24]

Patients with RLS that is refractory to iron supplementation, or patients with an initial ferritin over 75 mcg/L may be considered for dopamine therapy specifically with carbidopa/levodopa. Low-dose clonazepam in the evening may also be considered.[19] As with any medication considered during pregnancy, side effects and the benefit to potential harm ratio must be discussed openly with each patient. However, even in patients with refractory RLS, reassurance can be given that most cases of pregnancy-related RLS will improve or resolve within one month after delivery.[1-3]

Non-pharmacologic treatment considerations that have been proven to improve RLS include moderate-intensity exercise, yoga, massage, and pneumatic compression devices.[25-27] Anecdotally, many patients describe relief with compression stockings during the day, warm bath/shower before bedtime, or wearing socks to sleep. Lastly, care should be taken to avoid common RLS exacerbating factors, such as sedating antihistamines, like our patient has tried.

Case conclusion: The patient and her physician decide to check her hemoglobin and ferritin. They find that her ferritin is only 8 mcg/L and begin an additional iron supplement in addition to her prenatal vitamin. Within three weeks she has significant improvement in her leg restlessness and is now able to fall asleep more quickly and sleep through the night.

The National Healthy Sleep Project involves a partnership between the American Academy of Sleep Medicine (AASM), the Center for Disease Control (CDC) and Sleep Research Society (SRS). The long-term goal of the project is to promote improved sleep health in the U.S. The project will increase public awareness of the importance of healthy sleep. It also will promote the treatment and prevention of sleep disorders. ▲

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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

This Medical Journal activity, *Perspectives: A View of Family Medicine in New Jersey*, has been reviewed and is acceptable for up to 4.00 Prescribed credit(s) by the American Academy of Family Physicians. Term of approval begins 01/01/2016. Term of approval is for one year from this date. Credit may be claimed for one year from the date of each session. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

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NAME: _____ AAFP MEMBERSHIP NUMBER: _____

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1. *True or False:* Most patients will readily discuss symptoms of depression with their physician.

2. *True or False:* Postpartum depression is common, affecting both mother and child.

3. *True or False:* The PHQ-2 depression screening tool has been shown to be as effective as the Beck Depression Inventory.

4. *True or False:* Older depressed adults will present with the same articulated sadness as seen in younger depressed adults.

5. *True or False:* It is not feasible to integrate mental health into primary care practice.

6. *True or False:* Changes in the USPSTF guidelines for screening for depression present an opportunity for family physicians to identify and treat patients with MDD.

7. *True or False:* Children with Developmental Coordination Disorder have trouble with their fine motor movements.

8. *True or False:* Children who have the sensory component DCD have difficulty with balance.

9. *True or False:* It is hypothesized that there is a connection between low iron status and RLS.

10. *True or False:* Sedating antihistamines are an exacerbating factor in RLS.

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ANSWERS ON PAGE 17

2016 Scientific Assembly

Sheraton Atlantic City Convention Center Hotel
Atlantic City, NJ

June 9, 2016
Pre-Conference Symposium
Evidence-Based Health Coaching for Clinical Encounters

June 10-12, 2016
NJAFP Family Medicine Conference

To register go to: https://www.regonline.com/2016SANJFM

Dates to Remember:

Thursday, June 9, 2016

- Pre-Conference Symposium: Evidence-Based Health Coaching for Brief Clinical Encounters
- Town Hall

Friday, June 10, 2016

- House of Delegates
- Scientific Assembly Begins
- Exhibitors' Reception
- Resident Knowledge Bowl
- Research Poster Contest

Saturday, June 11, 2016

- Scientific Assembly Continues
- President's Gala
- Research Poster Contest Concludes

Sunday, June 12, 2016

- Skills Workshops
- Scientific Assembly Concludes at 1:00pm
- SAM Study Hall on Hypertension from 1:00pm – 6:00pm

Information on the conference is posted on the NJAFP website and updated as more information becomes available.

The Sea is calling
– or rather the Land by the Sea

We are headed back to Atlantic City for the annual NJAFP Scientific Assembly. We are planning an exemplary scientific program packed with the vital new information, practice transformation tools, hands-on workshops and of course, a SAM Study Hall.

Join us for the Pre-Conference Workshop in June 9, led by the NJAFP HTT group, followed by the Town Hall meeting where a lively discussion is sure to engage you and offer some key ideas for 2016 – 2017 legislative session.

Friday, June 10 kicks off with the House of Delegates meeting at 8am. Be a voice for Family Medicine and present resolutions that may become integral the changing face of healthcare delivery in New Jersey.

Exciting and interactive CME sessions begin on Friday, followed by an evening packed with fun and excellent networking with industry leaders at our Healthcare Expo. Then join us for the renowned NJAFP Residents Knowledge Bowl—where family medicine residents vie for the Coveted Cup as they test their knowledge on medicine, science and (a little) geography.

Saturday, June 11 puts CME into full-swing. The day is packed with important and Family Medicine applicable topics such as Managing T2DM in Special Populations; Identifying and Addressing Addiction vs. Dependence; Screening in Women's Health and Understanding and Implementing POLST, plus many more, including Management of Sports-Related Concussions.

Join us Saturday evening for the President's Gala as we honor incoming President, Adity Bhattacharyya, MD and recognize New Jersey family physicians who have done great things this year to advocate for and enhance the practice of Family Medicine. Dance and jam to the always entertaining and extremely diverse music of the Kenny I Orchestra. A good time is promised to all.

Sunday rounds out the conference with more CME and finishes with a SAM Study Hall on Hypertension.

All this learning, excitement, networking, and celebrating will take place at the Sheraton Atlantic City Convention Center Hotel from June 10-12 with a Pre-Conference program on June 9. Go to www.njafp.org for meeting updates.

