VOLUME 15, ISSUE 3 • 2016

Perspectives

A VIEW OF FAMILY MEDICINE IN NEW JERSEY

Adity Bhattacharyya, MD, FAAFP Installed as NJAFP President

CME Inside:

- Zika Virus
- Overcoming HPV Immunization Barriers

Highlights from the 2016 Scientific Assembly

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Keep *Perspectives* fresh by sending us new ideas and articles. Let us hear from you, tell us what you would like to see featured in this journal. If you are interested in becoming a contributor to *Perspectives*, a peer-reviewed CME publication, please contact the NJAFP office (609/394-1711) or email editor@njafp.org

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Good-bye Dear Friend

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

THIS PAST JULY, the Academy suffered a great loss with the passing of Mike Doyle. When we became aware of the severity of Dr. Doyle's illness, several members moved to honor the influence he had on their lives by instituting the "Michael J. Doyle, MD, FAAFP New Jersey Resident of the Year Award." The first recipient of this award was Zeeshan Khan, MD – a third year resident at CentraState in Freehold, NJ. Thankfully, Dr. Doyle was well enough to attend the Gala to witness the award presentation and share his thoughts about his years as a family physician and a mentor to so many of his colleagues. Dr. Doyle continued to care deeply about the Academy up to the end, as evidenced by three voicemails he left for me with suggestions on how we might improve the Gala to draw younger physicians and residents to the event. It is my great sadness that I was not in the office when he called and so I missed the chance to speak with him directly. Many members reached out to us to share their memories of Dr. Doyle. In turn, we share those reflections with you in Foundation View. I would also like to echo the thoughts of our EVP, Ray Saputelli. In a note to the NJAFP Board, Ray said,


Doyle

"…We most often think of your patients when we talk about the difference you make, but rarely are we given such a keen glimpse into the incredible effect each one of you has on the world. So many of you, whom young family physicians see as mentors, saw Mike as yours. His influence on your lives influenced theirs downstream, and all of the families touched by all of those people are in turn touched by influence…it once again reminds me of my good fortune – blessing, if you would like to call it that – to have worked in the service of family physicians for the last 17 years. Perhaps in those times when the hamster wheel and alphabet soup of medicine makes you wonder why you don't…just flip burgers, you will remember that the mark you leave on the world is a reward that is reserved for a small, and truly lucky, group."

I would like to echo Ray's thoughts. I too am truly blessed to work in the service of family medicine and hope to do so for many, many more years.

Happy Reading,

Theresa

Just Yesterday…

ADITY BHATTACHARYYA, MD, FAAFP

> "Meaningful change is hard to come by when non-physicians are making healthcare laws and the pharmaceutical industry rules the game as they have more money and lobbying power."

IT IS HARD TO BELIEVE that my term as President of this Academy started four months ago. It seems just yesterday that I was the Board Liaison to the Executive Committee. It was a daunting path in front of me as I had a lot to learn. I have been in teaching all my life and had no experience in running a practice myself. Well running your residency practice counts somewhat, but a lot of management decisions are often out of your control. I've learned a lot in the past five years, though one year my job was limited to announcing that we had a quorum at meetings. I am indeed honored and humbled to have the opportunity to serve you as the new president of the New Jersey Academy of Family Physicians. Coming from a background of education, I hope to bring with me another way of looking at the problems that face family physicians in our state today. Every year for the past 10 to 12 years, I have been going to Kansas City and have heard the great educators of Family Medicine talk about their passion, hard work, and vision for the future of our specialty. What really inspired me about them was their resilience and optimism in the face of so many obstacles, for that is what family physicians do. We take care of our patients first, even under the most trying circumstances.

Talking about obstacles that we face, there are many. We work in a health system where profits are put before care and access to basic health needs is denied to many of our citizens. Our health care spending is astronomical and our health outcomes are poor. Many are talking about these issues but meaningful change is hard to come by when non-physicians are making healthcare laws and the pharmaceutical industry rules the game as they have more money and lobbying power. Change is also hard to come by in the fee-for-service model that exists today, which encourages unnecessary testing and procedures for profit.

But there is hope and there is data to support what we have been saying all along.

1. Having family physicians at the core of health care reduces costs and improves outcomes as many other developed countries have shown.
2. Family physicians, with their emphasis on prevention, are key to keeping populations healthy and out of hospitals, leading to lower overall healthcare costs.
3. Family physicians that run hospitalist services have lower length of stays
4. We take care of patients of all ages, in all situations, and have excellent patient satisfaction scores.

The list goes on. How can we bring this message to the people of New Jersey? How do we fulfill the mission of this Academy to advance the specialty of Family Medicine through education and advocacy for the benefit of the public and its members? Over the coming year I hope to continue some of the great, ongoing work started by my predecessors. I would also like to focus on new things on the horizon that will soon affect our practices. These are a few areas the Academy will focus on in the coming year:

1. The Academy would like to educate our members about the new payment reforms from CMS that are being rolled out. To that end, we had a representative from AAFP at this year's annual meeting to talk to us about MACRA and its ramifications to our practices and reimbursements. As more details become available, we will attempt to bring you the latest information. For practices that are looking for Alternative Payment Models (APM), the Academy can help with specific information to help them utilize current resources for maximum reimbursements. For small practices that will fall under the Merit Based Incentive Payment System (MIPS) the Academy can help with practice transformation to increase Clinical Practice Improvement Scores for maximum reimbursements.
2. Advocacy is a big area that needs work. I feel that a lot of practicing family physicians in our state are not engaged with our Academy and do not participate in our meetings and CME activities. Some of this could be due to busy work schedules from increased administrative burden. The medical schools in our state also have a poor record of having their students choose careers in Family Medicine. I would like to spend this year meeting with Department of Family Medicine Chairs across the state to find out why member involvement is low and how we can help increase the participation of family physicians in their individual departments and with the Academy. I would also like to meet with the deans of our four medical schools to find ways to increase medical student entry into our specialty.

3. The Academy continues to work on advocacy with the State Legislature, thanks to our Government Affairs Committee and Claudine Leone's excellent work over the years. Scopes of practice and loan repayment are some of the topics we are working on.
4. The Academy continues to provide excellent Continuing Medical Education through the annual meeting and the monographs thanks to the work done by our Deputy Executive Vice President, Theresa Barrett, PhD. I would like feedback from all our members about how we can better meet their CME needs.
5. I would like to help in any way I can with the work on physician burnout that was started by my predecessor Robert Gorman, MD. This is an important problem facing physicians especially our specialty.

I joined this Academy to have a voice. I wanted Family Medicine to have a voice. My voice alone may not make a difference, but if I can inspire a few more of you to join us then our united voice will be stronger. As your new president, I pledge to continue working on our Academy's mission for the benefit of our members and the people of New Jersey. I am looking forward to working with our excellent staff under the leadership of Executive Vice President Ray Saputelli, MBA, CAE, with my predecessors Drs. Gorman and Bhaskarabhatla, and President Elect, Peter Carrazzone, MD. ▲

Dr. Bhattacharyya is Associate Director of the JFK Family Medicine Residency Program in Edison, NJ.

