Perspectives

A VIEW OF FAMILY MEDICINE IN NEW JERSEY

VOLUME 15, ISSUE 2 • 2016

2016 SCIENTIFIC ASSEMBLY

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Zika Virus, Physician Burnout, MACRA
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CME Inside:
Overview of Chronic Pain

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IN THIS *Issue*

Volume 15, Issue 2 • 2016

On the Cover

Come to Atlantic City and join your colleagues at the the shore for the 2016 NJAFP Scientific Assembly.

4 President's View
5 Executive Vice President's View
6 Academy View
8 Clinical View
11 CME Quiz
12 New Jersey View
16 Government Affairs View
17 Quality View
18 Practice Management View
19 Resident View
20 Special Projects View
21 Physician Profile View
22 Foundation View

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856-813-1153 • www.mckella280.com

Medical Knowledge, Are You Keeping Up?

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

In 2014, the National Library of Medicine added a total of 750,000 new citations to the Medline database.[1] In 2015, that number rose to 806,326 citations across 5,618 journals.[1] According to futurist Jim Carroll, genetics research for common diseases revealed one or two new discoveries starting in 2000; by 2007 there were thousands of discoveries being made.[2] What does this mean? According to Carroll, increases in knowledge *"…reorients the entire medical system, from one where patients are treated once they are sick to one where patients are treated for what they are likely to develop as a result of their genetic makeup. The volume of medical knowledge is doubling every eight years, and similar changes are occurring in other trades and professions."*[2]

In his President's View article, NJAFP President, Robert Gorman, MD stated he was told that half of what he learned in medical school would be obsolete in five years. It has been proven that physicians' formal clinical knowledge is less useful with the passage of time and must be constantly updated with new information.[3]

Fortunately, there is no lack of educational opportunities for family physicians to not only maintain, but also increase, their medical knowledge. One very important educational event on the horizon is the NJAFP Scientific Assembly, to be held June 10-12, 2016 at the Sheraton Atlantic City Hotel in Atlantic City, NJ. This year's annual meeting will contain education on the most common diseases seen in primary care – diabetes, obesity, cardiovascular disease – but also some unique sessions. For example, New Jersey's response to the Zika virus presented by Edward Lifshitz, MD, the Medical Director of the Communicable Disease Service for the New Jersey Department of Health and a session on chronic stress and physician burnout presented by Corey Martin, MD. There are also hands-on skills workshops on contraceptive procedures and quality improvement. Additionally, there will be a pre-conference session on health coaching.

Besides excellent educational offerings, plan to come to the Scientific Assembly to attend the House of Delegates, a Town Hall on the hottest legislative issues, and of course the Resident Knowledge Bowl and President's Gala honoring incoming President, Adity Bhattacharyya, MD.

For education, for supporting family medicine, for the networking, and for the fun… we all hope to see you in Atlantic City.

Happy Reading,

Theresa

References

1. https://www.nlm.nih.gov/pubs/factsheets/medline.html
2. https://www.jimcarroll.com/2011/10/trend-the-future-of-knowledge/#.VzMxQWf2bIU
3. Robin BR et al. (2011). Academic Medicine, 86(4), 435-439

Strengthening Our Workforce

ROBERT T. GORMAN, MD

When we graduated from medical school, we knew that we were starting a career in which attention to lifelong learning was mandatory in order to be effective physicians throughout our practice years. I remember being told that half of what we learned in medical school would not be valid five years later. I really hoped they would tell us which half, because there was so much to learn. Nevertheless, I eventually felt prepared by residency and I had a plan for keeping up to date. This involved reading numerous journals, attending live CME events locally, and engaging in frequent discussions with colleagues in Family Medicine and various consultants. The annual meeting of the NJAFP provided me with an opportunity to obtain CME and to also network with colleagues and friends from around the state. What I did not realize then was that at least as much effort was needed to stay abreast of how we would practice medicine in the ever-changing world of regulations and outside mandates imposed upon us by federal and state agencies, as well as the insurance industry.

During my year as president of the NJAFP, I have had the privilege to represent you at a variety of national meetings and to visit other state chapters. Each time I did this, I came away greatly impressed by the caliber of talent and the strength of commitment possessed by the leaders I have met.

I have written several times about the work our national leaders have been doing to help shape the evolution of the implementation of MACRA into legislation. MACRA will strengthen the primary care workforce by reducing many of the administrative burdens we have endured under programs such as Meaningful Use, and will compensate us fairly for the patient care that we deliver during face-to-face visits and coordinating care in between visits. Some of our senior leadership at the AAFP believes that the changes that occur with MACRA will have a greater impact on Family Medicine than anything else in the last 40 years.

It seems to me that we all have several choices of practice delivery going forward. More of us are opting for new practice styles like Direct Primary Care (DPC) or concierge style practices. Some of us are resisting change and trying to hold on as long as possible to the "way we always did it." Many of us are trying to find new ways to adapt to the changes that come with MACRA and to find opportunities to care for our patients on a larger scale with team-based approaches in collaboration with other physicians, NPs, PAs and medical assistants. We are trying to provide resources through the NJAFP for whatever path you choose.

At the Family Medicine Congressional Conference in April, Past President Dr. Tom Shaffrey, and Executive VP of the NJAFP, Ray Saputelli, joined me in meeting with members of Congress and their staffs. Washington, DC is a fascinating place to visit. The experience was very educational and at times entertaining. Our NJ elected representatives told us that the AAFP does a great job of keeping them informed on national issues, so we used much of our time to advocate for issues within NJ and to establish relationships for future dialogue. We all felt that it was time well spent.

I remember being told that half of what we learned in medical school would not be valid five years later. I really hoped they would tell us which half.

The Annual Chapter Leader Forum in Kansas City was my last trip as president this year. In addition to the usual discussions of important national topics, we also used this opportunity to network again with the American Board of Family Medicine. At the start of my term, I stated that one of my goals was to work on the "quadruple aim" which, as its fourth component, has a goal of improving the work-life of the healthcare work force (us!).

The advocacy work that I have been writing about is part of the equation, but helping family physicians identify burnout and give them tools to effectively deal with it is the final goal. We have engendered enthusiasm within the ABFM and the AAFP to collaborate to produce a tool that would be educational and helpful in both a preventive and remedial way, as well as satisfying requirements for maintenance of certification.

As I wind down my year as president and prepare to pass the baton to Dr. Adity Bhattacharyya, your incoming president, I do so with a sense of pride and satisfaction. I will continue to work with a wonderful group of leaders as Chairman of the NJAFP Board of Trustees. Our Academy is strong and well respected around the country. I mentioned in my last article the energy and enthusiasm that you derive from interacting with and teaching medical students. I can assure you that the same thing happens when you work with enthusiastic physician colleagues and staff like those we have at the NJAFP. I want to thank you very much for giving me the privilege of serving as your president. It was a very exciting and rewarding year. ▲

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

The Bus is Leaving…

RAY SAPUTELLI, MBA, CAE

IT'S TIME. As you read this, the truck is loaded and ready to move the whole NJAFP to Atlantic City for the 2016 Family Medicine Conference; our annual effort to mix one part education with one part advocacy and one part fun and fellowship in the hope that we come out with a one-of-a-kind experience for family physicians in NJ and the surrounding states. As I mentioned in this column last quarter, this year's meeting is shaping up to be different than many in the past, and perhaps far more important. While the pace of change in medicine has been off the scale for some time, the changes ahead are more significant than any others that most of us have faced. For so many years our rallying cry was designed to end payment based on the volume of services delivered, and to transition to a system that rewarded the value that family physicians routinely provide. It seems that we were always fighting to stem the mandatory fee reductions of the failed SGR (sustainable growth rate) formula. Even when we were confident that we would be able to defeat those cuts, we dealt with the potential cash-flow implications that each year threatened to devastate your practices – especially those of you in small, independent practices. Enter MACRA – the Medicare and CHIP Reauthorization Act of 2015. Suddenly, payment reform is upon us, and while it's complicated and still a work in progress, and fraught with many potential pitfalls, the AAFP and the NJAFP are working hard and devoting significant resource to helping members prepare for the changes that MACRA will bring. (For more information on MACRA and the resources available through the AAFP go to www.aafp.org/macraready).

While MACRA is certainly at the top of the list of challenges that we face, it's definitely not the only one. Many of you are still dealing with ICD-10 changes, or with questions about integration and practice transformation. Of course one only needs to open the newspaper (I was going to edit that out in favor of something more electronic, but I wonder how many of you – like me -- miss the good ol' paper?) to find yet another story of a celebrity, or even a neighbor whose death is attributable to opioids or the downstream heroin addiction. Many family physicians feel unfairly condemned as the easy target for blame in a crisis where there is plenty of blame to share throughout the system. More importantly perhaps, many are correct when they point out the multi-factorial cause of the crisis. They note a range of factors from a system that decided pain should be a "fifth vital-sign" and linked quality scores to the management of a patient's pain, to the lack of inter-operability and inter-connectivity of PDMPs in so many states that limit a family physician's ability to single out the bad-actors and "doctor-shopper" addicts. Each one of these items and so many more are a part of every conversation I have with members on a daily basis, and those members are right to ask: "What is the NJAFP and the AAFP doing to help me?"