This Year's Speakers Include…

Matthew Jacks, Capt. DC USN
Capt. Jacks is Department Chief of Oral and Maxillofacial Surgery, Walter Reed National Military Medical Center, Bethesda MD

Seth Martin, MD, MHS
Dr. Martin is Associate Director of the Lipid Clinic and Assistant Professor of Medicine/Cardiology, Johns Hopkins Hospital, Baltimore, MD

Sara Mullins, MD
Dr. Mullins will present on the impact of new age "ersatz" smoking devices. She is a family physician at Stoney Better Family Medicine, Wilmington, DE

Michael Munger, MD
Dr. Munger is the AAFP Board of Directors representative for this year's meeting. He is a family physician at St. Luke's Primary Care, Overland Park, KS

Joseph Ranieri, DO
Dr. Ranieri is an addiction specialist and medical director for Seabrook House, Bridgeton, NJ

Joseph Tollison, MD
Dr. Tollison is Senior Advisor to the President of the American Board of Family Medicine, Lexington, KY

New Jersey View continued on page 17

NJAFP
New Jersey Academy of Family Physicians
SCIENTIFIC ASSEMBLY

SAVE THE DATE...

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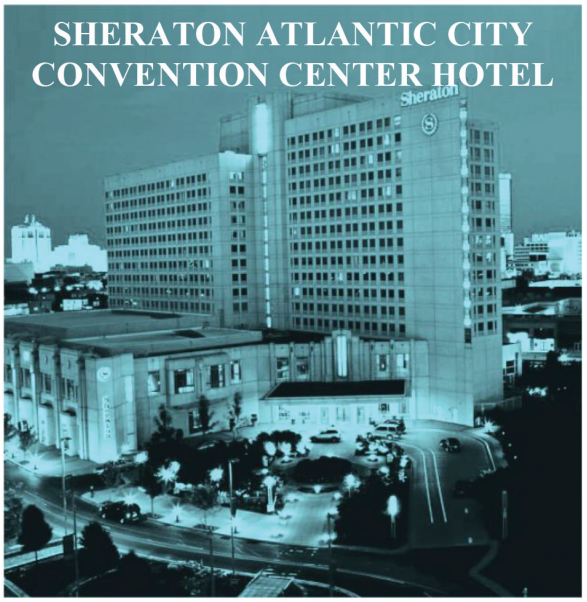
with

Pre-Conference Symposium:

Evidence-Based Health Coaching for Brief Clinical Encounters

June 9



ATLANTIC CITY 2016

Join us for another exciting educational experience jam-packed with topics vital to your practice, including interactive sessions and hands-on workshops.

WHAT'S HAPPENING

- ***Town Hall** will meet on Thursday, June 9 at 7:00pm*
  Join us in a thought-provoking discussion on the state of Family Medicine in New Jersey.

- *Be a voice for the future of Family Medicine in New Jersey and participate in the **House of Delegates.***
  Write a Resolution and/or sit as a Delegate for your county. The House convenes on Friday, June 10 at 8:00am.

- *Meet our **Exhibitors** and learn about the latest technology and advancements in products and services to enhance your practice. The floor opens with the Exhibitors' Reception on Friday, June 10 at 6:00pm.*

- *Join us for the **Resident Knowledge Bowl** and cheer on your favorite team as New Jersey FM Residency programs vie for the "Coveted Cup" on Friday night, June 10 at 8:15pm, following the Exhibitors' Reception.*

- *Dance, dine and celebrate at the **President's Gala** as we install new president, Dr. Adity Bhattacharyya and present awards to this year's outstanding family physicians on Saturday evening, June 11. Be entertained and dazzled by the extraordinary sounds of the Kenny I Orchestra. The festivities begin at 6:00pm.*

- *And throughout this amazing 4-day event, we will present cutting-edge **CME** from the latest information on office tools and procedures to enhance your practice, to hands-on workshops to sharpen your skills, and interwoven with stimulating discussions and networking opportunities. Complete your conference experience with the SAM Study Hall – this year's topic: Hypertension.*

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MEET AC

Pre-Conference Symposium:

Evidence-Based Health Coaching for Brief Clinical Encounters

Developed especially for healthcare providers, this highly interactive seminar will guide you to experience the paradigm shift in thinking to create a 50/50 patient/provider partnership in health that taps into the patient's own motivation to act! Learn and practice skills of Evidence-Based Health Coaching with Motivational Interviewing for Brief Clinical Encounters. This session will be conducted by the National Society of Health Coaches, which has the #1 Health Coach Certification program in the U.S. Great for any member of the healthcare team who wants to more effectively engage patients.

For more information contact Pam Joyce at pam@njafp.org or 609-394-1711.

NEW Topics include…

Zika Virus and Other Infectious Diseases

While the Ebola epidemic may be a memory, a new threat has emerged to take its place, the Zika virus. Attend this session to get an update on how this virus and others infectious diseases threaten you and your patients and what you can do about it.

Identifying and Addressing Addiction vs. Dependence in Medical Practices: What Do I Do Next?

The decision to discontinue opioids and / or sedative hypnotics is very challenging. Knowing when to refer a patient for inpatient withdrawal management or considering inpatient residential vs. outpatient care, proper tapering of these drugs is paramount for success and patient safety. This presentation will review strategies on safely weaning patients off opioids and sedative hypnotics.

Over Screening in Women's Health

The recommendations for screening for breast and cervical cancer have changed, creating a challenge for both patient and physician. We will provide tips on how to start a conversation with your patients around screening guidelines.

Understanding and Implementing POLST for End-of-Life Planning

POLST - Physician Orders for Life Sustaining Treatment - is an approach to end-of-life planning based on conversations between patients, loved ones, and health care professionals designed to ensure that seriously ill or frail patients can choose the treatments they want or do not want and that their wishes are documented and honored. In this T2P session, participants will learn about the POLST form and process for implementation.

MACRA, APM, and MIPS – The Academy Perspective - MACRA, APM, MIPS

The debate over payment models continues to be in the forefront of physicians' minds. Plan to join AAFP Director, Michael Munger, MD as we discuss these important issues and the AAFP response.

Skill Building Workshops

Skill-building workshops are a great way to test your technique or learn a new one whether the procedure is something you do a lot - or perhaps not quite exactly enough to be as adept as you would like. This year the Assembly will feature two skills workshop: Contraceptive Procedures and Quality Improvement 101. Space is limited, so sign up early.