MACRA Ready?

RAY SAPUTELLI, MBA, CAE

On September 8 the Acting Administrator of the Centers for Medicare and Medicaid Services, Andy Slavitt, announced plans for the Quality Payment Program – a key component of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). In his blog post on the CMS website (https://blog.cms.gov/2016/09/08/qualitypayment-program-pickyourpace/) Mr. Slavitt noted that after dialogue with many organizations and individual physicians, CMS has determined that the implementation of the new law will offer physicians four distinct pathways to participation in 2017. The AAFP was a critical voice in helping CMS to recognize that the complexity of the law made it crucial that family physicians have flexibility in the initial years of the program to determine which of the two payment pathways is best for them, their practices and their patients. The AAFP also noted the need to mitigate the potential penalties for smaller practices which might be adversely affected by reporting and measurement methodologies biased against them due to the small size of their patient populations. CMS has labeled the option to choose the best pathway for implementation "Pick Your Pace" and while it provides some breathing room for family physicians and other primary care clinicians, it is important that members maintain focus. This is not a true delay in implementation, and the potential for penalties and reduction in payment is still very real. I urge you to learn about the four pathways and make an informed decision about what is best for you and your practice. It is also important to remember that none of the four options allow you to do nothing in 2017. With that as a backdrop, your options as of January 1, 2017 are the following:

Option 1:

Test the Quality Payment Program

As the title suggests, with this option practices can evaluate their internal systems by submitting some data, including some from after January 1, 2017 in order to prepare for broader participation in 2018 and beyond. This method will allow practices to avoid a negative payment adjustment in 2019, but will not qualify for a positive rate adjustment.

Option 2:

Participate for a Part of the Calendar Year

You may choose to submit Quality Payment Program information for a reduced number of days. This means your first performance period could begin later than January 1, 2017 and your practice could still potentially qualify for a small positive payment adjustment. There is some flexibility in the process by which you report as you could select from the list of quality measures and improvement activities available under the Quality Payment Program. As in Option 1, participation at this level will avoid a negative payment adjustment in 2019.

Option 3:

Participate for the Full Calendar Year

For practices that believe they are ready to participate as of January 1, 2017, you may choose to submit Quality Payment Program information for the full calendar year. This means your first performance period would begin on January 1. Unlike the first two options, practices selecting to submit for the full year would be eligible for full positive payment updates in 2019, but they also could face potential penalties depending upon performance. I advise practices to be explicitly certain of their readiness prior to selecting this option.

Option 4:

Participate in an Advanced Payment Model (APM) in 2017

Instead of reporting quality data and other information, the law allows you to participate in the Quality Payment Program by joining an Advanced Alternative Payment Model, such as CPC+, a Medicare Shared Savings Track 2 or 3, or participation in a Next Generation ACO model in 2017. If you receive enough of your Medicare payments or see enough of your Medicare patients through the Advanced Alternative Payment Model in 2017, then you would qualify for a 5 percent incentive payment in 2019.

> **"The promise of a payment model that rewards the value that family physicians bring to the system and recognizes the need to rebuild our primary care infrastructure is one to celebrate. It's up to us to be sure that the promise is fulfilled.**

Almost two years ago I used this space to celebrate the death of Healthcare's Wicked Witch, the Sustainable Growth Rate (SGR) formula which left so many of you facing the annual fear of life without Medicare payments for some unknown period of time. In that same article I reminded you that while the Munchkins celebrated, the Witch's sister was setting her flying monkeys loose on Oz. That's not to suggest that MACRA will be worse than the SGR, and in fact the NJAFP and AAFP firmly believe that the transition to value-based payment and the specific value that

Continued on page 7

Changes to National AAFP CME Requirement

THE AAFP BOARD OF DIRECTORS approved a change to the AAFP's CME membership requirement. Currently, members may earn CME credit in formal and informal categories. To simplify the requirements for members and consolidate informal CME options, the Board condensed these types of activities into one category for scholarly activities. Previously, members could claim a maximum number of credits for individual activities such as published research, clinical research, paper presentations, exhibit presentations, medical writing, peer review, and writing test questions. Effective immediately, these activities can be reported simply as scholarly activities and will qualify as Prescribed credit. Members may claim a maximum of 100 credits in this area per re-election cycle. As a reminder, AAFP members must also obtain a minimum of 25 credits from live learning activities every three years to meet the AAFP's CME membership requirement. Additional information on the types of CME credit can be found online. If you have questions about this CME requirement change, please email the AAFP Member Resource Center at aafp@aafp.org or call (800) 274-2237.

AN OPPORTUNITY TO HAVE YOUR VOICE HEARD

The AAFP has developed Member Interest Groups (MIGs) to ensure that all AAFP members have a voice in an increasingly diverse organization. MIGs support members with shared professional interests.

To join a MIG visit http://www.aafp.org/about/member-interest-groups/mig.html, review the list of MIGs and click "Visit the Online Community" for those MIGS that interest you.

Current MIGs

Adolescent Health: Foster collaboration, communication, and support among family physicians engaged in adolescent health.

Community Health: Forum for providers interested in the intersection of primary care and public health.

Direct Primary Care: Increase awareness of the DPC model among family physicians and advocate for members currently practicing in this model or anticipate transitioning to it.

Emergency Medicine / Urgent Care: Promote workforce policies, educational goals, and credentialing standards consistent with the AAFP policy on family physicians in emergency medicine.

Global Health: Facilitate professional development in the area of global health and opportunities for engagement in the broader global health movement.

Hospital Medicine: Serve as a voice for family physicians that practice hospital medicine. Advocate for educational resources specific to hospital medicine.

Independent Solo / Small Group Practice: Represent the interests of members who practice in independent solo and small group practices. Advocate policies that enable independent solo and small group practices to deliver the highest quality of care while remaining financially viable.

Lifestyle Medicine: Increase networking opportunities for members who have a passion to improve health through a focus on healthy lifestyle and foster communication and dialogue on debates in nutrition, fitness and other self-care areas.

Oral Health: Increase awareness of oral health resources for members so that they might serve their patients better and improve their overall wellness.

Point-of-Care Ultrasound: Work to improve access to education and resources to help incorporate Point-of-Care Ultrasound (POCUS) into family physicians' practices and advocate for related education in medical school and family medicine graduate medical education.

Reproductive Health Care: Promote evidence-based reproductive health care in family medicine.

Rural Health: Grow connections among members with a distinct interest in rural health, inclusive of rural practice topics and rural medical education issues.

School Doctor: Provide peer support and serve as a resource for family physicians who work with schools.