The NJAFP – your voice in Trenton, and the AAFP – your voice in Washington, DC, are working diligently to provide the answer to that basic question, and those two voices will come together in Atlantic City on June 9th through the 12th. In addition to the quality educational programming which is highlighted elsewhere in this issue, there are two distinct and valuable opportunities to engage leaders of both organizations, to voice your concerns, and even participate in the work that those leaders will do on your behalf. The first of those is the annual Town Hall Forum which will be held in the evening on June 9th. This year's Town Hall will be an informal discussion where leaders from the NJAFP will join Mike Munger, MD – candidate for AAFP President-Elect and current member of the AAFP Board of Directors – in a dialogue with everyone in attendance focused on the AAFP and NJAFP responses to MACRA, the Opioid epidemic, and all of the other critical areas where members look to the Academy for guidance and support.

The second opportunity for members to discuss the issues facing primary care, the specialty of family medicine, and the patients you care for will take place on Friday, June 10 at the NJAFP House of Delegates. The House convenes at 8:00am and runs through 3:00pm or the conclusion of House business. As I noted here in previous issues, the House of Delegates is the official governing body of the NJAFP. When in session, the House sets policy for the Academy and then empowers the board and officers it elects to drive that policy throughout the year in

Continued on page 7

As I am often heard saying, there is no other organization on the face of the planet whose sole focus is directed to supporting family physicians in New Jersey.

CDC Releases New Pain Management Guidelines

Centers for Disease Control and Prevention (CDC) released their *Guideline for Prescribing Opioids for Chronic Pain.*[1] Released in March of 2016, the objective of the guidelines are to not only prevent overdose from opioids, but also to improve patient care and safety. The guidelines were developed using the best research currently available and will be revised as new science emerges.

The guidelines provide a flexible tool for informed decision-making for primary care physicians who prescribe about half of all opioid medications for pain. The tool also promotes improved communication between physicians and patients and improves confidence regarding how and when to use opioids for chronic pain management. Pain management information is provided to help physicians learn about safer and effective options and encourages partnerships with other providers, such as pain management specialists, behavioral health specialists, and pharmacists.

Chronic pain is the focus of the guidelines, not acute pain. When treating acute pain, the guidelines recommend the lowest effective, immediate-release opioid dose be prescribed and not to prescribe any more medication than is needed, usually three days or less. Rarely is medication warranted for more than seven days to treat acute pain.

The guidelines contain 12 recommendations based on three key principles:

1. Opioids should not be the first line of treatment for chronic pain.
   - Non-opioid therapy is preferred for chronic pain that is not related to active cancer, palliative and end-of-life care. Opioids should only be used when the benefits are expected to outweigh the substantial risks.
2. Start low and go slow when using opioids.
   - Start with the lowest possible effective dose and increase only gradually.
3. Use caution when prescribing opioids and closely monitor every patient.
   - Physicians can mitigate patient risk through actions such as having a plan to taper opioids if the desired response is not attained and checking the state's prescription drug monitoring program.

The guidelines are intended to assist patients and physicians in assessing the risk and benefits of using opioids and determine the best options for treatment. Tools and resources in the guideline include a decision checklist. There are materials and resources for patients as well.

References

1. CDC. (2016). Transcript for CDC Telebriefing: Guideline for Prescribing Opioids for Chronic Pain. Retrieved from http://bit.ly/CDC_Guidelines

HEALTH IS PRIMARY UPDATE

Health is Primary has partnered with America's Health Rankings® on a new report - *Spotlight: Impact of Unhealthy Behaviors.* The report examined five "unhealthy behaviors" - smoking; excessive drinking; insufficient sleep; physical inactivity; obesity - and found that more than 25 million American adults report having multiple unhealthy behaviors (three or more) and, as a result, face more than 6 times greater risk of fair or poor health status than those reporting zero unhealthy behaviors. The goal of the partnership is to tell the story of how a strong primary care system can improve health behaviors and increase access to prevention. It is also intended to demonstrate the role of primary care in addressing and minimizing health disparities across the country.

According to the report, 10.9 % of New Jersey residents report three or more unhealthy behaviors. The majority of those who report unhealthy behavior have not completed a high school education, are male, Black, and between 45 and 65 years of age.[1] On the positive side, 28.5% of New Jerseyans report zero unhealthy behaviors. To read the full report visit http://www.americashealthrankings.org/spotlight/unhealthybehaviors.

References

1. Americas' Health Ratings. (2016). New Jersey - Spotlight: Impact of Unhealthy Behaviors. Retrieved from http://bit.ly/NJ_health-behavoir

NJAFP SUPPORTS PENNSYLVANIA'S ORGAN DONOR PROJECT

Organ donation cuts across state lines, especially with Medicare's new payment for end-of-life conversations. The United Network for Organ Sharing (UNOS) reports that there are more than 121,000 people nation-wide waiting for organs. New Jersey has two Organ Procurement Organizations (OPOs): Gift of Life and New Jersey Sharing Network. Gift of Life is responsible for the southern part of the state including Burlington, Camden, Gloucester, Salem, Cumberland, Cape May and Atlantic counties. New Jersey Sharing Network is responsible for the northern part of the state including Ocean, Monmouth, Mercer, Middlesex, Hunterdon, Somerset, Union, Hudson, Essex, Morris, Warren, Bergen, Passaic and Sussex counties. NJAFP is proud to support organ donation in both New Jersey and Pennsylvania.

Kris Samara (left), Lead on the Organ Donor project with a representative from the Center for Organ Recovery & Education (CORE: serving western PA). NJAFP is partnering with CORE to recruit organ donors in Pennsylvania physician practices and community health centers.

If you are interested in learning more about organ donation in New Jersey contact Kris at kris@njafp.org

Turn to Quality View on page 17 for the full story on the Organ Donation Project.

Perspectives

A View of Family Medicine in New Jersey

The Journal of the New Jersey Academy of Family Physicians

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Perspectives: A View of Family Medicine in New Jersey is published four times a year by the New Jersey Academy of Family Physicians. Deadlines for articles and advertisements may be obtained from the NJAFP office. The editors reserve the right to accept or reject any article or advertising material. Some material may be submitted to the Board of Trustees for review.

The Bus is Leaving...

Continued from page 5

collaboration with the staff team. In addition, each year the delegates and attendees hear from an assorted list of policymakers and other healthcare stakeholders. This year the NJAFP has invited NJ Assembly Health and Senior Services Committee Chair, Herb Conaway, MD to address the House. In addition, the NJAFP will present Dr. Conaway with the Edward A. Schauer, MD Award for Public Policy. The long-time Assemblyman from the 7th district has been invited to address the issues previously discussed from the NJ perspective. He will no doubt also discuss potential policy changes in a new administration, and listen to feedback from the members in attendance. In addition, Dr. Munger will continue the dialogue on AAFP policy from the Town Hall, and the delegates will debate resolutions that will guide our work in the coming 12 months.

The NJAFP Family Medicine Conference truly provides a unique experience, and I encourage you to take part. As I am often heard saying, there is no other organization on the face of the planet whose sole focus is directed to supporting family physicians in New Jersey. As we prepare each year for our trip to Atlantic City, your staff and leadership work tirelessly to design a meeting that makes a difference. Still, I'm realistic. The problems are many, the challenges great. I don't suggest that we can solve every problem or mitigate every challenge with one meeting in June. We can, however, provide useful and timely information, important advocacy, and quality education that will make your life as a family physician better, and while we do that we can help you connect with old friends, make new ones, share ideas and best practices, have your voice heard by those who serve as leaders in your academy, and maybe have a little fun in the process. I hope you will join us – for a day or the entire weekend, and as I do every year, I look forward to seeing many of you there. ▲

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

CME Overview of Chronic Pain Management

FACULTY/AUTHORS: KENNETH FAISTL, MD, FAAFP; TRACY JACKSON, MD; LOUIS KURITZKY, MD

Adapted from CME Report: *The Many Facets of Chronic Pain*

Drs. Faistl and Jackson report no conflicts of interest. Dr. Kuritzky has disclosed that he is a consultant for Boehringer Ingelheim, Eli Lilly and Company, Novo Nordisk, Sanofi-Aventis, Janssen Pharmaceuticals, Inc., AstraZeneca, and Pfizer, Inc.

Learning Objectives:

- Use the CDC's Guideline for Prescribing Opioids for Chronic Pain
- Design individualized pain management plans
- Use shared decision-making to develop individualized pain management plans

Pain – An Emerging Epidemic

Relieving Pain in America[2] revealed that the incidence of reported pain across all demographic groups has continued to increase steadily, from 19.4% (1999-2000) to 24.8% (2003-2004) in men, and from 24.8% (1999-2000) to 30.4% (2003-2004) in women. It has been shown that chronic pain is more prevalent in the US population than the combination of diabetes, cancer, and heart disease.[3] It has been surmised that the reason for this phenomenon is related to the increase in chronic diseases, outpatient surgery where the patient is discharged before pain can be adequately assessed, and advances in technology that allow patients who have experienced devastating injuries to live, even if the cost is incapacitating pain.[2]

What is Chronic Pain?

"An unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage."