SAM Study Hall – Hypertension

Join family physician and session moderator, Ryan Kauffman, MD for this year's Self-Assessment Module on Hypertension. You can complete part A and B, with a passing grade.

Lend Your Voice, Share Your Ideas

NEW JERSEY continues to be a hotbed of issues and NJAFP needs your input to craft our message to improve the landscape of healthcare delivery in our state. As payment models change requesting better outcomes for adequate reimbursement, and your time with patients is being chipped away so you can address more red tape – lend your voice to reverse this unproductive trend.

If this is your experience, help the NJAFP improve its arguments. Consider writing a resolution and plan to attend this year's House of Delegates. Resolutions authored at the House of Delegates may be submitted to the AAFP for consideration at the Congress of Delegates – effecting change not just in New Jersey, but on a national scale as well.

The House of Delegates will convene at 8:00am on Friday, June 10, 2016 at the Sheraton Atlantic City Convention Center Hotel.

BECOME AN ACADEMY LEADER

"Time is neutral and does not change things. With courage and initiative, leaders change things."

– Jesse Jackson

ARE YOU JOTTING DOWN GREAT IDEAS, yet no one sees them? Do you say to yourself, "I know how I would do that…?" The NJAFP is seeking member family physicians to join the leadership of the Academy and support family medicine in New Jersey. Interested members should review the nomination criteria at http://www.njafp.org.

Nominations are being sought for the following positions:

Board Trustees: three positions
Resident Trustee: one position
Student Trustee: two positions
New Physician Trustee: two positions
AAFP Delegate: one position
AAFP Alternate Delegate: one position

Contact EVP, Ray Saputelli, MBA, CAE, at (609) 394-1711 or email him at ray@njafp.org for information.

A New Perspective on Embedding a "Culture of Quality" in Primary Care

SANDI SELZER, MSHQ

Before joining NJAFP in October of 2015 I spent most of my almost 20 years in health care learning about the science of quality improvement (QI) from experts in the field, preaching the importance of quality measurement to healthcare organizations across the country, and heeding the call for health care to embrace a "culture of quality" in order to improve patient outcomes and overall population health. Over the past few months, however, I've had the privilege of meeting some of NJAFP's members, visiting their practices, and participating in their QI-related events - an experience that has changed my perspective on what constitutes a "culture of quality" in a healthcare organization.

The three-part framework for healthcare quality improvement - structure, process and outcomes - published by Avedis Donabedian in the 1966 article *Evaluating the Quality of Medical Care*, is still the gold standard in QI guidelines. (1) However, what I've recently learned from four New Jersey practices is that a truly embedded culture of quality is not just about implementing Donabedian's framework, it's about how the elements are embedded into the primary care setting in a way that benefits both the practice and its patients.

1. **Embracing Patients as Partners in Transformation:** I was asked by Dr. Sloan Robinson of Meetinghouse Family Practice in Mt. Laurel to join his most recent quarterly Patient Advisory Committee meeting to provide an overview of how the current culture of change in health care affects primary care practices and their patients. I had never presented this topic to a patient audience, and admittedly, I had concerns about the likelihood of engagement and interest; however, I was pleasantly surprised to find a highly involved and inquisitive Committee. We had an informed and lively discussion about the pros and cons that quality-based payment reform could have on patient care. The Meetinghouse team clearly recognizes the role that their patients have as partners in the transformation journey, and realizes that success in this new era of value-based care cannot be achieved without them.

2. **Overcoming Barriers to Patient Education:** Dr. Margarita Borghini from Moreno Medical Associates in Jersey City has made meeting her patients on common ground a major focus of her care services. For much of her career, Dr. Borghini has cared for individuals who fall into the demographic classified as "vulnerable." Her experience has taught her that many patients classified as vulnerable simply don't receive the same level of health care as other patients; this experience made her strive to bridge this gap. Dr. Borghini's team is focused on addressing patient engagement and self-management of chronic conditions - two common themes in health care these days. However, Dr. Borghini's approach is anything but common. Dr. Borghini identifies her patients' barriers to understandtheir health issues, such as literacy, language and culture, and provides hands-on education in a way that reaches her patients more effectively. This includes using hands-on models and in-practice videos to educate patients during office visits. After-hours, she conducts condition-specific group sessions. She embraces the "teach back" method to ensure that her patients leave the office with a clear understanding of their condition and important self-management techniques. Moreno Medical's team sees the impact of these techniques in their outcomes - many of their patients have been able to decrease medication dosages, or in some cases, eliminate medications completely; condition-specific measures (e.g., A1C) show consistent improvement; and as a qualitative measure of QI initiatives, her patients are highly satisfied with their health care and feel more in control of their health.

3. **Relentless Care Coordination:** Dr. Joseph Schauer's Farmingdale Family Practice has taken a different approach to providing effective care coordination. Daniel Martinez (affectionately nicknamed "The Pit Bull" by his teammates) has taken a "no holds barred" approach to his role in the practice. While Daniel provides all of the typical care coordination services, such as post-discharge follow-up and medication management assistance, he has also found effective means to overcome the obstacles faced by many care coordinators. When faced with patients that are difficult to engage, Martinez is relentless, providing caregiver outreach and utilizing "old school" techniques like mailing letters when necessary. When trying to improve the practice's rates for hospital discharge follow-up, he was so driven in his efforts that he was successful in gaining login credentials for the EMR portals for two of their most utilized hospitals. These processes have had a direct impact on the practice's QI outcomes, in the form of a more engaged patient population and better quality outcomes, not to mention a satisfied and productive practice team.

Martinez

4. **Creating a Well-Oiled Machine:** When I met Erin Zielinski from Marc Feingold, MD LLC in Manalapan, it was clear to me that she not only takes her role as Practice Manager very seriously (she utilizes an iRobot when she's working offsite!), but she also enjoys this role and relishes the opportunity to find new and creative ways to solve old problems. Dr. Feingold and Erin also take transparency very seriously. The practice's most recent and past quality metrics are proudly displayed in the staff's break room, where all team members have access to them. The staff is cross-trained in an effort to mitigate workflow disruption, and they have embraced an important structural element - an effective EMR system. The practice has placed an emphasis on the utilization of templates, allowing them to quickly and efficiently produce accurate quality reports. In addition, all team members have the same level of access to the EMR - an example of how truly engaged this practice is, and one where every

team member recognizes their importance in the running of a patient-centered practice.