Single Payer Health Care: Investigate the current outlook on single payer financed health care among members. Educate members on the ability of single payer financed health care to streamline and simplify patient care and improve family physicians' professional satisfaction by greatly decreasing administrative complexities and burdens.

Telehealth: Provide education and support for the family medicine community on the many facets of Telehealth with a view toward enriching the practice of medicine and patient care.

Transforming Clinical Practice Initiative: Serve as a resource for members interested in practice enhancement and the activities of the Transforming Clinical Practice Initiative (TCPI). Establish a collaborative learning and problem-solving environment focused on practice enhancement. ▲

NJAFP DELEGATION AT AAFP CONGRESS OF DELEGATES

NJAFP was well-represented last month at the AAFP Congress of Delegates in Orlando, FL.

New Jersey proposed two resolutions for consideration, plus a Resolution of Condolence for Michael J. Doyle, MD. See page 12 for a description of the resolutions that NJ presented.

Attending from left to right are Richard Corson, Terry Shlimbaum, Adity Bhattacharyya, Arnie Pallay, Mary Campagnolo, Bob Gorman, Sal Bernardo, and Bob Eidus.

Perspectives

A View of Family Medicine in New Jersey

The Journal of the New Jersey Academy of Family Physicians

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The views, opinions, and advertisements in this publication do not necessarily reflect the views and opinions of the Board of Trustees, members or staff of the New Jersey Academy of Family Physicians unless stated.

MACRA Ready?

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CMS seems to be placing on Primary Care has the potential to move us in a meaningful way towards achievement of the quadruple aim and its promise of lower costs, improved quality, and greater satisfaction for both patients and physicians. Still, the details matter, and a one-size-fits-all approach is one that is not likely to succeed. The AAFP and NJAFP remain vigilant in our efforts to ensure that the requirements for participation in MACRA have a true positive impact on the quality of care that you provide for your patients every day and are not simply a meaningless data gathering exercise.

In addition, both the NJAFP and the AAFP are working to support our members in preparing for MACRA. The NJAFP and our Healthcare Transformation Team provide ground-level support to our members through multiple programs and services designed to assist practices of every size and configuration to prepare for MACRA and to take advantage of the many opportunities to improve efficiencies and access new payment streams. More information is available at http://njafp.org/content/healthcare-transformation-services. At the same time, the AAFP has devoted significant effort to their "MACRA Ready" campaign and has a full suite of web-based resources available to members at http://www.aafp.org/macraready. I urge you to take advantage of everything your academy has to offer both at the national and state level. There is no doubt that this is a challenging time, but it is also a time for optimism. The promise of a payment model that rewards the value that family physicians bring to the system and recognizes the need to rebuild our primary care infrastructure is one to celebrate. It's up to us to be sure that the promise is fulfilled. ▲

Editor's note: *On October 14, 2016 the US Dept. of Health and Human Services released the "Final Rule." To get this latest information, please go to http://www.aafp.org/news/macra-ready/20161014MACRAfinalrule.html*

Raymond J. 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.

SHARE YOUR STORIES AT *HEALTH IS PRIMARY'S* NEW WEBSITE

Health is Primary has a new website that is easier to navigate and contains a number of resources and tools that can be shared to spread the word about the importance of primary care. Through the website you can share your stories about how primary care results in better health and lower costs. Visit the new website at HealthisPrimary.org

CME

Zika Virus: An Update with Guidelines in Assessing Exposure

SUNG Y. CHAE, MD AND ADITY BHATTACHARYYA, MD

Dr. Chae has disclosed that her spouse has received a consulting fee from the Johnson & Johnson Foundation for statistical consulting on a clinical grant. Dr. Bhattacharyya reports no conflicts of interest.

Conflicts have been resolved via NJAFP Policy.

Learning Objectives:

1. Demonstrate knowledge about the effects of Zika virus infection in the general population and in pregnant women.
2. Develop the ability to conduct appropriate follow-up and testing procedures in New Jersey when patients come with suspected exposure to the Zika virus.

A 30 year old pregnant female in her early second trimester presents to the office for routine prenatal follow-up care. She mentions to you that she returned from a Caribbean vacation two weeks ago. She denies any fever, rash or illness while abroad. What should you do now? This question comes up frequently as news about Zika infection spreads and more cases are reported on a daily basis.

The Zika virus is a single stranded RNA flavivirus closely related to yellow fever, dengue, and West Nile virus. It has caused recent alarm due to its rapid spread in Southeast Asia, Central and South America, and the Caribbean regions mostly due its association with severe congenital mortality and morbidity including microcephaly.[1] It is usually transmitted via mosquito vectors but can be transmitted via sexual contact between male or female partners, perinatally, and possibly via blood transfusion and laboratory exposure.[2] Perinatal adverse outcomes include fetal death, central nervous system injury including microcephaly, intracerebral ventricular calcifications, and fetal growth restriction.[1]

Zika virus infection is not new. It was first discovered in a rhesus monkey from the Zika forest in Uganda in 1947.[3] The first reported case of human infection was in Nigeria in 1953. The virus is endemic in Africa and South Asia but for unknown reasons, large pockets of infection were not reported in medical literature until 2007 when there was an outbreak of about 5000 cases in the Yap Islands of Micronesia. Subsequent outbreaks were reported in the Pacific region, but none in the Americas until March 2015 when an outbreak was reported from Bahia, Brazil.[4] Later that year Brazilian investigators noted an increase in birth defects especially microcephaly in the same areas that Zika virus infection was prevalent. Subsequent studies have reported that the viral particles were present in the amniotic fluid of pregnant women who had infants with microcephaly and in the brain tissue of fetuses and still births with microcephaly, demonstrating a link between Zika virus infection in pregnancy and microcephaly.[5] A "congenital Zika syndrome" has been described as characterized by microcephaly, overlapping cranial sutures, redundant scalp skin, and significant neurologic impairment suggestive of a fetal brain disruption sequence.[6] A recent study from Brazil has also reported a possible association of perinatal Zika infection with arthrogryposis, which is characterized by joint contractures in the upper and lower extremities at birth.[7]

Zika infection causes a mild self-limited illness in symptomatic individuals. The incubation period is possibly between 4-7 days. However, an estimated 80% of cases are asymptomatic. Those who get symptoms complain of a fever, a maculopapular rash, or non-purulent conjunctivitis. Others complain of joint pain and body aches. Rare cases of Guillain Barre Syndrome have also been reported after Zika virus infection.[8] In the US, and its territories the CDC has reported 32 cases of Guillain Barre associated with Zika infection.[9]