– *International Association for the Study of Pain*

The concept of pain may be thought of as pain that persists beyond recovery from tissue damage or that has continued beyond its "physiologic purpose" of directing attention to potential or existing tissue damage. While patients with pain syndromes may be able to identify the cause of their pain, others suffer in the absence of tissue damage or injury. Additionally, central sensitization or central hypersensitivity syndrome has also been associated with chronic pain.[4]

Pain in Primary Care

There are multiple mechanisms by which pain may be expressed. These include nerve damage (diabetic peripheral neuropathic pain, post-herpetic neuralgia, phantom limb pain), mechanical/compressive issues (musculoskeletal pain), inflammation (arthritis, tissue injury, infection,), and muscle pain (myofascial pain syndrome).[5] Many patients who experience persistent pain will visit their family physician for treatment. In addition to pain, these patients may also present with apathy, depression, anxiety, anger, or even hostility. Chronic pain is also associated with illicit substance use, and abuse of alcohol and opioids.[6,7] Each of these concomitant conditions must be addressed. Therefore treating chronic pain is a multi-step process of patient engagement.

Screening – The first step in managing chronic pain is to assess its severity and the impact on the patient's ability to function. Screening is a subjective process as the patient must provide feedback about the duration, location, intensity and frequency of the pain. A number of pain scales are available for use in the family medicine office. These scales range from simple graphs or graphics that ask the patient to rate their pain to more complex screening tools like the University of Washington's PainTrackerTM.[8] The National Initiative on Pain Control has also assembled a collection of pain assessment scales to assist physicians.[9]

Intervention - The complete elimination of pain may often be an unrealistic goal in the treatment of pain. Rather, the goal should be focused on a return to function (the ability to participate in activities of daily living).[10] Interventions should help patients reduce or manage their pain in the context of daily life. Both physician and patient need to come to agreement on the best treatment plan, which may involve a mix of non-pharmacologic interventions (see sidebar) and/or medication.[11]

Whatever modality of treatment is chosen, regular follow-up is essential in order to monitor functional performance and the efficacy of any medications that have been prescribed. The management of chronic pain is an evolving process and family physicians will need to evaluate the patient's ability and readiness to be involved in their care.[11] The healthcare team should work with the patient to foster the patient's sense of control and

PAIN FACTS[1]

- An estimated 1 out of 5 patients with non-cancer are on prescribed opioids
- Nearly 2 million Americans abused or were dependent on prescription opioids in 2014
- From 1999 to 2014 more than 165,000 people died from overdose related to prescription opioids
- Since 1999 sales of prescription opioids in the US have quadrupled
- As many as 1 in 4 people receiving prescription opioids long-term in the primary care setting struggles with addiction

NON-PHARMACOLOGIC INTERVENTIONS FOR PAIN MANAGEMENT[11]

- Lifestyle changes
- Exercise
- Physical/occupational therapy or rehabilitation
- Cognitive behavioral therapy (CBT) or psychological therapy
- Acupuncture, chiropractic treatment
- Electrical nerve stimulation
- Meditation, guided imagery
- Relaxation techniques
- Hypnosis and self-hypnosis

responsibility. An engaged patient will understand the process of managing pain and the role they should play in daily management, which will result in better outcomes.[11]

Pharmacology – While non-pharmacologic interventions may result in improved functional status and pain reduction, it takes time to accomplish these benefits. Therefore, some form of pharmacologic therapy may be necessary to lessen the pain burden (see side bar).[11] It is important to be aware of the fact that it may take several trials of medication and doses before finding the correct therapy for the patient. It is not uncommon for a patient to respond to one form of medication and not another.[11] The most widely used class of medications for pain is opioids, whose effects have been known for thousands of years.[12]

AGENTS COMMONLY USED TO TREAT CHRONIC PAIN SYNDROMES

- Over-the-counter medications: NSAIDs, acetaminophen, topical agents (capsaicin, lidocaine, ketamine)
- Anti-epileptic agents (carbamazepine, gabapentin, pregabalin)
- Antidepressants (tricyclic agents, SSRIs, SNRIs
- Opioid analgesics - codeine*†§, hydrocodone*†§, hydromorphone, morphine, oxycodone*†§oxymorphone, tapentadol, tramadol*
  - Available in combination formulations with *acetaminophen, †aspirin, or §ibuprofen

The Opioid Epidemic - In 1998 changes in the statues that limited the long-term use of opioids were relaxed as a result of lobbying by pain-advocacy groups successfully.[13] The change in policy led to an increase in the manufacture of opioids and resulted in an upsurge of prescriptions.[14] Between 1999 and 2010 the sales of opioid medications quadrupled.[14] By 2012, 289 million prescriptions for opioids had been dispensed, nearly half of which were prescribed through primary care specialties.[15]

This escalation in opioid use correlates with the increase in opioid-related overdoses and deaths that have been seen in the past two decades. The CDC stated that the number of US deaths attributable to opioid analgesics and heroin increased 200% between 2000 and 2014.[16] In 2010 alone, 43% of US deaths from pharmaceuticals were opioid-related (n=16,651).[17]

In response to this crisis, the CDC has released the *CDC Guideline for Prescribing Opioids for Chronic Pain – United States, 2016*.[18] The guideline provides recommendations in three areas: 1) when to begin or continue opioids for chronic pain; 2) opioid selection, dosage, duration, follow-up, and discontinuation; and 3) assessing risk and addressing harms of opioid use. The guideline is a tool to help improve physician/patient communication regarding the risks and benefits of opioids for chronic pain. The guideline also aims to reduce the risks of long term opioid therapy – including use disorders, overdose, and death – while improving the safety and effectiveness of pain treatment.

The CDC has created a checklist for prescribing opioids for chronic pain (available at http://stacks.cdc.gov/view/cdc/38025) as well as a website with other tools to assist physicians in implementing the guidelines. The site can be accessed at http://www.cdc.gov/drugoverdose/prescribingresources.html

NJ Prescription Drug Monitoring Programs (NJPMP) - http://www.state.nj.us/lps/ca2/pmp/

The NJPMP is a statewide electronic database that collects and stores data on controlled substances that are dispensed within the state. NJPMP supports access to legitimate medical use of controlled substances, while helping to identify persons addicted to prescription drugs, and educate individuals about use, abuse, diversion, and addiction to prescription drugs.

Access to the NJPMP is available to both pharmacists and physicians who are licensed in New Jersey and are in good standing with their licensing boards. Qualified prescribers are able to access the database before prescribing or dispensing a drug to request patient history for Controlled Dangerous Substances (CDS) and Human Growth Hormone (HGH). The request must be made for a specific, current patient.

NJPMP patient information is a supplement to an evaluation of the patient, confirmation of a patient's drug history, and/or documentation of compliance with a therapeutic regimen or drug history. When there is concern of a patient's drug use, the physician or pharmacist is urged to help the patient locate assistance and to take other actions as deemed appropriate.

Conclusion

There are many underlying mechanisms that can result in chronic non-cancer pain. Managing chronic pain requires shared decision-making, incorporating pharmacologic and non-pharmacologic therapies to arrive at treatment options that are acceptable to both physician and patient. Physicians need to help patients understand that the complete elimination of pain is unlikely, and instead focus on improved function with reduced pain. Following the CDC guidelines and using the NJPMP can aid physicians in providing safe, effective pain management care and reduce the potential risks associated with the use and misuse of opioid agents, while improving their patients' quality of life.

Candidates for opioid therapies should be carefully selected using a risk stratification process that incorporates various screenings and evaluations. Interdisciplinary pain rehabilitation programs should be tailored to the needs of the patient. To codify expectations and outcomes of treatment, it is essential that the provider and patient sign a medication agreement before initiating opioid therapy. Clinicians and patients must maintain an ongoing dialogue about the safe use of opioids for pain management. All aspects of the treatment paradigm, including modifications, must be carefully documented. By following appropriate screening and responsible prescribing, clinicians can incorporate pharmacotherapy into an overall pain management plan that can enhance the quality of life for the patient who suffers from chronic non-cancer pain.