The healthcare providers that I have met over the past few months accurately reflect the diverse patient populations seen in most cultures in our country. The patient populations varied in socio-economic status, geographic representation, health-care education, and literacy levels. Yet, the common variable is that, in every case, these practices have embedded their own unique culture of quality - and one that doesn't come solely from a Physician Quality Reporting System (PQRS) measure or a Plan-Do-Study-Act (PDSA) cycle. Each practice has leveraged the required elements for successful QI change to find what works best for *their* patients in *their* practice, and what they have created is much more than a culture of quality. They have created a culture of dedication.

I look forward to meeting more of our members, learning more about their practices and their patients, and telling their impressive stories. ▲

Reference

1. Donabedian A. (1966) Evaluating the quality of medical care. *Milbank* Q. 83(4):691-729.

CME *Quiz* ANSWERS:

1. False; 2. True; 3. True; 4. False; 5. False; 6. True; 7. False; 8. True; 9. True; 10. True

In the News

Thomas R. Ortiz, MD *(West Orange)* NJAFP Past President, Dr. Tom Ortiz was interviewed by WNYC about the lack of influx of patients in primary care offices following Medicaid's expansion in New Jersey. Read the full article at http://bit.ly/WNYC_Ortiz

Robert Gorman, MD *(Verona)*, and **Lauren Carruth, MD** *(Galloway)*, NJAFP President, Dr. Robert Gorman and NJAFP Treasurer, Dr. Lauren Carruth were interviewed by Dr. Oz's *The Good Life Magazine* for an article entitled, "Doctors Anonymous," appearing in the January 2016 issue.

NJ.com and DelawareBusinessNow.com covered **NJAFP** for being selected to provide practice transformation services in Delaware. Read both articles at http://bit.ly/NJAFP_Transformation1 and in http://bit.ly/NJAFP_Transformation2

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Important Changes to Physician Assistants' Scope of Practice

CLAUDINE M. LEONE, ESQ.

GOVERNOR CHRISTIE signed legislation to modernize the Physician Assistant Practice Act, which is now P.L. 2015, c. 224. **The law will take effect on July 1, 2016.**

While nothing changes immediately, please note that this law will allow a physician assistant's supervising physician, **if the physician so chooses**, to delegate certain medical tasks to physician assistants through a delegation agreement. Under the new law, a supervising physician may choose to allow a physician assistant to work beyond their current enumerated scope of practice (see inset for existing law).

After July 1, 2016, if a physician chooses to expand the medical services performed by physician assistants in their practices, it will be the obligation of each supervising physician to outline in a delegation agreement:

1. The physician assistant's role in the practice, including any specific aspects of care that require prior consultation with the supervising physician;
2. A determination of whether the supervising physician requires personal review of all charts and records of patients and countersignature by the supervising physician of all medical services performed under the delegation agreement, including prescribing and administering medication as authorized under section 10 of P.L.1991, c.378 (C.45:9-27.19). If no review and countersignature is necessary, the agreement must specifically state such provision; and
3. The locations of practice where the physician assistant may practice under the delegation agreement, including licensed facilities in which the physician authorizes the physician assistant to provide medical services.

Again, this is totally voluntary on the part of the supervising physician, but would require a delegation agreement to be established between the supervising physician and physician assistant. **If you do not choose to have a delegation agreement, nothing will change from the way you hire and utilize physician assistants in your practice.** There will be more guidance to come over the next few months in anticipation of the law's implementation. ▲

Procedures that a physician assistant is *currently* authorized to perform on a discretionary and routine basis:

1. Approaching a patient to elicit a detailed and accurate history, perform an appropriate physical examination, identify problems, record information, interpret and present information to the supervising physician, determine and implement therapeutic plans jointly with the supervising physician and compile and record pertinent narrative case summaries;
2. Suturing and follow up care of wounds including removing sutures and clips and changing dressings, except for facial wounds, traumatic wounds requiring suturing in layers and infected wounds;
3. Providing patient counseling services and patient education consistent with directions of the supervising physician;
4. Assisting a physician in an inpatient setting by conducting patient rounds, recording patient progress notes, determining and implementing therapeutic plans jointly with the supervising physician and compiling and recording pertinent narrative case summaries;
5. Assisting a physician in the delivery of services to patients requiring continuing care in a private home, nursing home, extended care facility, private office practice or other setting, including the review and monitoring of treatment and therapy plans;
6. Facilitating the referral of patients to, and promoting their awareness of, health care facilities and other appropriate agencies and resources in the community;
7. Collecting fluids for diagnostic purposes, including, but not limited to, blood, urine, sputum and exudates;
8. Placing and utilizing access catheters and tubes for diagnostic, therapeutic or interventional purposes, including, but not limited to, intravenous, arterial, nasogastric and urinary;
9. Performing minor surgical procedures such as simple excisions, incision and drainage, debridement and packing of wounds;
10. Applying and removing medical and surgical appliances and devices such as splints, casts, immobilizers, traction, monitors and medication delivery systems;
11. Management of emergency and life threatening conditions;
12. Performing low-risk obstetrical deliveries in a licensed hospital with the supervising physician or physician designee on premises and available to respond immediately; and
13. Subject to review by the Board, such other written procedures established by the employer, provided the procedures are within the training and experience of both the supervising physician and the physician assistant.

In addition, physician assistants are also currently authorized to perform the following procedures, provided the procedures are within the training and experience of both the supervising physician and the physician assistant, but ONLY when the supervising physician directs the physician assistant to perform the procedures or orders or prescribes the procedures, or the procedures are specified in a written protocol approved by the Board.