As of August 17, 2016 there were 2260 confirmed cases of Zika virus infection in the continental United States and 8035 cases in the US territories.[9] Among those in the continental US, the large majority are travel-related, however 14 cases were locally acquired mosquito-borne infections in Florida. Twenty-two of these 2260 cases were sexually transmitted. New Jersey has 66 confirmed cases, all of which are travel-related. As of August 11, 2016, there were 17 live born infants with birth defects and six pregnancy losses associated with possible Zika infection in the United States and its territories per the US Zika Pregnancy registry.[10] Given the recent local transmission in Miami-Dade and Broward counties in Florida, these areas would also be considered Zika endemic areas and the same precautions apply.[11]

Zika virus infection is spread primarily through the bite of the Aedes mosquito, specifically the aegypti and the albopictus species in the Americas. Both species bite during the day and are present in the United States and its territories, including New Jersey.[4] Transmission can also occur sexually, via blood transfusion or laboratory exposure, and in the intrauterine environment as well as intra-partum during delivery from an infected mother to her newborn.[8] Zika virus particles have been isolated from the semen of infected males over 60 days after the onset of symptoms. Zika virus has also been reported in samples from blood banks, but there have been no reported cases of Zika acquired through blood transfusions in the United States. However, there have been reported cases in Brazil which are under investigation.[2] Zika particles have also been isolated in the breast milk of infected women but there are no reported cases of transmission via this route to infants. The World Health Organization encourages all women in Zika infested areas to continue to breast feed.[12]

Zika virus infection can be confirmed by the presence of viral RNA by reverse transcription-polymerase chain reaction (RT-PCR) or anti-Zika immunoglobulin M (IgM) antibodies by enzyme-linked immunosorbent assay (ELISA) with neutralizing antibody titers against Zika at levels ≥ 4 fold higher than those against the dengue virus. The plaque reduction neutralization test (PRNT) is not recommended as a first line test but is used as a confirmatory test.[13] In many patients, Zika virus RNA may not be detected in the serum after the first week of illness, but may be detected in the urine for at least two weeks after the onset of symptoms. As a result, urine should be obtained in conjunction with serum samples.[14] However, Zika RNA has been found to remain in the serum longer in some symptomatic pregnant women. Thus, symptomatic or asymptomatic pregnant women presenting <2 weeks after the exposure should be offered RT-PCR testing of blood and urine. Depending on the presence or lack of symptoms, and the time frame at which women present, the testing recommendations vary. [13]

The CDC recommends that all persons with signs or symptoms suggestive of Zika with potential

exposure be tested. They also recommend screening all asymptomatic pregnant women with possible exposure within the past 12 weeks.[15] Women with possible exposure include those who traveled to an area where Zika is endemic, or those who have had unprotected sex with a partner who traveled to or lives in a Zika endemic region. The CDC also recommends following any pregnant woman with possible or confirmed Zika infection with serial fetal ultrasounds every 3-4 weeks assessing for the presence of anatomic abnormalities or growth retardation.[13]

Zika Prevention Guidelines for Pregnant Women from the Centers for Disease Control (CDC) :

a. CDC recommends that pregnant women not travel to areas with active Zika infection and if travel is essential she should avoid mosquito bites and sexual transmission.

b. If a pregnant woman has a partner who has travelled to a Zika endemic area, she should use barrier protection or abstain from sexual intercourse with the partner throughout pregnancy. This includes vaginal, anal and oral intercourse.

c. For symptomatic pregnant women with exposure to Zika, RT-PCR testing of urine and blood samples is recommended for up to 2 weeks after symptom onset.

d. Asymptomatic pregnant women with exposure to Zika should be offered screening with serological testing using Zika virus IgM testing within 12 weeks after the last possible exposure. Asymptomatic pregnant women who live in areas where there is active Zika transmission should have Zika virus IgM testing as a part of their routine obstetrical care during first and second trimesters. If the test is positive, they should immediately undergo RT-PCR testing for Zika.

Zika Prevention Guidelines for Women of Reproductive Age from the Centers for Disease Control (CDC):

a. All couples in which a partner has travelled to an area with Zika can reduce the risk of sexual transmission by abstaining from sex or using barrier protection.

b. Women who have been diagnosed with Zika should wait at least eight weeks after their first symptoms before attempting pregnancy. Men should be counseled to wait for six months before attempting pregnancy.

Zika Testing in New Jersey from the New Jersey Department of Health:

In New Jersey, the Public Health and Environmental Laboratories (PHEL) perform the CDC-approved molecular and serologic clinical tests for Zika virus. Tests available are:

a. The Trioplex real-time RT-PCR assay allows for early detection and differentiation between the RNA of Zika, dengue and Chikungunya viruses in specimens collected during the acute stage of the illness.

b. Zika MAC ELISA IgM is a qualitative test for the presumptive detection of IgM antibodies to Zika virus from four days to 12 weeks post exposure.

c. Confirmation of all positive, equivocal and inconclusive IgM results by the Plaque Reduction Neutralization Test (PRNT) is required. Currently, PRNT specimens are referred to the New York State Wadsworth Center. Requests for Zika testing must be preapproved by the New Jersey Department of Health (NJDOH) Communicable Disease Service.

Paperwork Required for Zika Testing in New Jersey from NJDOH:

PHEL recommends referring patients to local hospital laboratories for Zika testing in blood and urine.

To request Zika testing, the physician must contact the Local Health Department (LHD) where the patient resides. They recommend using the following website to identify the correct health department to call: http://www.localhealth.nj.gov. Epidemiologists from the health department will review criteria for testing, and if testing is indicated, will collect patient and physician information and provide an approval number on an SRD-1 form which is faxed to the physician's office. The ordering physician should review the SRD-1 to verify that the information has been accurately and completely recorded. The patient should take the physician verified SRD-1 form containing the approval number, with the script for Zika testing, to the recommended hospital laboratory for specimen collection. The hospital laboratory technician must complete the SRD-1 specimen collection date and time fields and the laboratory contact information, including an accurate and secure fax number for receipt of reports. Physicians should be aware that commercial Laboratories that offer Zika testing only offer the RT-PCR assay and currently do not offer the Zika IgM testing.

Treatment for Zika focuses on symptomatic treatment including rest, fluids and antipyretics or analgesics. However, aspirin and other non-steroidal anti-inflammatory drugs should be avoided until dengue can be ruled out. Mosquito exposure should be avoided during the first few days of illness to limit the risk of local transmission. These measures include air conditioning and the use of screens when indoors, wearing long pants and long sleeved shirts when outdoors, and using EPA-registered repellents including N,N-Diethyl-meta-toluamide (DEET). When used according to the product label, DEET repellents can be safely used in children older than 2 months as well as pregnant and lactating women.[8]

No Zika virus vaccine is currently available but one candidate vaccine is slated to begin Phase I clinical trials this summer.[16] Currently the emphasis remains on prevention of transmission by avoiding travel to Zika infected areas, prevention of sexual transmission and mosquito control measures. However, our knowledge of the assessment for and management of Zika infections continues to evolve, so providers are advised to check the Centers for Disease Control website http://www.cdc.gov/zika/hc-providers/index.html for the most up to date recommendations.