References

1. CDC. CDC Guideline for Prescribing Opioids for Chronic Pain. 2016; http://www.cdc.gov/drugoverdose/prescribing/guideline.html.
2. Institute of Medicine. *Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research.* Washington D.C.: National Academies Press; 2011.
3. National Institute of Nursing Research. Fact Sheet--Pain Management. https://report.nih.gov/nihfactsheets/ViewFactSheet.aspx?csid=57. 2010.
4. Institute for Chronic Pain. Understanding chronic pain--central sensitization. http://www.instituteforchronicpain.org/understanding-chronic-pain/what-is-chronic-pain/central-sensitization. 2016.
5. Hooten WM, Timming R, Belgrade M, et al. Assessment and Management of Chronic Pain. 2013: https://www.icsi.org/_asset/bw798b/ChronicPain.pdf.
6. Reid MC, Engles-Horton LL, Weber MB, Kerns RD, Rogers EL, O'Connor PG. Use of opioid medications for chronic noncancer pain syndromes in primary care. *J Gen Intern Med*. 2002;17:173-179.
7. Proctor SL, Estroff TW, Empting LD, Shearer-Williams S, Hoffmann NG. Prevalence of substance use and psychiatric disorders in a highly select chronic pain population. *J Addict Med*. 2013;7:17-24.
8. University of Washington. University of Washington's PainTrackerTM 2016; http://paintracker.uwmedicine.org/.
9. The National Initiative on Pain Control. Patient Assessment Scales. 2016; http://www.painedu.
10. Ablin JN, Buskila D. "Real-life" treatment of chronic pain: Targets and goals. *Best Pract Res Clin Rheumatol*. 2015;29:111-119.
11. Faistl K, Jackson T, Kuritsky L, Goldwaithe C. CME Report: *The Many Facets of Chronic Pain (in press)*. New Jersey Academy of Family Physicians; 2016.
12. Al-Hasani R, Bruchas MR. Molecular mechanisms of opioid receptor-dependent signaling and behavior. *Anesthesiology*. 2011;115:1363-1381.
13. Franklin GM. Opioids for chronic noncancer pain: a position paper of the American Academy of Neurology. *Neurology*. 2014;83:1277-1284.
14. Manchikanti L, Abdi S, Atluri S, et al. American Society of Interventional Pain Physicians (ASIPP) guidelines for responsible opioid prescribing in chronic non-cancer pain: Part I--evidence assessment. *Pain Physician*. 2012;15(3 Suppl):S1-S65.
15. Levy B, Paulozzi L, Mack KA, Jones CM. Trends in opioid analgesic-prescribing rates by specialty, U.S., 2007-2012. *Am J Prev Med*. 2015;49:409-413.
16. Rudd RA, Aleshire N, Zibbell JE, Gladden RM. Increases in drug and opioid overdose deaths - United States, 2000-2014. *MMWR Morb Mortal Wkly Rep*. 2016;64:1378-1382.
17. Jones CM, Mack KA, Paulozzi LJ. Pharmaceutical overdose deaths, United States, 2010. *JAMA*. 2013;309:657-659.
18. Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016 *MMWR Recomm Rep*. 2016;65:1-49.

CME

Obstructive Sleep Apnea in Commercial Drivers

ERIN O'SHEA, DO AND ANTHONY IZZO, DO

The authors have no financial conflicts of interest relevant to this activity.

Dr. O'Shea is a sleep medicine specialist in Wooster, MD.

Dr. Anthony Izzo is Associate Chief of Neurology and sleep specialist/neurologist at the Saint Vincent Hospital location of the Saint Vincent Medical Group at Worcester Medical Center.

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 US. The project will increase public awareness of the importance of healthy sleep. It also will promote the treatment and prevention of sleep disorders.

The two central components of healthy sleep are sufficient quantity and quality. On average, adults require about 7.5 hours of good quality sleep per night. Obstructive sleep apnea (OSA) is a prevalent, yet under-diagnosed condition in the general population characterized by repeated upper airway collapse that leads to oxygen desaturation and arousals from sleep, which in turn disrupts quality of sleep. In addition to increasing risk for cardiovascular disease, hypertension, stroke and atrial fibrillation, OSA has short term consequences that range from mild to severe. Untreated OSA can lead to chronic sleep insufficiency, and the most prominent symptoms include excessive daytime sleepiness (EDS) and unrefreshing sleep.

The estimated prevalence of OSA in the US general population is 4%. Risk factors include obesity, male sex, increasing age, increased neck circumference (greater than 16 inches in women and 17 inches in men) and certain craniofacial features – retrognathia, macroglossia and highly arched palate. In the population of commercial drivers, the prevalence is estimated to be much higher at 15 to 30%, largely due to the increased number of males in the profession as well as increased prevalence of obesity and sedentary lifestyle in drivers.

One of the most prominent symptoms of OSA is excessive daytime sleepiness. This is measured subjectively using the Epworth Sleepiness Scale (ESS), which asks patients to rate their likelihood of falling asleep in eight difference scenarios from 0-3. A study from Australia showed that adults without evidence of a chronic sleep disorder had a mean ESS of 4.6 ± 2.8.[1] The normal range (defined by 2.5 and 97.5 percentiles) is 0 to 10. A higher score is correlates with a higher level of subjective daytime sleepiness.

In the setting of occupational health, EDS is arguably the most important consequence of OSA as it leads to drowsy driving or even falling asleep behind the wheel (sleep attacks). The effects of EDS are comparable to those of alcohol consumption,[2] leading to psychomotor deficits, concentration, judgement and memory impairment, and slowed reaction times. This is especially concerning for commercial and professional drivers as these impairments lead to an increased risk of motor vehicle accidents. An estimated 10 to 30% of all crashes and 21 to 31% of fatal crashes have found drowsy driving and/or falling asleep behind the wheel as the root cause.[3,4,5] Since OSA can lead to EDS, which in turn can lead to drowsy driving, it is not surprising that drivers with OSA had more than a two times greater risk of crashing than drivers without OSA (RR = 2.43, 95% CI:1.21-4.89).[6] Indeed, Hakkanen and Summala found that 22% of long haul truck drivers in Finland admitted to dozing while driving at least 2 times in the past 3 months of their study.[7] Commercial vehicle crashes are 7 times more likely to be fatal compared to non-commercial vehicle crashes.[8]

Currently in the US, the only mandated screening of the 14 million commercial driver's license holders for any sleep related disorder is to complete a federal medical examination questionnaire, which includes only one sleep-related question: "Do you have sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring?" In 2009, a study by Parks et al revealed that among drivers at high risk for OSA, 85% answered "no" to this question.[9]

Self-reporting of sleep related problems may be biased due to drivers' fear of perceived financial and/or occupational consequences of such problems, such as losing their job or having to incur the additional costs of diagnosis and treatment.

In 2006, the Joint Task Force of representatives from the American College of Chest Physicians (ACCP), the American College of Occupational and Environmental Medicine and the National Sleep Foundation, published guidelines for identifying OSA in commercial drivers.[10] The summary of the recommendations is as follows:

Drivers meeting one or more of the six criteria are considered to have OSA or probable OSA:

1. Any of the following symptoms: snoring, EDS, witnessed apneas
2. History of MVA likely related to sleep disturbance (run off road, at-fault, rear-end collision)
3. Previous OSA diagnosis; prior PSG with AHI>5; reported CPAP prescription and/or use
4. ESS > 10
5. Sleeping in examination or waiting room
6. Two or more of the following:
   a. BMI >/= 35kg/m^2
   b. Neck circumference > 17 inches in men, 16 inches in women
   c. Hypertension (new, uncontrolled or requiring 2 or more medications for control)

Diagnosis of OSA is by polysomnography (PSG) or home sleep test (HST) demonstrating sleep disordered breathing with an apnea-hypopnea index (AHI) of greater than 5.

The mainstay of OSA treatment is CPAP (continuous positive airway pressure). With this modality effectiveness of and compliance with treatment can be objectively monitored. Other treatment modalities include surgical options, oral appliances, lifestyle modification (weight loss, alcohol restriction) and positional sleeping, which cannot be objectively monitored. Once diagnosed, commercial driver's license holders are often required to demonstrate compliance with OSA treatment, which most often includes CPAP therapy.

There is evidence that treatment of OSA with CPAP decreases the risk of vehicle crashes in the general population in those subjects who are compliant with treatment. Tregear et al conducted a meta-analysis of 9 observational studies investigative the risk of crashing in drivers diagnosed with OSA before and after treatment with CPAP and found a risk reduction after treatment (risk ratio = 0.278, 95% CI 0.22 to 0.35; P < 0.001).[11]

In conclusion, untreated obstructive sleep apnea, which is very common in the US commercial driver population, leads to increased risk of both fatal and non-fatal motor vehicle crashes. There is currently no federally mandated effective screening, but effective screening tools do exist. If diagnosed with obstructive sleep apnea, literature demonstrates that effective treatment with CPAP therapy can decrease the risk for vehicle crashes and associated morbidity, mortality and cost.[12] ▲

References

1. Johns MW, Hocking B. Daytime sleepiness and sleep habits of Australian workers. *Sleep* 1997: 844-949
2. Dawson A, Reid K. Fatigue, alcohol and performance impairment. *Nature* 1997; 388:235.
3. AAA Foundation for Traffic Safety. A report on the determination and evaluation of the role of fatigue in heavy truck accidents. Washington DC: AAA Foundation for Traffic Safety, October 1995.
4. Radun I, Summala H (2004) Sleep-related fatal vehicle accidents: characteristics of decisions made by multidisciplinary investigation teams. *Sleep* 27, 224–7.
5. Philip P (2005) Sleepiness of occupational drivers. *Industrial Health* 43, 30–3.
6. Tregear S, Reston J, Schoelles K, Phillips B (2009) Obstructive sleep apnea and risk of motor vehicle crash: systematic review and meta-analysis. *J Clin Sleep Med* 5, 573–81.
7. Hakkanen H, Summala H (2000) Sleepiness at work among commercial truck drivers. *Sleep*, 23, 1-9.
8. NHTSA. Traffic Safety Facts: 2007 Data. DOT report number DOT HA 810 98.
9. Parks P, Durand G, Tsismenakis AJ, Vela-Bueno A, Kales S (2009) Screening for obstructive sleep apnea during commercial driver medical examinations. *J Occup Environ Med* 51, 275–82.
10. Hartenbaum N, Collop N, Rosen IM, Phillips B, George CF, Rowley JA, Freedman N, Weaver TE, Gurubhagavatula I, Strohl K, Leaman HM, Moffitt GL; American College of Chest Physicians; American College of Occupational and Environmental Medicine; National Sleep Foundation (2006) Sleep apnea and commercial motor vehicle operators: statement from the joint task force of the American College of Chest Physicians, the American College of Occupational and Environmental Medicine, and the National Sleep Foundation. *Chest* 130, 902–5.
11. Tregear S, Reston J, Schoelles K, Phillips B. Obstructive sleep apnea and risk of motor vehicle crash: systematic review and meta-analysis. *J Clin Sleep Med* 2009;5:573–81
12. Kales S, Straubel M (2014) Obstructive sleep apnea in North American commercial drivers. *Industrial Health* 2014, 52, 13-24.