1. Performing non-invasive laboratory procedures and related studies or assisting licensed personnel in the performance of invasive laboratory procedures and related studies;
2. Giving injections, administering medications and ordering diagnostic studies;
3. Suturing and caring for facial wounds, traumatic wounds requiring suturing in layers and infected wounds;
4. Ordering and prescribing medications and writing orders to implement therapeutic plans;
5. In the operating room, assisting a supervising surgeon as a first assistant or as a second assistant when deemed necessary by the supervising surgeon and when a qualified assistant physician is not required by N.J.A.C. 13:35-4.1;
6. Performing other procedures for diagnostic, therapeutic or interventional purposes such as, but not limited to, introduction of contrast material for radiologic studies, use of endoscopic instruments and aspiration of fluid from joints and body cavities, collection of cerebrospinal fluid, biopsy of tissues, placement of central venous catheters or chest tubes, and endotracheal intubation.

Claudine M. Leone, Esq. is the Government Affairs Director for the New Jersey Academy of Family Physicians.

Changing Medicine

New Payment Model Provides Personal Satisfaction for NJAFP Member and His Patients

THE INTRODUCTION of the Patient Protection and Affordable Care Act in 2009 raised significant questions and caused nearly all physicians to wonder about the future of medicine. In response to the anticipated changes, Stephen Nurkiewicz, MD, a family physician with a solo practice in Hammonton, began investigating how to best maintain a financially viable practice while simultaneously providing his patients the best quality care and practicing the type of medicine that gave him personal satisfaction.

Initially, Dr. Nurkiewicz assumed he would join a physicians group, either associated with a hospital system or independently, to find the technical support required to maintain a practice while wading through the changing healthcare industry. However, after examining the requirements, he was not comfortable moving forward with either option.

"The options, which included up to a 30 percent cut in income, significant financial outlays at the onset and a two-year holding pattern, were not desirable to me. That's when I decided to investigate the concierge-style practice," said Dr. Nurkiewicz.

Similar to the direct primary care model, concierge medicine provides family physicians with an alternative to traditional fee-for-service insurance billing. Patients, who are still responsible for carrying their own medical insurance, pay standard co-pays for visits as well as an annual, semi-annual or monthly retainer or membership fee that provides enhanced access and communication with their physician, expanded clinical and laboratory services and in-depth care coordination and care management.

After speaking with other physicians who switched to the concierge model and completing a 3-month long evaluation with a concierge network to determine the feasibility for his practice, Dr. Nurkiewicz made the decision to move forward with implementing the change.

The appeal for Dr. Nurkiewicz was he would be able to practice the "old style" of medicine he found enjoyable while ensuring financial stability. Limited to 400 patients, not only would Dr. Nurkiewicz be available to patients through modern technology – via cell phone, texting and encrypted email – but he would also be available to see patients in local hospitals, nursing homes, rehabilitation facilities and their homes and still have the flexibility to spend more time with them.

The concierge network chosen by Dr. Nurkiewicz would also allow him to retain existing patients uninterested in or unable to afford the retainer fee, rather than discharging patients to another practice. Those patients could be treated by a nurse practitioner, with Dr. Nurkiewicz consulting on complex cases, or an associate physician at the practice ensuring the continuation of long-standing relationships with patients.

"During the evaluation period, I was provided with an estimate on the number of my existing patients who would likely sign-up for the concierge-style of care as well as revenue estimates based on specific numbers of contracted patients. Once I looked at the financials, I felt that it was a good choice for me," he said.

In April 2014, almost five years after he started his research, Dr. Nurkiewicz went live with his concierge services. After introducing the model of care to his patients, 110 patients signed contracts to receive concierge care. Based upon the estimates provided, it was financially viable to move forward.

Since he implemented concierge care at his practice, Dr. Nurkiewicz has found the change to be worthwhile and rewarding.

"It's really a win-win for me and my patients. I can practice at a normal pace and be more thorough when I need to be. When a patient gets ill, I can be there physically. It's good for the continuity of care for patients and for my own personal satisfaction," he said.

Dr. Nurkiewicz's cites the story of a now deceased patient as a testament to the positive benefits of providing concierge care. The 86-year-old widow, who lived alone and suffered from hypertension, was enrolled in Dr. Nurkiewicz's concierge care by her daughters. After diagnosing her with aortic stenosis, he was able to admit the patient into the hospital and continue providing care for her, consult with her cardiologist and guide her and her family through the testing required prior to a transcatheter aortic valve replacement (TAVR). While the patient successfully completed a rehabilitation program after her surgery, she was later diagnosed with a brain tumor. Dr. Nurkiewicz was then able to transition the patient to hospice, during which time he continued to manage her care through home visits.

"Because I was personally able to care for the patient through both situations, the family was very happy with the service," said Dr. Nurkiewicz. "It was a lot of technical medical management, and I was readily available for the patient and her family." ▲

Dr. Nurkiewicz

Developing a Social Medial Policy

SUSAN B. ORR, ESQ.

As technology changes, physicians need to periodically review and update their policies and procedures to keep pace with the fast changing world of communication. Social media sites are a great way to network and to obtain educational information, but they also create numerous issues for employers and specifically for healthcare providers.

Personal social media sites such as Facebook, Twitter, Instagram, and Tumblr are a great way to connect with family and friends and share photos, but they are public and unsecure and as a result, they are prone to missteps by providers, patients and staff.

Policies on the use of social media, emails and texting should be part of any employee manual and include specific do's and don'ts. Key issues for medical practices include confidentiality, failure to have encryption or other security measures in place, maintaining appropriate boundaries between patients and providers/staff and establishing limits associated with social media.

Furthermore, social media policies must comply with the National Labor Relations Act. The Act protects the rights of employees to act together to address conditions at work. While many associate the National Labor Relations Board (NLRB) with unions, these rights apply to all employees, not just unionized employees. This protection extends to certain work-related conversations conducted on social media, such as Facebook and Twitter.

To assist employers in developing social media policies, the NLRB has issued guidelines as to what *can* be included and what *should not* be included. The NLRB has indicated that the following statements are acceptable in such a policy:

- Forbid employees from impersonating the employer, making statements on behalf of the employer without authorization, or making statements that can be construed as establishing the employer's official position or policy on any particular issue;
- Encourage employees to resolve workplace grievances internally with an invitation to refrain from posting malicious, obscene, threatening, intimidating comments or those that could create a hostile environment on the basis of race, sex, disability, religion or other legally protected status;
- Request that employees do not disclose trade secrets, publish internal reports, provide tips based on inside information;
- Restrict employees from accessing or using social media for personal purposes during company time with company equipment, unless they have secured prior authorization to do so.