Our patient had negative testing results for Zika virus infection. Her second trimester ultrasound revealed no fetal anomalies. She was advised to use barrier methods when having sex with her partner as he had traveled with her to the Caribbean to further reduce the risk to her pregnancy.

Editor's Note: *A recent report out of Utah has indicated that it is possible that the Zika virus may have been transmitted through perspiration or tears. In addition, the CDC has developed an interim response plan. For additional information please see the AAFP News Story at http://www.aafp.org/news/health-of-the-public/20161005zikaupdate.html*

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CME

Overcoming Barriers to HPV Immunization

THERESA BARRETT, PHD

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Learning Objectives:

1. Describe the relationship between HPV and cancer.
2. Recognize barriers to HPV Immunization.
3. Implement strategies to overcome barriers to HPV immunization.

The human papillomavirus (HPV) is a group of 150 related viruses, each with an HPV type number.[1] There are more than 40 HPV types that can infect the male and female genital areas.[1] The virus is so common that almost every sexually active individual will contract the virus at some point in their lives.[2] The Centers for Disease Control and Prevention (CDC) estimates that one in four people are infected with HPV in the United States.[3]

HPV AND CANCER

Persistent HPV infection is linked to:[4]

- Almost all cervical cancer
- About 91% of anal cancer

Most HPV infections will resolve without treatment. However, persistent HPV infection can result in the development of genital warts and/or cancer of the cervix, vulva, vagina, penis, anus, and throat.[2] Development of these cancers can take years, sometimes decades, after exposure to the virus.[4]

The HPV type that results in genital warts is different from the HPV types that cause cancer, and there is no way of knowing who will develop cancer.[4] It is surmised that people with weakened immune systems, such as people with HIV or AIDs, may be more susceptible to the virus (less likely to clear the virus) and thus more likely to develop health problems.[4] HPV vaccination can prevent most of these cancers.[4]

HPV Vaccine

There are three HPV vaccines currently licensed in the US – a bivalent, a quadrivalent, and a nonavalent.[5] The bivalent vaccine, labeled HPV2, protects against the HPV types responsible for HPV-associated cancers, types 16 and 18. HPV4, the quadrivalent vaccine, also protects against types 16 and 18 as well as types 6 and 11 (the types responsible for genital warts). The nonavalent vaccine, 9vHPV, protects against the types already mentioned, but also offers protection against five other oncogenic HPV types – 31, 33, 45, 52, and 58.[5]

The Advisory Committee on Immunization Practices (ACIP) recommends routine HPV immunization in adolescents and adults with one of the three available HPV vaccines.[6] Immunization is recommended for:[6]

- Routine vaccination at age 11 or 12 years
- Females aged 13 through 26 years not vaccinated previously
- Males aged 13 through 21 years not vaccinated previously
- Men who have sex with men through age 26 and for immunocompromised persons (including those with HIV infection) if not vaccinated previously

An objective for *HealthyPeople 2020* calls for increasing vaccination coverage for the three (3) doses of the HPV vaccine for females age 13 to 15 years from the baseline of 28.1 to 80%, and to increase the coverage among males from 6.9% (baseline) to 80%.[7] As can be seen in tables 1 and 2, immunization rates nationally fall far below the desired 80% coverage levels. New Jersey specific data shows that that the state falls well below the national averages for the number of female and male adolescents who received the HPV vaccine.

Table 1:

Female adolescents receiving 3+ doses of HPV vaccine by age 13–15 years (percent)[8]		
2012 (baseline)	2013	2014
28.1	**32.7**	**34.4**
New Jersey[9]		
Not available	**30.9**	**24.4**

Table 2:

Male adolescents receiving 3+ doses of HPV vaccine by age 13–15 years (percent)[10]		
2012 (baseline)	2013	2014
6.9	**13.5**	**30.6**
New Jersey[11]		
Not available	**Not available**	**22.6**

Note: ACIP began recommending the HPV vaccine for males in 2011.

Barriers to HPV Immunizations

A recent systemic review of the literature[12] revealed numerous barriers to HPV immunization which must be overcome before HPV immunization rates will begin to rise. The authors found that while most parents and caregivers were aware of the vaccine, they wanted more information about it and cited the lack of information as a barrier to immunization.[12] Another common reason cited for resistance to HPV vaccination was the young age of the child.[12]

HPV and its relationship to sexual activity, is also seen as a barrier to immunization.[13,14] In one qualitative study,[13] African American and Haitians parents thought by allowing their children to be immunized, they were condoning sexual activity. In another study,[14] parents were concerned that having to explain HPV immunization to their children would lead to a discussion about sexual activity.

It has been shown that sometimes the barrier to HPV immunization is the clinician.[15-17] Gerend et al.[16] found that physician recommendation for the HPV vaccine varied by the characteristics of the patient. Results of Gerend's studies[16] showed that patients were more likely to receive a recommendation for the HPV vaccine if they were young, female, and had health insurance. Allison et al.[15] showed that pediatricians and family physicians were less likely to recommend HPV immunization for boys than for girls (52% and 41% [boys] vs. 60% and 59% [girls]). The same study also showed that physicians who occasionally/rarely discussed HPV immunization were more likely to be male, practicing family medicine, and think that parents would not accept a recommendation for the HPV vaccine if discussed with other vaccines. Gilkey et al.[17] found the quality of the physician's recommendation was lower when the physician believed the parent did not value the vaccine or if the physician was uncomfortable talking about the vaccine.

Overcoming the Barriers

Strategies for overcoming the barriers to HPV immunization are necessary to improve immunization rates. One important strategy is to standardize immunization reminders in the EHR workflow.[18,19] A systemic review of the literature showed that reminders resulted in improved immunization rates.[20] In their review of the barriers and interventions to improve HPV immunization, Beavis and Levinson[18] also cite EHR reminders as a proven option.

Improving communication is another strategy to improve immunization rates. Beavis and Levinson[18] stated that the language used in communicating with patients about immunization has a large impact on whether or not the patient or parent will act on the recommendation. Gilkey et al.[17] noted higher quality recommendations when physicians simply stated that the child was due for the HPV vaccine. A study of 325 women showed that knowledge of the importance of the HPV vaccine was high and variables, such as the strength of a physician recommendation, increased the likelihood of a woman receiving the vaccine.[21]

Conclusion

Study after study continues to validate the importance of a strong physician recommendation in determining whether a patient will receive the HPV vaccine. Studies that have looked at different populations (parents, underserved/disadvantaged populations, minorities, males) all have shown that

"Not Receiving a Health Care Professional's Recommendation for the HPV Vaccine" was a key barrier to adolescent immunization with the HPV vaccine.[12] While there are many strategies for overcoming barriers to immunization, such as increasing the length of immunization visits to educate families on vaccines[19] and offering immunizations outside of the physician office,[12] it is the quality of the recommendation by the physician that has the biggest impact. ▲

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CME Quiz

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.