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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Members – To obtain credit:

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

NAME: _____ AAFP MEMBERSHIP NUMBER: _____

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1. *True or False:* An estimated 1 out of 5 patients with non-cancer are on prescribed opioids.

2. *True or False:* The first step in managing chronic pain is to assess its severity and the impact on the patient's ability to function.

3. *True or False:* Complete elimination of pain is a realistic goal in pain management.

4. *True or False:* Once pain is controlled, follow-up is usually not necessary.

5. *True or False:* Patient engagement is not usually helpful in the management of chronic pain.

6. *True or False:* Cognitive behavioral therapy (CBT) or psychological therapy is one of the non-pharmacological options available to treat chronic pain.

7. *True or False:* The number of US deaths attributable to opioid analgesics and heroin increased 200% between 2000 and 2014.

8. *True or False:* Pain scales are a reliable method to screen a patient for pain.

9. *True or False:* NJPMP patient information is not helpful in documenting compliance with a therapeutic regimen.

10. *True or False:* On average, adults require about 7.5 hours of good quality sleep per night.

11. *True or False:* Excessive daytime sleepiness is not a hallmark of OSA.

12. *True or False:* The effects of EDS are comparable to those of alcohol consumption.

13. *True or False:* Less than 4% of family physicians have organ donation discussions with their patients.

14. *True or False:* There is an age limit to organ donation.

Answers on page 14

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

NJAFP in Washington, DC

NJAFP President, **Robert Gorman, MD** (Verona); Past President, **Tom Shaffrey, MD** *(Middlesex)*, and EVP, **Ray Saputelli** represented New Jersey family physicians at the annual AAFP Family Medicine Congressional Conference in Washington, DC.

Congratulations to…

Karen Wei-Ru Lin, MD, a 2016 recipient of the Clement A. Price Human Dignity Award sponsored by The Committee to Advance Our Common Purposes. The award recognizes outstanding individuals or groups that have demonstrated extraordinary achievement and commitment to promoting and practicing diversity and inclusion at Rutgers University and/or in partnership with the broader community. Dr. Lin is the Assistant Dean for Global Health & Associate Professor in the Family Medicine and Community Health Department at Robert Wood Johnson Medical School in New Brunswick.

(l to r) Al Tallia, MD; Robert Like, MD; Karen Wei-Ru Lin, MD; David Swee, MD

Robert Gorman, MD; Thomas McCarrick, MD; Richard Cirello, MD; Melissa Mascaro, MD; Carmine Mazzella, MD; Michele Moscato, MD; Richard Murray, MD and **Stephanie Smith, MD**, all family physician members of the Vanguard Medical Group *(Verona, NJ)*, and recipients of the Comprehensive Primary Care Champion Award by the Centers for Medicare & Medicaid Services (CMS) at a national conference held in Baltimore, MD on May 5th.

The honor signifies that the Vanguard Medical Group Verona Office (formerly Town Medical Associates) excelled among 63 New Jersey practices participating in CMS' Comprehensive Primary Care (CPC) initiative and did more to go above and beyond required standards than any other enrolled practice in this region.

NJAFP *(Trenton)* was awarded the 100% Resident Membership award at the Annual Chapter Leader Forum (ACLF), which was held at the beginning of May. A big thank you to our program directors and their systems for supporting resident membership in NJAFP.

2016 Scientific Assembly

June 10-12, 2016

Sheraton Atlantic City Convention Center Hotel, Atlantic City, NJ

Pre-Conference Symposium

– Evidence-Based Health Coaching for Brief Clinical Encounters

Thursday, June 9, 2016

Sheraton Atlantic City Convention Center Hotel, Atlantic City, NJ

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

There is still time to register for the 2016 Scientific Assembly! Don't wait!

We are headed back to Atlantic City for the annual NJAFP Scientific Assembly and there is still time for you to join us. This year's session is packed with vital clinical information and hands-on workshops and of course, a SAM Study Hall. We will also host an outstanding pre-conference, *Evidence-Based Health Coaching for Brief Clinical Encounters* on 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.

Conference at a Glance

Thursday, June 9, 2016

Happenings

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

11:30am – 4:00pm

Developed especially for healthcare providers, this highly interactive workshop 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, 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 health team who wants to more effectively engage patients.

Conversations

Town Hall

7:00pm – 9:00pm

The healthcare landscape is constantly changing This event will provide you with the most current information available about happenings that are going to affect you and your practice. Plan to attend this informative conversation.

Friday, June 10, 2016

Moving Forward

House of Delegates

8:00am – 3:00pm

The House of Delegates, the annual business meeting for the NJAFP, convenes promptly at 8:00am and will recess at 3:00pm , or upon the conclusion of business. Registration for delegates opens at 7:00am.

Learn 1

CME Sessions

CME sessions begin Friday afternoon at 3:30pm .

Scholarship

Family Medicine Research Poster Presentations

(Posters are on display beginning at 6:30pm through Saturday at 2:00pm)

Family physicians, family medicine residents, and medical students attending one of New Jersey's allopathic medical schools are asked to submit research projects in areas of interest to the specialty of Family Medicine. Contact the NJAFP office for more information.

Networking

Exhibitors' Reception

6:30pm – 8:00pm

Catch up with old friends, make some new ones, and thank our exhibitors and sponsors who help make this conference possible. Food, drink, and excellent conversation are ensured!

Fun

The Resident Knowledge Bowl

8:00pm – 10:30pm

Come and support your favorite Knowledge Bowl team at this Jeopardy-style event

Saturday, June 11, 2016

Learn 2

CME Sessions - CME sessions begin at 8:00am

Celebrate!

The President's Gala

6:00pm – 11:30pm

Kenny I returns to help us celebrate the installation of Adity Bhattacharyya, MD as well as the installation of new Trustees and presentation of awards. What better way to build an evening to honor those family physicians that have made a difference in the world of family medicine.

Sunday, June 12, 2016

Learn 3

CME Sessions - CME Sessions begin at 8:30am

Build Your Skills

(Extra fee – Limited space!)

Contraception Procedures Workshop

8:30am – 10:30am

Quality Improvement 101

11:00am – 1:00pm

MOC Made Easy

SAM STUDY HALL – Hypertension

1:15pm – 6:00pm

Leave this year's assembly with your entire SAM completed! This year's module is Hypertension. *(Separate registration required. Space is limited*

Agenda Highlights

Friday, June 10

Zika and Other Infectious Diseases (3:30pm)

Edward Lifshitz, MD

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 other infectious diseases threaten you and your patients, and what you can do about it.

Overcoming Barriers to Adult Immunizations (4:30pm)

Panel Discussion, Facilitator: Ryan Kauffman, MD

Sometimes the biggest obstacle to improving immunization rates is the reluctance of the patient to receiving them. This session will feature a panel of physicians who have overcome this barrier and will share their secrets to success.

Saturday, June 11

Understanding Payment Reform Models - MACRA, APM, MIPS (11:00am)

Michael Munger, MD (AAFP)

Payment models and the debate around them continue to be in the forefront of physicians' minds. Plan to join AAFP Director Michael Munger, MD as he discusses these important issues and the AAFP response.

The Impact of E-Cigarettes and Hookahs on Health (3:00pm)

Sarah Mullins, MD

After adjusting for other risk factors for smoking, baseline e-cigarette use was associated with a greater likelihood of use of any combustible tobacco product, including conventional cigarettes, cigars, and hookahs. This session will address the latest research on e-cigarettes and smoking cessation strategies.

Sharpen Your Skills Workshops

Contraceptive Procedure Workshop (8:0am - 10:30am)

Jeff Levine, MD, MPH

This session will provide practical hands-on experience in contraceptive procedures. Attendance is limited to 30 attendees. Fee: $30

Quality Improvement 101 (11:00am - 1:00pm)

Neil Goldfarb

This interactive, hands-on session provides an overview of quality improvement methods for the family medicine setting. The session is intended for family physicians and their staff who have limited or no familiarity with methods that can be employed to measure and improve performance in their practice. Learn how to implement a PDSA (plan-do-study-act) cycle for improving practice and how to leverage EHRs to support improvement. Need help to get started on QI measures – this is the workshop for you.

Attendance is limited to 30 attendees. Fee: $30

CME Quiz ANSWERS:

1. True; 2. True; 3. False; 4. False; 5. False; 6. True; 7. True; 8. True; 9. False; 10. True; 11. False; 12. True; 13. True; 14. False

Alert New Horizon Policy for Participating Physicians:

OMNIA Health Plan Tier Awareness Policy

CLAUDINE M. LEONE, JD

In recent years, as health insurance plan options have moved toward greater cost sharing responsibility for patients, there has been a movement in NJ by the state and health plans to require participating physicians to take on the role of insurance counselors for their patients. The NJAFP has been a strong advocate against these policies. That is not to say that physicians and their practices should not have an understanding of the cost sharing implications of their patients' health insurance policies, including, copayments, coinsurance and deductibles. However, there are some policymakers that believe it is an in-network physician's responsibility to understand each patient's individual health insurance policy and explain the cost implications of recommended healthcare services to their patients when referring patients out for additional services. While the sentiment is likely shared by most plans, Horizon has specifically stated that their participating physicians have always been expected to discuss treatment in the context of insurance coverage with their patients.