Statements the NLRB found to be problematic and would warrant issuance of a complaint because of unlawful restrictions on the exercise of protected concerted activity, include:

- Prohibiting posts discussing the employer's non-public information, confidential information, and legal matters (without further clarification of the meaning of these terms);
- Prohibiting employees from harming the image and integrity of the company, making statements that are detrimental, disparaging or defamatory to the employer, and prohibiting employees from discussing workplace dissatisfaction;
- Prohibiting posts that are inaccurate or misleading or that contain offensive, demeaning or inappropriate remarks; and instructing employees to use a friendly tone and not engage in inflammatory discussions;
- Requiring employees to secure permission prior to posting photos, music, videos, quotes and personal information of others;

- Prohibiting the non-commercial use of the employer's logos or trademarks;
- Discouraging employees from "friending" co-workers;
- Prohibiting online discussion with government agencies concerning the company;
- *Encouraging* employees to solve work problems in the workplace rather than posting about such problems online; and
- Threatening employees with discipline or criminal prosecution for failing to report violations of an unlawful social media policy.

Employers must also consider whether to include a disclaimer intended to minimize the potential for an employee to believe that protected concerted activity is restricted by the employer's policy, such as:

- "This policy is not intended to interfere in any way with any applicable federal, state or local law";
- "Application of this policy will be consistent with the National Labor Relations Act"; or
- "This policy is not intended to interfere with employee rights to form, join or assist unions or to engage in other concerted activity protected by the National Labor Relations Act."

Therefore, any social media policy needs to be carefully and thoughtfully constructed to ensure compliance with the law and with a professional's ethical requirements. ▲

Susan B. Orr, Esq. is a health law attorney in the law firm of Rhoads & Sinon LLC located in Exton and Harrisburg, PA, and a frequent presenter at the NJAFP Scientific Assembly.

For more information or assistance in constructing a social media policy, contact Susan B. Orr, Esquire at Rhoads & Sinon LLP at 610-423-4200 or sorr@rhoads-sinon.com.

The Primary Care Specialist

SABINA REBIS, MD

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FOR THE PAST TWENTY YEARS the number of American medical school graduates has steadily remained constant, a sprout in physician supply in the 1970's after the passing of the Health Professions Educational Assistance Act of 1963.[1,6] At the time, this act forced medical schools to admit more students to their hallowed halls, as the need for generalists grew. However, the gap between graduates who choose to enter specialties and those who commit to primary care has continued to widen. Only one-third choose to stay in primary care, with two- thirds electing to acquire further specialty training.[2] Finding innovative ways to recruit fresh graduates to serve as the gatekeepers to the medical system has been a hot topic over the last few decades.[3]

The opportunities to specialize and sub-specialize have carved out a tiered training system, catering to the sky-high ambitions of medical students. The growing time constraints placed on visits, declining reimbursements, electronic medical record documentation requirements, and the mushrooming amount of information have lessened the appeal of primary care fields such as family medicine and pediatrics. Today, even the medical students with the most romanticized ideals are seeking out residencies that will minimize the strain.

Despite nuances of the challenges faced by GPs, the reality is that even the most fruitful specialties branch from the roots that sprouted from seeds of primary care training. Prior to the 1900's doctors were apprenticed into the profession as generalists, learning to taste test urine for diabetes, deliver babies at the bedside, treat ulcers, and appease the woes of the village census. In the 20th century, as America lagged behind its European neighbors, new sets of requirements raised the bar for entrance into the profession. Patient volume increased.[4] Physicians needed a funnel for the cacophony of health concerns.

The era of the specialist blossomed. In 1917, the American Board of Ophthalmology led the way. By 1964 the percentage of graduates going into general practice fell from 47% in the 1900's to just 19%, with more students wanting to obtain what came to be sought as crème de la crème training, in fields like radiology, dermatology, or ophthalmology.[5] Specializing seemed to be the answer in decreasing the workload and breadth of knowledge faced by primary care doctors.

Yet training, which focused on individualized organ systems also compartmentalized medicine. The social climate of the 1960's called for a more humanitarian approach that shifted away from the focus on academia and brought medical practice closer to its house call roots. Family medicine was the bearer of the torch meant to address the need for a different approach to patient care, one that would encompass comprehensive care for all ages.[5] The field was to combine preventative methods such as health screens and patient education, along with treatment of chronic conditions.

Despite incentives to enter primary care, the desire to obtain specialized training has not abated. Currently physicians who maintain a strong interest in pursuing family medicine include those with a particular interest in rural medicine, those with no ties to a research career, and those who do not have great expectations for exorbitant income.[3] The costs of education, years spent in training and breadth of knowledge required turns away many tired and indebted medical students. Family physicians are at the forefront of change in health care and its management, but the responsibility of being on the front lines of medicine can lead to early burnout.

Primary care specialists are family medicine residents who choose to specialize in a specific area of primary care after a year or two of fellowship. The AAFP now lists up to 378 new fellowships. Unlike subspecialties in internal medicine, where the focus is on addressing individual organ systems, primary care fellowships focus on the patient as a whole, integrating all aspects of patient care surrounding the needs of a specific population. Fellowships in geriatrics, adolescent and sports medicine, or women's health are already widely available.

Can family physicians with expertise training in diabetes or the management of chronic heart failure in the context of all facets of a patient's life, act as the next era of specialists? Pipelining patients to physicians with higher levels of expertise in one population or in a type of chronic disease may be a way to optimize the type of care provided.

Critics believe it is important to stay true to the traditional practice of family medicine, providing continuing and comprehensive medical care to all. However, the overwhelming explosion of knowledge and information available has created new demands and expectations for patients and doctors alike. Patients who years ago placed their trust in the family doctor have shed some of that trust, disproportionally replacing it with gigabytes in their Smartphones. With this explosion of faster, better, newer information patients may be more willing to spend their time and money on accessible specialists who will provide more effective outcomes.