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 issue. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

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

Members – To obtain credit:

1. Complete and return this quiz to the NJAFP
2. Report your credit directly to the AAFP

Nonmembers – To obtain credit:

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

NAME:_____ AAFP MEMBERSHIP NUMBER:_____

STREET ADDRESS: _____

CITY/STATE/ZIP: _____

EMAIL ADDRESS: _____

PHONE: _____ FAX: _____

1. *True or False:* The Zika virus is only spread through mosquito vectors.

2. *True or False:* The Zika virus can result in perinatal death.

3. *True or False:* 80% of Zika virus infections are asymptomatic.

4. *True or False:* It is not possible to confirm the presence of Zika.

5. *True or False:* To request Zika testing, the physician must contact the Local Health Department (LHD) where the patient resides.

6. *True or False:* While most HPV infections will resolve without treatment, persistent HPV infection can result in cancer.

7. *True or False:* ACIP does not recommend routine HPV immunization for males.

8. *True or False:* New Jersey matches the national average for male and female adolescents immunized with the HPV vaccine.

9. *True or False:* One barrier to HPV immunization is that parents feel they are condoning sexual activity.

10. *True or False:* The quality of the recommendation that a patient/parent receives about HPV immunization is the biggest factor in whether or not the vaccine will be administered.

Answers on page 21

NEW JERSEY *View*

Highlights from the 2016 Scientific Assembly

Actions from the 2016 House of Delegates

The Following Resolutions HAVE BEEN ADOPTED:

NJAFP 2016 Resolution #1 (Lauren Carruth, MD)

Accessibility of Lab Reports

RESOLVED: that the NJAFP advocate to improve physician access to labs ordered for their patients by other physicians, and be it further

RESOLVED: that the NJAFP request, through a resolution to the AAFP Congress of Delegates or other appropriate channels, that the AAFP advocate for improved physician access to labs ordered for their patients by other physicians.

NJAFP 2016 Resolution #2 (Robert Eidus, MD)

Confidence Intervals in Performance Reports

RESOLVED: that the AAFP strongly advocate to CMS that all provider performance reports on quality or cost of care for programs that tie performance to payment include confidence intervals and other indices of validity and reliability, and

RESOLVED: that the AAFP advocate strongly to CMS that provider performance reports provide transparency as to the method of risk stratification.

2016 AAFP COD Report *(Orlando, FL)*

NJAFP resolutions were debated and discussed in Reference committees and had the following outcomes:

RESOLUTION NO. 316 (New Jersey A)

Accessibility of Lab Reports

Introduced by the New Jersey Chapter
Referred to the Reference Committee on Practice Enhancement.

(Action taken by the 2016 Congress of Delegates: Referred to the Board of Directors. The Board of Directors referred this resolution to the Commission on Quality and Practice. AAFP could address this resolution by editing current policy to more directly reflect access of laboratory test results and by promoting those policies to appropriate stakeholders.)

RESOLUTION NO. 317 (New Jersey B)

Confidence Intervals in Performance Reports

Introduced by the New Jersey Chapter
Referred to the Reference Committee on Practice Enhancement.

(Action taken by the 2016 Congress of Delegates: Referred to the Board of Directors. The Board of Directors referred this resolution to the Commission on Quality and Practice.)

RESOLUTION NO. 516 (Late Resolution B)

Patient Access to Pharmaceuticals in Cases of Monopoly

Introduced by the New Jersey, Delaware, Alaska, California, Connecticut, Georgia, Indiana, Kansas, Missouri, New York, Ohio, and Virginia Chapters
Referred to the Reference Committee on Advocacy.

(Action taken by the 2016 Congress of Delegates: Adopted as amended on the floor. The Board of Directors referred this resolution to the Commission on Governmental Advocacy.)

Richard Cirello, MD Retires as Speaker of the House

After 23 years serving the NJAFP House of Delegates, **Rich Cirello, MD** retired as Speaker of the House at the conclusion of the 2016 HOD meeting. He will be succeeded by past president, Dr. Joseph Schauer of Farmingdale, NJ. Dr. Cirello was presented with a personalized clock by his colleagues, upon which he (with unique humor) questioned the wisdom of gifting a clock to someone upon their retirement.

NJAFP Honors Assemblyman Herb Conaway with The Edward A. Schauer, MD Public Policy Award

The Edward A. Schauer Public Policy Award is presented to a person who promotes positive interaction between family medicine advocates and governmental leaders to advance the delivery of high quality healthcare services to the citizens of New Jersey. The Academy was proud to present this award to Assemblyman **Herb Conaway** for his significant efforts to use public policy to improve opportunities for access to comprehensive health care and promote high quality standards for family physicians who are providing health care to the public.

NJAFP Installs New Board Members

Adity Bhattacharyya, MD Installed as NJAFP President

Dr. Bhattacharyya (right) was installed as President of the NJAFP for the 2016-2017 term at the President's Gala by AAFP Director, Mike Munger, MD.

New Trustees

NJAFP welcomes new officers and trustees to the Board installed by Michael Munger, MD. Below, from left to right next to Dr. Munger: Peter Carrazzone, MD (President- Elect), Lauren Carruth, MD (Vice President); Maria Ciminelli, MD (Treasurer); Michael Cascarina, MD (Secretary); Sara Leonard, MD; Kevin James Berg, MD (Board Trustees); Donna Marie Kaminski, DO (New Physician); Michael Cacoilo; James Kahn (Student Trustees).

Maria F. Ciminelli, MD, FAAFP named 2016 NJ Family Physician of the Year

Maria Ciminelli, MD, FAAFP is the Family Medicine Residency Director at the Rutgers Robert Wood Johnson Medical School at CentraState in Freehold, NJ. She is a fierce champion of family medicine and sees family physicians as key leaders in how systems of care should be organized.

Dr. Ciminelli has been practicing and advocating for family physicians in New Jersey for more than 20 years, inspiring every new Family Medicine resident who trains under her and earning the respect and heartfelt admiration of her colleagues, and especially her patients.

Dr. Ciminelli is known for her "laser-like focus" in the management of the family medicine residency program at CentraState, while simultaneously serving on several committees and even an IT group to advise the hospital on its growing needs. Dr. Ciminelli's advocacy work to create loan forgiveness programs in New Jersey is another important factor in keeping graduating residents in the state.

Dr. Ciminelli (L) is pictured here with her nominating physician, Dr. Lisa Lucas.

Dr. Ciminelli has also been an active community member in Freehold working with the Medical Sciences Learning Center – a magnet public high school program in Freehold for honor roll and academically-talented students. She has successfully advocated for an externship program that introduces these high-performing students to Family Medicine through hands-on workshops, lectures and mentoring. The high school faculty involved with the program have seen first-hand how Dr. Ciminelli's influence has shaped and developed many students' perspective on medicine and particularly those who are now considering family medicine as a career choice. It is yet another way that Dr. Ciminelli is working to encourage New Jersey to produce and keep family physicians in our communities.