Over the years, NJAFP has testified and shared these concerns with the New Jersey Legislature in the context of the Out-of-Network debate that has continued in Trenton. Initially, in an attempt to curb some of the hospitals' and providers' abuse of the out-of-network payment system, there were efforts to require in-network physicians to educate patients on their cost sharing responsibilities when they refer patients to third party providers, whether to specialists or facilities for testing or procedures. Over the last few years, NJAFP, specifically speaking on behalf of in-network family physicians, has convinced legislators that it is not the role of an in-network physician to explain the intricacies of a patient's cost sharing responsibilities for medical care, especially outside of their services. However, there are certain patient disclosures that are reasonable and practical, including notice of the providers' plan participation, that do not add additional burdens to in-network providers.

That brings us to March 2016: It came to our attention March 16, 2016 that Horizon published on its website a new Administrative Policy, the "OMNIA Health Plan Tier Awareness Administrative Policy," for its participating physicians and providers. https://www.horizonblue.com/providers/resource-center/news/review-our-omnia-health-plan-tier-awareness-administrative-policy.

So, what does this mean for your practice? What other plans have similar policies? And, what is NJAFP doing about it?

What does this mean for your practice?

WHO must comply with this policy? All participating Horizon Managed Care Network physicians and other healthcare professionals who may send OMNIA Health Plan members and/or their dependents for specialty care or other health care/healthcare facility services.

WHAT is the policy? Participating physicians and other healthcare professionals who are treating/coordinating the care of members and/or dependents enrolled in an OMNIA Health Plan are required to discuss the cost sharing implications of using physicians, other healthcare professionals and facilities designated as OMNIA Tier 1 or Tier 2 with their patients or the parents, guardians or designated personal representatives of patients enrolled in an OMNIA Health Plan.

WHERE/WHEN does this discussion occur? This conversation should be conducted at the time a determination to send a patient to a physician, other healthcare professional and/or facility occurs and should be fully documented within the OMNIA Health Plan members/covered persons' medical record.

HOW to document the discussion? The documented details of this conversation should be maintained within the patient's medical record and made available to Horizon BCBSNJ upon request.

To access more information on this Horizon-specific policy, registered NaviNet® users affiliated with participating practices should log in to NaviNet.net, select *Horizon BCBSNJ* from the *My Health Plans* menu, and: Health Plans menu, and 1) Mouse over Policies & Procedures and click Policies; 2) Click Administrative Policies; and 3) Click OMNIA Tier Awareness Policy.

Do other plans have these types of requirements? Horizon is justifying this policy and pointing to United's Non-Participating Providers Consent Form Protocol that is intended to ensure that a patient is aware when accessing out-of-network services. This policy is not quite the same as Horizon's Tier Awareness Policy. The United policy requires participating providers to make disclosures and receive written consent of the patient when the participating provider is using out-of-network providers or services, specifically: 1) Ambulatory Surgical Centers – free-standing and hospital outpatient non-emergent; 2) Assistant Surgeons - a physician or other healthcare professional who is assisting the physician performing a surgical procedure, where the participating surgeon selects the assistant surgeon; 3) Home Health; 4) Air Ambulance, fixed-wing non-emergency transport; 5) Laboratory Services – for specimens collected in the physician's office and sent out to a non-participating laboratory for processing; 6) Outpatient Dialysis; and 7) Specialty Drug vendors.

What is NJAFP doing about this? NJAFP is joining other specialty medical societies in New Jersey to ask the NJ Department of Banking and Insurance to look into any state regulatory violations on the substance of this policy, as well as the manner in which notice was provided to its contracted, participating physicians of a new administrative policy. It is our hope that Horizon will reevaluate this policy in light of the negative attention it has received, especially in light of the criticism Horizon has received from providers and policymakers for the lack of transparency in how the OMNIA health plan was formulated and manner in which it was rolled out.

If you have any questions or would like to share your thoughts about this new policy, NJAFP wants to hear from you. Feel free to email Claudine@njafp.org to discuss further. ▲

Claudine M. Leone is the Governmental Affairs Director for the New Jersey Academy of Family Physicians.

Expanding End-of-life Conversations: Organ Donation

KRISTINE SAMARA

The NJAFP is managing a project in Pennsylvania to recruit organ donors in primary care practices, but the issue of organ donation cuts across state lines, especially with Medicare's new payment for end-of-life conversations. The bottom line: physicians typically receive little training, have few resources and as a result don't discuss organ donation.[1]

Thorton found that only 30% of primary care physicians have end-of-life discussions with their patients and less than 4% discuss organ donation. The results of a Kaiser Family Foundation poll in 2015 reported that only 17% of patients had the conversation with their physicians. While those numbers will likely increase with the new Medicare payment (you're never too old to become an organ donor), the Institute of Medicine recommends having these conversations with patients as early as 16 years old.[2]

The United Network for Organ Sharing (UNOS) reports that there are more than 121,000 people nation-wide waiting for organs, and the gap between the number of patients waiting for a transplant and the number receiving a transplant continues to widen. In 2015, organ donations peaked at about 30,000 transplants across the country. On average, 22 people die every day while waiting for an organ. Physicians can make a difference by talking to their patients and educating them on the importance of organ donation.

Why family physicians? It's simple. Family physicians have a trusted relationship with their patients. Evidence shows that a physician's office is the preferred environment for people to register to donate. Incorporating the topic of organ donation into end-of-life conversations with patients provides the opportunity to educate patients with reliable information to help them decide if organ donation is right for them. Only a small percentage of patients ask about organ donation so it's important for the physician to initiate the discussion by reinforcing that ANYONE can register regardless of age (under the age of 18 requires consent of a parent or legal guardian) or health history, and addressing any questions or concerns they may have on the subject.

Organ and tissue donation has a much broader impact than most people realize. Tissues like tendons, ligaments and cartilage can restore mobility. Donated skin can help fight infection in burn victims, and donated corneas can restore sight. The power of one donor can potentially save as many as eight lives, and even more through tissue donation.

The Role of the Organ Procurement Organization (OPO)[3]

A national network of federally designated, not-for-profit organizations called ***Organ Procurement Organizations (OPOs)*** are responsible for coordinating the recovery of organs and matching them to potential recipients on the waiting list. There are a total of 58 OPOs in the United States. Each has a designated service area. These organizations educate medical staff and the general public about organ and tissue donation, and provide support for donor families.

New Jersey has two OPOs, Gift of Life and New Jersey Sharing Network. Gift of Life is responsible for the southern part of the state including Burlington, Camden, Gloucester, Salem, Cumberland, Cape May and Atlantic counties. Individuals living in these counties who are interested in becoming organ donors can register through the DMV, or through the Gift of Life website at www.donors1.org. The New Jersey Sharing Network is responsible for the northern part of the state and includes Ocean, Monmouth, Mercer, Middlesex, Hunterdon, Somerset, Union, Hudson, Essex, Morris, Warren, Bergen, Passaic and Sussex counties. Individuals residing in these counties can register through the national website at www.donatelife.net.

Organ donation is a personal decision that everyone has the right to make. By educating patients, family physicians can provide facts and reliable information to help potential donors make an informed decision. Help make a difference in someone's life by having that conversation with your patients today. ▲

References

1. Thornton JD, Curtis JR, Allen MD. Primary care physicians' attitudes and practices regarding discussing organ donation with their patients. *J Natl Med Assoc*. 2010;102(1):52–58.
2. Institute of Medicine. (2014). Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life. Retrieved from: http://iom.nationalacademies.org/hmd/Reports/2014/Dying-In-America-Improving-Quality-and-Honoring-Individual-Preferences-Near-the-End-of-Life.aspx?_ga=1.190748075.1852167187.1458142044
3. US Department of Health & Human Services, Organ Procurement and Transplantation Network available at: https://optn.transplant.hrsa.gov/learn/about-transplantation/donor-matching-system/ Accessed 4/27/2016.

BUSTING DOWN THE MYTHS

Despite continuing efforts at public education, misconceptions and inaccuracies about organ donation remain. Patients may say…

"I'm too old or sick be an organ donor."

The fact is that there is no age limit for organ donation. Potential to donate, regardless of age and health, is determined by a medical physician at the time of death.

"If I'm a registered donor, medical personnel won't try to save my life if I'm in an accident or become ill."

Saving someone's life is the first priority in the medical community. Every effort is made to save someone's life before their organs are considered for donation.

"My family will be financially responsible for costs related to organ donation."

Neither donors nor their families are responsible for any costs associated with donation.

"I don't think my religion supports organ donation."

Most major religions in the United States support donation, or consider it an individual choice. Patients may wish to discuss the subject with their spiritual advisor or clergy if they are uncertain.

CMS Issues Final Rule on Reporting and Returning of Overpayments

SUSAN B. ORR, ESQ.

On February 12, 2016, CMS published the Final Rule regarding the Reporting and Returning of Overpayments which provided much needed clarity as to when providers were required to report and return overpayments.