The trickle of primary care specialists with solid training in family medicine has opened the door to new ways of providing care. The focus on prevention and health maintenance is the closest we have come to the fountain of youth, and one way to optimize this approach is to create a wide panel of experts in primary care and prevention. ▲

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Coming Back

JENNIFER RYAN, MD

I admit I was nervous when beginning the program. After all, it had been 11 years since my last patient encounter. I quickly found that I had nothing to fear.

THE TRAJECTORY of my life was radically altered on December 26, 2001. This is my story about going through very tough times and making a "comeback." It is essentially a story about endurance and resilience.

While dancing at a party I heard a "pop" and felt severe left-sided back pain. Nothing could prepare me for the anguish that I was about to endure for the next several years. From that point onward I had chronic back pain. Fast-forward to May, 2002 and 4 epidurals later and the discussion began with my surgeon about needing back surgery. I was reluctant, but felt I had no other option and thought at least this would help restore me to normal. But was I ever WRONG!

Making things more difficult was the fact that I was in a solo practice with no one to help me out. I managed to get physician coverage for six weeks while I was recovering from the spinal fusion. I came back to work on a part-time basis. But the back pain was still there. I kept telling the surgeon that I was still having pain. After nine months he finally ordered a CT scan of my spine and told me there was a "non-union" of the fusion. WHAT? I had just spent about a year of my life trying to get better.

After that debacle, I decided to go to a specialized hospital in New York. I had two additional surgeries to help with the pain, but these were considered "salvage surgeries." "How could this be happening to ME?" I thought.

I sold my practice in 2004 and applied for Social Security Disability. Eighteen months later I was enrolled in Medicare. At age 48 - this was hard to believe.

Sometime in 2005 I overheard my dad talking to his brother on the telephone saying, "I don't know if she will ever work again." It crushed me to hear that. With dogged determination I said to myself, "If it is possible, I will."

Although disabled, I maintained my medical license as well as keeping my board certification and CME credits current. I started feeling somewhat better around 2011, but didn't know how to go about getting back into medicine. We buried my mother in 2010 and my father in 2012, so emotionally it was not the best time for me.

Serendipitously on my birthday in February, 2013 I received an email from the program coordinator of medical student education at my alma mater, Rutgers New Jersey Medical School. "This is a good omen," I thought. She asked me to help out with teaching OSCEs. I had been a voluntary clinical assistant professor since 1999. The timing was right and it was a good entry back in to medicine. From that moment onward, I started to believe that I could make a comeback…

I started Googling about physicians returning to practice after time away. The answers weren't easy. Then I found an article about the Drexel Medicine Physician Refresher/Re-entry Program. This sounded like the answer. Its focus is on physicians who for one reason or another have been out of clinical practice. Some, like me, had medical issues. Others stayed home to raise children. Still others were referred by their respective state Boards of Medicine.

The Drexel program has been in existence since 2006. Prior to that, from 1968 to 1993, it was under the direction of Medical College of Pennsylvania. Though successful with more than 400 trainees the program ceased in 1993 when the hospital closed. In 2006, this program was reinstituted, enhanced and renamed Drexel Medicine Physician Refresher/Re-entry Program.

In April, 2014 I called the program director to get more information. The next step was to make a site visit (which I did in August of 2014). It seemed challenging, but I knew I was up to it.

The program director indicated that I would need to spend 12 weeks at Drexel. First, I had to complete a medical knowledge update. I chose Drexel's online course which was over 100 lectures with Q and A and took me 7 months to complete.

The overall cost of the program was prohibitive. The medical knowledge fee alone was $1,500 - then $7,500 for each 6-week rotation. Additional fees included exam fees anywhere from $4000-$6000. In total I spent more than $22,500.

I had to find housing in Philadelphia for six months. This was a huge undertaking but I managed to find an apartment that was within two miles of Drexel. Then add in parking at $120/month for 3 months. And I had to find a dog walker for my Shih Tzu and try to explain to her what was going on.

I admit I was nervous when beginning the program. After all, it had been 11 years since my last patient encounter. I quickly found that I had nothing to fear. For me, it was like riding a bicycle again after I had fallen off. After a few weeks I felt as though I had never left medicine. There were four other physicians in the program with me. We were a good team.

It was like a mini-residency. My day started at 7:30 am with Morning Report and ended anywhere from 4:00 to 6:00 pm. We had Standardized Patient (SP) evaluations, history and physical write-ups, NBME Post Licensure Assessment System (PLAS) Exams, clinics, patient rounds, Grand rounds and online homework assignments. The time passed quickly and before I knew it I was planning to move back to New Jersey.

Overall the experience was excellent and I would highly recommend it to anyone who wants to come back to medical practice after time away. It certainly is one way to address the physician shortage in primary care.

As of this writing I am working with firms and looking for part-time work. ▲

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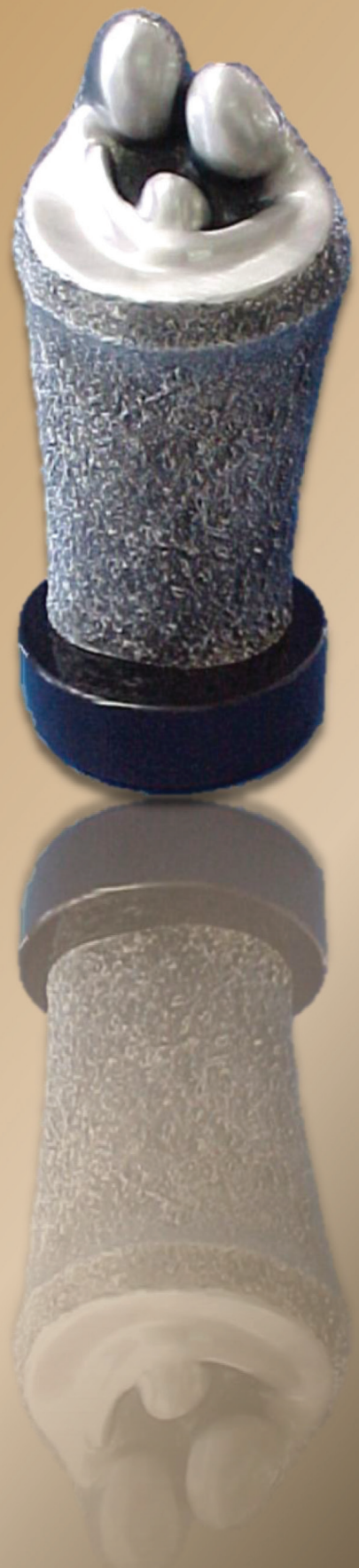
Dr. Ryan is a family physician and a graduate of the Drexel Medicine Physician Refresher/Re-entry Program.