The New Jersey Academy of Family Physicians is proud and honored to name Dr. Maria F. Ciminelli the 2016 New Jersey Family Physician of the Year. The Academy will place her name into nomination for the 2018 AAFP Family Physician of the Year in March 2017.

Congratulations to:

Maria Ciminelli, MD *(Freehold)* who has been welcomed into The International Association of HealthCare Professionals with her upcoming publication in The Leading Physicians of the World (http://theleadingphysiciansoftheworld.com/).

Kathleen Saradarian, MD of Quality Family Practice *(Branchville)* and to the physicians of **Family Practice of CentraState** *(Freehold)* for being chosen for the intervention arm of the CMS Million Hearts® Project. This project is a randomized controlled trial that endeavors to close the gap in cardiovascular care. Rather than a focus on the individual risk components, participants stratify risk across their beneficiary panel, identifying those at highest risk for atherosclerotic cardiovascular disease (ASCVD).

South Jersey Magazine Names Top Docs

Congratulations to NJAFP members **Elyse B. Kernis, DO** *(Cherry Hill)* and **Samuel D. Weiner, MD** *(Voorhees)* for being selected as 2016 Top Family Medicine Docs in South Jersey!

Tara Perrone, MHA *(Chatham)*, NJAFP's Sr. Healthcare Transformation Specialist, and her husband Michael Perrone on the birth of their daughter, Mia Rose on August 17th at 6:53am, at 8 lbs., 1 oz. and 21 inches! And special congratulations as well go to big brother Carmine!

In the News...

Tom McCarrick, MD *(Verona)* Chief Medical Officer/CMIO of Vanguard Medical Group was quoted in a press release presenting the results of a study designed to evaluate the feasibility and reach of using a lay coach in conjunction with BlueStar® mobile prescription therapy to provide ongoing self-management support for people living with type 2 diabetes in a primary care setting. Read the full story here http://bit.ly/2b1f5zZ

In Memorium

NJAFP extends heartfelt condolences to the family of **Michael J. Doyle, MD, FAAFP** who passed away on July 22 surrounded by loved ones at home in his beloved seaside town of Neptune. Dr. Doyle was an important Academy leader and mentor to many family physicians, and a dedicated steward of the NJAFP Foundation. For the tribute story, turn to Foundation View.

NJ RESEARCH POSTER AWARD WINNERS

This year 25 posters were presented by New Jersey family physicians and residents in the annual poster competition. The awardees were recognized by EVP Ray Saputelli at this year's President's Gala. NJAFP congratulates the winners and thanks all those physicians and residents who participated.

Thank you to the judges of this year's poster competition:

- Lauren Carruth, MD
- Robert Gorman, MD
- Mike Munger, MD
- Tom Shaffrey, MD
- Jeff Zlotnick, MD

Poster Category – Physician

First Place

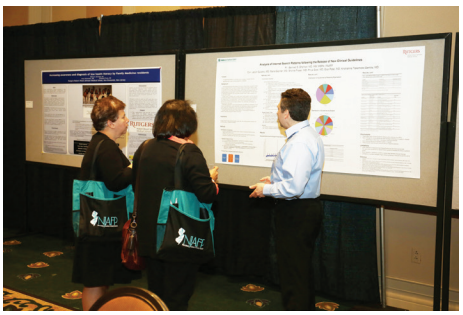
An analysis of Internet search patterns following the release of new clinical guidelines

Primary Author: Bennett Shenker, MD, MS, MSPH, FAAFP

Secondary Author: Jaclyn Guliano, MD

Additional Authors: Shonte Fraser, MD; Maria Espinar, MD; Gopi Patel, MD; Krishanna Takemoto-Gentile, MD; Priya Goel, MD

Poster Description: Our study reports Internet searching patterns after the release of new clinical guidelines. We found that only 12 of 52 new clinical guidelines from major organizations resulted in a peak in related Internet searches. No reliable predictors of a peak were identified. Public interest after guideline release may be low.



Second Place

Increasing awareness and diagnosis of low health literacy by family medicine residents

Primary Author: Rhina Acevedo, MD

Secondary Author: Elizabeth Evans, DO

Additional Authors: Anna Sliwowska, MD

Poster Description: The physician-patient communication and outcomes are influenced by patients' health literacy. Various studies have shown that low literacy is a contributing factor in the communication gap between physicians and patients. The goal of this study was to train family medicine residents on Health Literacy and ways to improve it in practice.

Poster Category – Resident

First Place

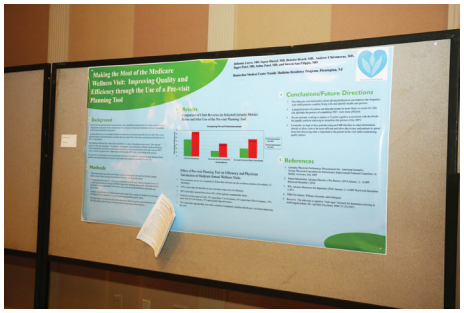
Making the most of the Annual Wellness Visit: Improving quality and efficiency through the use of a pre-visit planning tool

Primary Author: Steven Flippo, MD

Secondary Author: Julianne Lucco, MD

Additional Authors: Sapan Bindal, MD; Deirde Brazil, MD; Andrew Chiromeras, MD; Jigger Patel, MD; Selina Patel, MD

Poster Description: The Medicare AWV is an ideal time to discuss end-of-life care and perform falls risk assessment. A six-month chart review was performed with implementation of a developed pre-visit form. We found this form to improve efficiency of gathering this information and improve the visit for providers and patients.



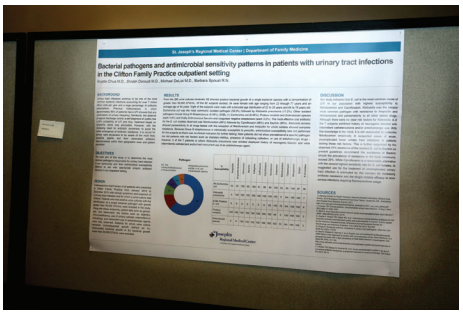
This year there was a tie for Second Place in the Resident category:

Bacterial pathogens and antimicrobial sensitivity patterns in patients with UTI in the Clifton Family Practice Outpatient Setting

Primary Author: Krystle Chua, MD

Secondary Author: Shideh Doroudi, MD
Additional Authors: Michael DeLisi MD, Barbara Spoust, RN

Poster Description: UTI's are common and account for a large percentage of antibiotic prescriptions. Treatment is often done empirically, based on symptoms alone. With increasing concern of antibiotic resistance, it is important to be aware of not only the most common causative organisms but also their sensitivity patterns within one's patient population.