The Affordable Care Act requires providers and suppliers receiving funds under the Medicare program to report and return overpayments they received to the Medicare carrier or contractor within sixty (60) days after the date on which the overpayment was "identified." It further provides that any overpayment retained after the deadline would be considered a liability under the False Claims Act.

Identification of an Overpayment

Under the earlier proposed rules, providers struggled with the concept as to when an overpayment was actually "identified." The question that arose was whether the sixty (60) day period included the time spent quantifying the actual overpayment or did it simply stop the clock to allow providers time to do so.

The Final Rule states that a person has identified the overpayment when the person "has or should have, through the exercise of reasonable diligence, determined that the person has received an overpayment and quantified the amount of the overpayment." Therefore, we now know that the sixty (60) days only starts to run once the provider discovers the overpayment and has determined the actual amount of the overpayment to be returned to CMS. CMS also clarified that the definition of "overpayments" includes all overpayments received by the provider in error regardless of whether the provider was the cause of the overpayment or whether CMS erred in issuing payments to the provider.

Providers must exercise "reasonable diligence" to uncover overpayments. CMS states that providers are said to have used reasonable diligence if they perform proactive compliance activities including monitoring of billing and payments and performing audits as part of the providers' compliance plan, as well as performing reactive investigative activities in response to receiving credible information about a potential overpayment such as from an employee or from CMS itself. Therefore, providers should establish compliance plans and conduct periodic audits to uncover any coding and billing irregularities that would give rise to overpayments. Furthermore, once a provider has received information that suggests a possible overpayment from an employee or even CMS itself, the provider must make a reasonable inquiry and investigation into the matter. Failing to take such action would result in the provider knowingly retaining the overpayment and a violation of the False Claims Act.

Look-back Period

The Final Rule also decreased the lookback period for identifying overpayments from ten (10) to six (6) years. Therefore, only those overpayments received within six (6) years from when the overpayment was actually received need to be reported and returned. The rationale for this reduced lookback period is that six (6) years is more in keeping with federal and state retention requirements.

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Reporting and Returning Overpayments

To report and return funds, providers must use a self-reported refunds process, claims adjustment, credit balances or other appropriate processes to report and return overpayments. Providers should generally first look to the existing available forms from the carriers to use when returning overpayments. If the amount of the overpayment was due to a statistical sampling methodology, the provider must describe the sampling and extrapolation methodology used. CMS reserves the right to revise the processes and create new ones in the future.

If you find yourself with an overpayment or need information as to how to determine an overpayment, please contact Susan Orr, Esquire at Rhoads & Sinon LLP at (610) 423-4200. ▲

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

The Day I Started Medical School

RAMY SEDHOM, MD

John was one of my high school teammates. He was strange at his best and an anxious mess at his worst. His upbringing was normal and unremarkable. His family had money, he went to church, graduated with a college degree, had a good relationship with his siblings, and earned a well paying job. He also abused heroine. With help, he attended therapy. But John is not doing that anymore. He died of a heroine overdose the day before I started medical school.

According to the CDC, drug abuse has been rising dramatically in the past twenty years. The overdose death rate has more than doubled. Over 150 people die every day. America, despite having only 5% of the world's population, consumes more than 80% of the world's opioid supply.[1] Addicted patients represent all socio-political spectrums. They come in different sizes, shapes, and colors. Some are fully functional, while others are nearly sedated and difficult to arouse. Yet, physicians are still lobbied and pressured to treat the 'fifth vital sign'- pain. This is what happens when medicine is graded on patient satisfaction and Press Ganey scores. Medicine - the newest domain of customer satisfaction.

Only recently have legislatures acted on the fact that patients abuse opioids and that doctors are pressured to prescribe them. But now, years later, we are left with addicted patients. Some cannot afford prescription medications and are injecting heroine. Hospitals have seen a significant increase in infections (especially endocarditis) related to less than ideal hygiene.[2] Though I am not a trained epidemiologist, logic begets a future rise in HIV and Hepatitis C years later as a consequence.

Only recently have legislatures acted on the fact that patients abuse opioids and that doctors are pressured to prescribe them. **But now, years later, we are left with addicted patients.**

Opioid pain killers are killing middle-aged Americans. And they have been prescribed by us - doctors. Last year alone, opioids were involved in nearly 40% of fatal drug overdoses. They were responsible for almost 30,000 deaths.[3] The number needed to kill for each prescription opioid is 550.[4] What is driving this opioid epidemic?

Prior to the turn of the century, opiate pain killers were limited to treat terminal diseases such as cancer. Today, they are often used to manage chronic nonmalignant medical conditions like lower back pain. Medical use for various conditions increased tenfold, much thanks to powerful marketing and the pressure to appease patient satisfaction. Nearly half of all prescriptions by pain specialists are opioids.[5] Patients are not required to see therapists, try physical therapy, nor are stepped-up the ladder of non-opiate analgesia. The consequences are staggering. Just walk into your local emergency room. Recent statistics dictate that 4 out of 10 patients in the ER are for non-medical drug use.[6] Imagine the direct and indirect healthcare costs.

The most worrisome part of this all is the lack of evidence for opiate use. Limited data exists regarding efficacy and more importantly, safety.[7] Paradoxically, and almost ironically, opioids can induce hyperalgesia, increasing an individual's sensitivity to painful stimuli.[8] We need a climate and culture change both within the medical community and the public health sector. It is our ethical and social responsibility.

The CDC appropriately released well-reasoned guidelines for how painkillers should be prescribed.[7] They advised doctors not to prescribe opioids for chronic pain in most situations. Exercise, physical therapy, and over the counter analgesics, such as acetaminophen, they write, are more effective. I hope to see the FDA follow suit and limit marketing of opioids. For our patients, more access for treatment programs related to addiction should be encouraged.

Sure, patients suffer, but clinical care has moved away from addressing suffering. People experience a wide spectrum of physical, emotional, spiritual, existential and financial pain. A whole person complaint of 'pain' doesn't fit within our current medical paradigm. This is particularly challenging in our age of specialized and atomized medicine. For too long, we have encouraged practice and policy that has caused harm. We are trained to identify and characterize problems and propose treatment. Limited time and external pressures limit our ability to recognize whole person complaints. And opioids are not a treatment solution. Biology and addiction are a revelation of a major societal problem within health care. I hope we can continue to recognize the burden of suffering, the epidemic of opiate abuse, and most importantly, how lobby groups and administrators are harming patients and physicians' ability to care for them. ▲

References

1. UNODC, World Drug Report 2011. United Nations Publication, Sales No. E.11.XI.10.
2. Pant S, Patel NJ, Deshmukh A, Golwala H, Patel N, Badheka A, Hirsch GA, Mehta JL. Trends in infective endocarditis incidence, microbiology, and valve replacement in the United States from 2000 to 2011. *J Am Coll Cardiol*. 2015 May 19;65(19):2070-6. doi: 10.1016/j.jacc.2015.03.518.
3. Rudd, R, Aleshire N, et al. Increases in Drug and Opiod Overdose Deaths. Morbidity and Mortality. Center for Disease Control and Prevention. Jan 1, 2016; 64(50); 1378-82.
4. CDC. Wide-ranging online data for epidemiologic research (WONDER). Atlanta, GA: CDC, National Center for Health Statistics; 2016. Available at http://wonder.cdc.gov
5. Sites BD, Beach ML, Davis M. Increases in the use of prescription opioid analgesics and the lack of improvement in disability metrics among users. *Regional anesthesia and pain medicine*. 2014;39(1):6-12.
6. Substance Abuse and Mental Health Services Administration. The DAWN Report: Trends in Emergency Department Visits Involving Nonmedical Use of Narcotic Pain Relievers. Rockville, MD: Office of Applied Studies; 2010.
7. CDC guideline for prescribing opioids for chronic pain — United States, 2016. *MMWR Recomm Rep* 2016;65(RR-1:1-49
8. Hina N, Fletcher D, Poindessous-Jazat F, Martinez V. Hyperalgesia induced by low-dose opioid treatment before orthopaedic surgery: an observational case-control study. *Eur J Anaesthesiol* 2015;32:255-261

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New Regulation Aims to Protect Americans from the Dangers of Tobacco

"Tobacco Products" Subject to the Federal Food, Drug, and Cosmetic Act, as Amended by the Family Smoking Prevention and Tobacco Control Act

The Food and Drug Administration (FDA) has finalized a rule that extends its authority over tobacco products to include e-cigarettes, cigars, hookah tobacco and pipe tobacco, among other devices. This rule gives the FDA the power to improve public health and protect future generations from the dangers of tobacco through a variety of steps, including restricting the sale of these tobacco products to minors nationwide.

Smoking is responsible for 480,000[1] deaths per year and is the leading cause of preventable disease and death in the US. However, as HHS Secretary Sylvia Burwell stated, "…. As cigarette smoking among those under 18 has fallen, the use of other nicotine products, including e-cigarettes, has taken a drastic leap. All of this is creating a new generation of Americans who are at risk of addiction."