Call for
New Jersey
Family Physician
Of The Year



The **New Jersey Family Physician of the Year Award** embodies the principles of excellence, combined with comprehensive and compassionate care, for which family physicians are known.

To be considered for the award, a nominee should demonstrate that they:

- Provide their patients with compassionate, comprehensive, and caring family medicine on a continuing basis
- Enhance the quality of their community by being directly and effectively involved in community affairs and activities
- Act as a credible role model professionally and personally in their community, to other health professionals, and residents and medical students.
- Stand out among their colleagues

Additional Requirements

- Must have practiced family medicine in New Jersey for at least ten consecutive years
- Must be Board-Certified in Family Medicine
- Must be a member in good standing in his/her community
- Must be a member of the New Jersey Academy of Family Physicians

Nomination materials to be included:

The following materials must be included to be considered:

- Complete a nomination form
- Name, address and phone numbers of the nominee
- Name address and phone numbers of the nominating individual
- A letter of nomination (no more than two pages)
- A current CV
- Three letters of support – two (2) from colleagues and one (1) from a person in his/her community
- Other supportive material, as appropriate (not over 15 pages)

The recipient of the **NJAFP Family Physician of the Year Award** also is presented for consideration for the **AAFP Family Physician of the Year Award.**

NJAFP
New Jersey Academy of Family Physicians

Members wishing to place a candidate in nomination should submit materials to:

NJAFP Selection Committee
c/o Candida Taylor
224 W State St., Trenton, NJ 08608

Nominations must be received by **April 30, 2016**

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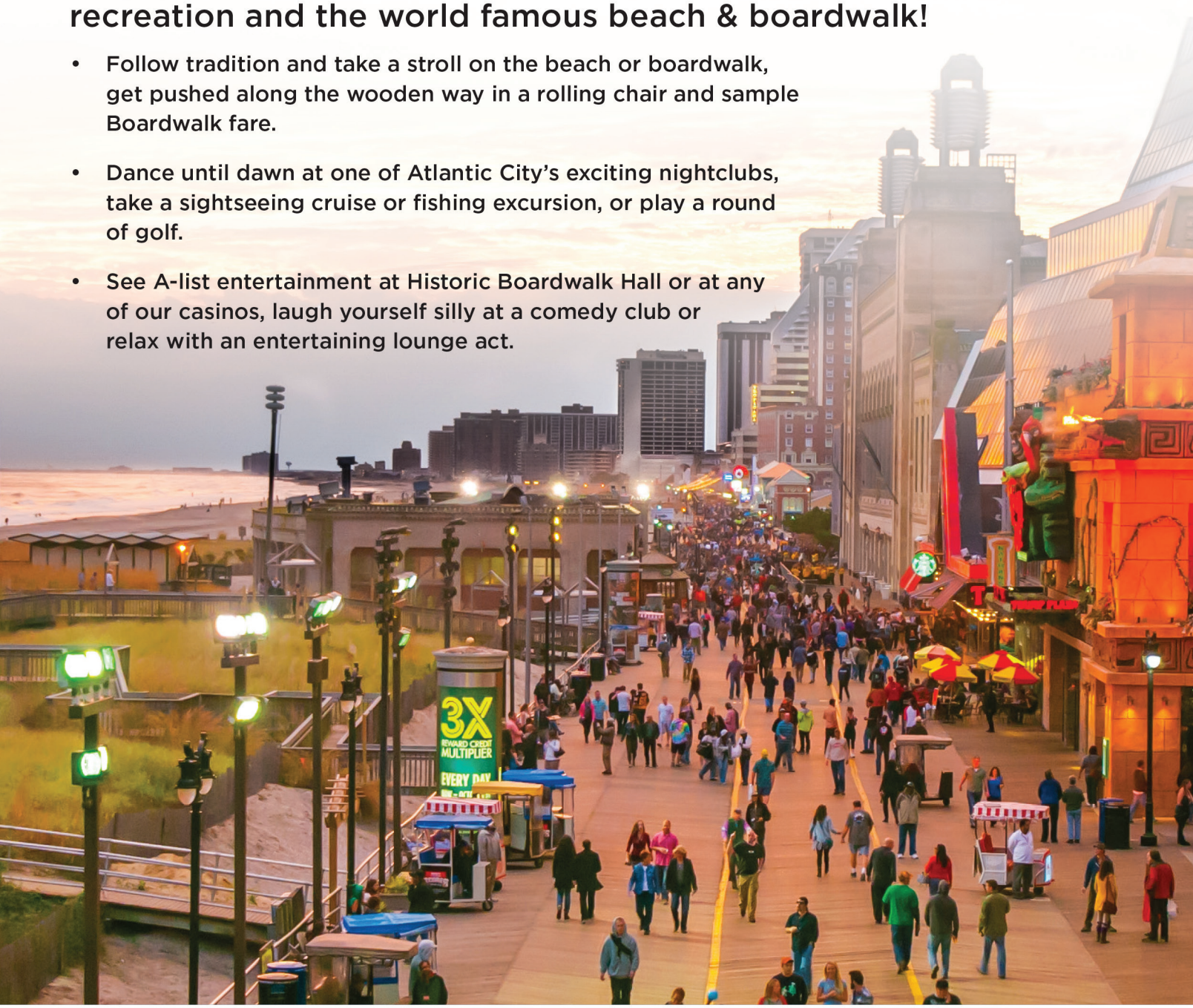

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