In 2015, 3 million middle and high school students were current e-cigarette users. A recent FDA/CDC survey shows current e-cigarette use among high school students has increased 900%, skyrocketing from 1.5% in 2011 to 16% in 2015.[2] Hookah use has risen significantly as well.[2] In addition, a FDA/National Institutes of Health Study found that 2013-2014 nearly 80% of current youth tobacco users reported using a flavored tobacco product in the past 30 days – with the availability of appealing flavors consistently cited as a reason for use.[3]

Up until the passage of this law, there was no federal law prohibiting retailers from selling e-cigarettes, hookah tobacco or cigars to people under age 18. This has now changed with the provisions geared to restricting youth access to these products. The law:

- Prohibits selling products to persons under the age of 18 years (both in person and online);
- Requires age verification by photo ID;
- Prohibits the sale of covered tobacco products in vending machines (unless in an adult-only facility); and
- Prohibits the distribution of free samples.

The FDA will now be able to prevent misleading claims by tobacco product manufacturers, evaluate the ingredients of tobacco products and how they are made, and communicate the potential risks of these products.

Since the first Surgeon General's report on Smoking and Health in 1964 warning Americans about the risks of smoking, significant progress has been made to reduce smoking rates among Americans. According to the 2014 Surgeon General's Report on the Health Consequences of Smoking, tobacco prevention and control efforts have saved at least 8 million lives in the last 50 years. This new law aids the FDA's efforts to end preventable tobacco-related disease and death and is a milestone in consumer protection. ▲

Reference

1. CDC. http://www.cdc.gov/tobacco/data_statistics/fact_sheets/fast_facts/index.htm
2. CDC. http://www.cdc.gov/media/releases/2015/p0416-e-cigarette-use.html
3. CDC. http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6438a2.htm

The Importance of Listening in Family Medicine

Doctors in a particular specialty only focus on the specific age group, body part, organ system or disease. Cardiologists focus on the heart and cardiovascular system, a nephrologist specializes in in the care and diseases of the kidneys, and pediatricians treat only children.

However, family physicians have the opportunity to treat patients of all ages.

Lauren V. Carruth, MD (Carruth-Mehnert), a Galloway-area family physician, enjoys family medicine because of the long-term aspect the practice provides. She can see entire families - children, parents, grandparents - and build relationships with each of her patients. Every day she treats patients with a broad spectrum of ailments and illnesses, all with the underlying goal of helping people when they need it, as well as providing preventative primary care to keep people healthy.

After graduating from Ohio Wesleyan University, Dr. Carruth began her quest for a medical degree at Robert Wood Johnson Medical School in 1999. In her first two years, she questioned whether family medicine was the right course for her, but during the time she spent in a family medicine office in her third year of medical school, she made her decision.

"Sometimes, treating a patient doesn't just mean prescribing medicine. Sometimes it's just knowing the patient's wishes and being an advocate for what they want."

"I got to see the nursery, pediatrics and the full spectrum of what family medicine included - and I really enjoyed it. The care and the job of a family physician revolves around overall health of an entire person, not just a single organ," said Dr. Carruth.

After completing her residency, Dr. Carruth worked at a practice located in an area with a high population of patients who lacked financial stability. Most patients needed care for chronic conditions and she worked hard to help them get healthier.

One patient that left a lasting impression was an older gentleman in his late 70s who was essentially homeless and lacked the social support needed to take care of his health. Dr. Carruth and her staff treated him and also worked to help him get the appropriate housing, avoiding nursing homes, at the patient's request. Just as the patient was on the verge of getting housing, he fainted from dehydration and ended up back in the care of Dr. Carruth.

During the patient's hospitalization Dr. Carruth found he had heart disease and recommended open heart surgery. However, the surgery would likely have ultimately cost him his independence which he valued above all else. Therefore, the patient strongly decided that he didn't want to have the surgery. Dr. Carruth and her staff advocated for him to go home with close outpatient follow up. For nearly two years, the gentleman was entirely independent and no longer homeless. He passed away in 2014 in his sleep, the way he wanted.

"Sometimes, treating a patient doesn't just mean prescribing medicine," says Dr. Carruth. "Sometimes it's just knowing the patient's wishes and being an advocate for what they want. In this case, that's how I treated the patient."

In her time in practice, Dr. Carruth has learned a very important lesson.

"It's the little things. A lot of the time patients are scared because they don't know medical terminology or what to expect - listening really goes a long way," she says. "I've heard many patients say 'I appreciated you just listening and explaining things to me.' It helps them feel more confident and engaged about their medical decisions and their overall health." ▲

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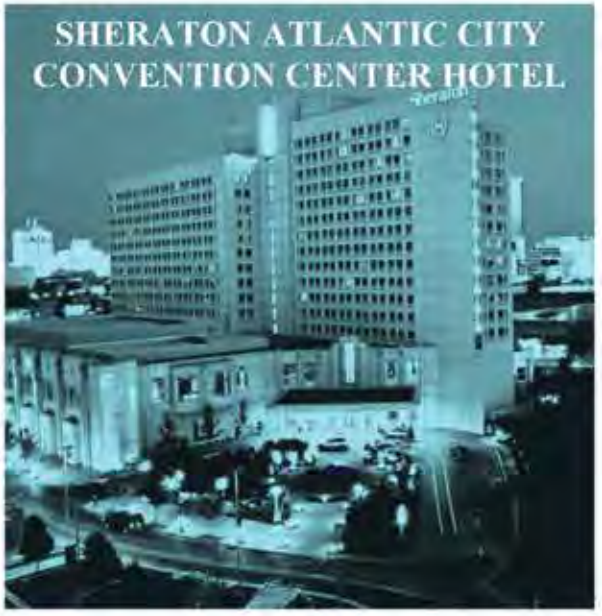

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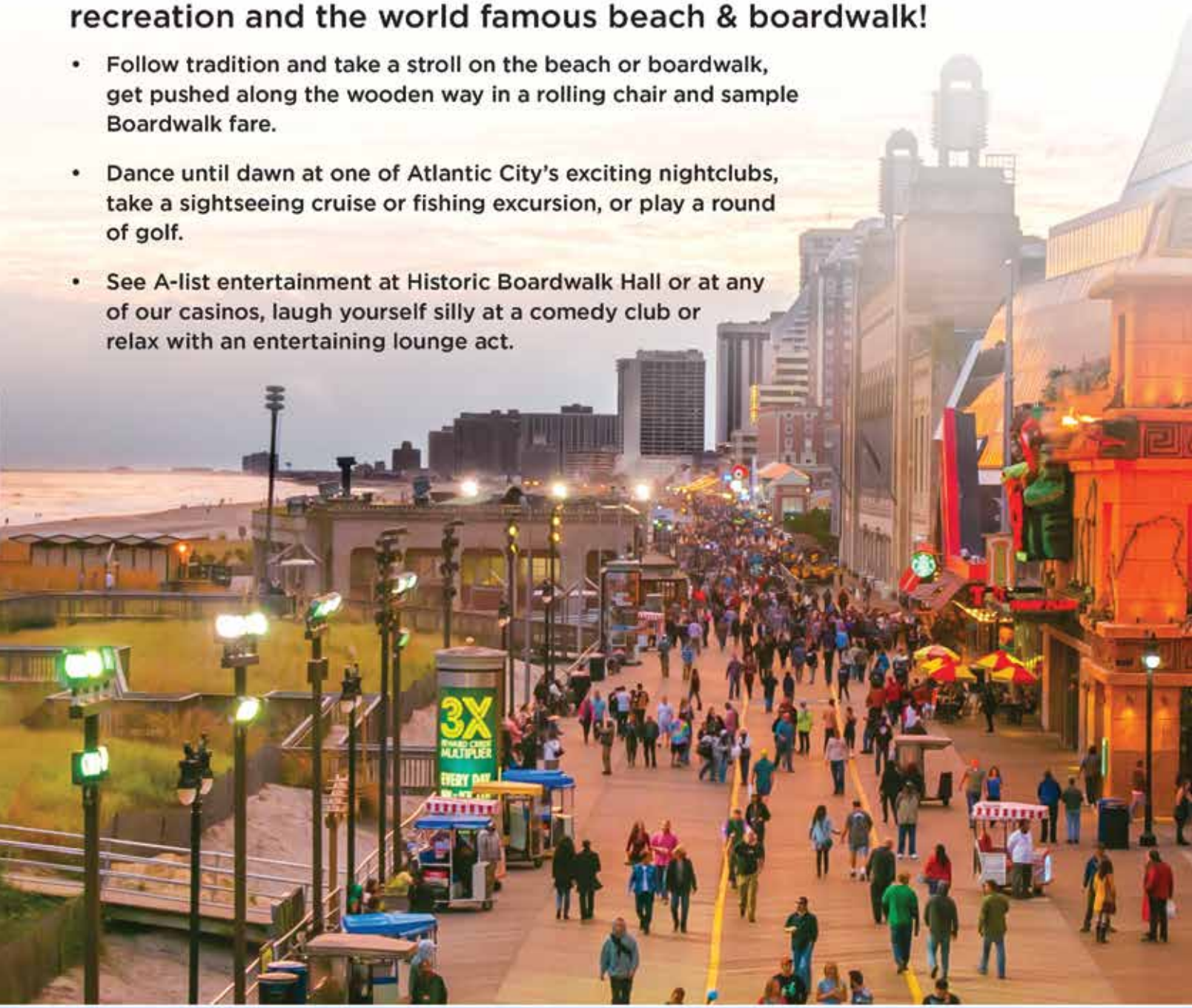

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