Improving diabetes coding accuracy for increased value

Primary Author: Ankit Malik, DO, MBA

Secondary Author: Helaine Levine, MD

Poster Description: To prepare for the transition to value-based compensation models physicians must improve their DM diagnostic coding skills. ICD 10 DM coding has a completely different hierarchy than ICD 9, which adds to the difficulty in coding accurately. Yet, we were able to achieve a 32% increase in correct DM control coding in eight months.

New Jersey's new laws addressing opiate abuse and addiction

CLAUDINE M. LEONE, JD

THE ISSUE OF ADDICTION and abuse has been at the forefront of Trenton health policy over the last two years. There has been a significant amount of legislation signed into law to prevent diversion, provide access to naloxone, coordinate law enforcement efforts, and promote medicine drops. Below is a list of laws that are new to New Jersey over the last year. Many of these bills were not perfect when introduced, but NJAFP and the physician community in Trenton worked on amendments to improve the legislation so that it functioned in real life practice.

There isn't a week that goes by in Trenton without a new bill being introduced on opiate prescribing and treatment in New Jersey. Most of these new bills attempt to limit either the day or unit dosage of opiates to patients, whether adult or children. And of course, there is a continued push in Trenton for mandating continuing medical education for prescribing opiates and alternative treatments for pain management. There are also bills that seek to improve insurance coverage and access to addiction treatment services, but there is a great focus in Trenton and nationally on addressing the initial and continued access to prescription medications.

NJAFP is working on your behalf in Trenton with legislators to make sense of all of these measures and help educate legislators on the day-to-day challenges some of these measures present to physician practices and your patients.

New Laws:

- Expanding access to Narcan. Physicians and other authorized prescribers can provide naloxone to any person who is at risk for opioid overdose or who may be in a position to help someone else who is experiencing an overdose. Through a standing order from a physician, healthcare practitioners, including pharmacists, can dispense naloxone to any recipient they deem capable of administering it to an overdose victim in an emergency. First responders and addiction prevention experts can now carry and administer this fast-acting and lifesaving drug in an emergency. *A-3720 (Conaway) Signed into law February 2015.*

- Requiring the Division of Mental Health and Addiction Services to annually prepare a Substance Use Treatment Provider Performance Report including patients' success of remaining abstinent from drugs and alcohol after completion of the program, employment figures, education and job training admissions and housing. *S-2373 (Vitale) Signed into law February 2015.*
- Requiring coordination between the Commissioners of Human Services and Corrections to ensure that state-owned correctional facility inmates are receiving mental health and substance abuse disorder services by licensed service providers. *S2380 (Vitale) Signed into law February 2015.*
- Coordinating law enforcement statewide to combat the illegal distribution of prescription opioid drugs. Under the direction of the Attorney General, law enforcement agencies, state agencies, and state licensing boards are now working in concert to identify, investigate, and prosecute the illegal trade of prescription opioids. *S-1436 (Caride) Signed into law April 2015.*
- Promoting and codifying "Project Medicine Drop."The State now publishes an up-to-date online database of locations of safe disposal locations. *A-2859 (Eustace) Signed into law April 2015.* http://www.njconsumeraffairs.gov/meddrop/Pages/Locations.aspx

This is just a sampling of bills currently pending consideration in the Legislature on opioid prescribing, abuse and addiction:

- Prevents abuse and diversion by mandating equal insurance coverage for opioids with abuse-deterrent properties *A1833 (Conaway)*
- Requires healthcare practitioners to inform patients of addiction potential of controlled dangerous substances prior to issuing prescription *S803 (Weinberg/Vitale)*
- Establishes certain limitations on prescription, dispensation, and administration of opioid medications to student athletes *A3992 (Huttle)*
- Restricts initial prescriptions for opioid drugs to seven-day supply *A4035 (Quijano)*
- Requires issues related to prescription opioids to be included in continuing education courses for certain healthcare professionals *S2419 (Vitale)*
- Requires all prescriptions be transmitted electronically, subject to certain exceptions *S2428 (Weinberg)*
- Requires opioid antidote dispensation to be monitored under PMP and authorizes certain entities to submit information regarding opioid antidote administration for inclusion in secondary, linked database *S2428 (Gordon)*
- Requires testing for infectious disease for certain persons who have been administered opioid antidote by first responder *S2445 (Kean)*
- Urges State Board of Medical Examiners to adopt CDC guidelines for prescribing opioids for chronic pain *SR60 (Gordon)*
- Requires certain healthcare professionals to complete continuing education courses regarding issues related to prescription opioids *A1549 (Petersen)*
- Directs poison control and drug information program to establish clearinghouse of drug overdose information, report on trends, and provide education on safe storage and disposal of medications; appropriates $500,000 *A1825 (Conaway)*
- Requires prescribers to discuss addiction risk associated with certain drugs prior to issuing prescription to a minor patient *A3424 (Lagana)*
- Requires electronic prescribing systems to default to three-day supply of opioid drugs, with ability for prescribers to issue prescriptions in any authorized quantity deemed medically appropriate *A3778 (Jones)*
- Requires healthcare practitioners prescribing opioid medications on first-time basis, or to minor children, to limit amount of prescribed medication to seven-day supply, except in certain circumstances *A3803 (Wolfe)*

- Requiring pharmacists to provide information on the safe disposal of unused prescription drugs and encouraging patients to not let expired or leftover medication fall into the wrong hands. Requires physicians when dispensing (not prescribing) controlled substances to notify patients of proper and safe disposal of unused medications. *A-709 (Angelini) Signed into law June 2015.*
- Curtailing drug seekers in the doctor's office by expanding the Prescription Monitoring Program. Prescribers are now automatically enrolled in the database through CDS registration/renewal and required to consult the online database the first time they prescribe a medication of an addictive nature (Schedule II CDS) to a patient for acute and chronic pain, and at least quarterly for patients that continue to receive prescriptions for this type of medication to identify patterns of abuse, addiction, and diversion. Certified Medical Assistants are now authorized to access the PMP when delegated. Additionally, pharmacies are now required to upload data more often to more quickly identify problem users. *A-3062 (Lagana) Signed into law July 2015.*
- Continuing to treat individuals in recovery through medical-assisted drug treatment while allowing them to successfully complete a probation drug court program. *A-3723 (Conaway) Signed into law August 2015.*
- Increasing access to treatment through a statewide database of available substance abuse treatment beds, accessible through the 2-1-1 system. This will allow individuals and families seeking help to quickly and easily identify the closest available treatment center, instead of making dozens of phone calls. *A-3955 (Conaway) Signed into law January 2016.* ▲

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

The Telemedicine Revolution

JESSICA RUNYON

Introduction

According to the American Telemedicine Association (ATA), more than 15 million Americans received remote medical care in 2015.[1] While there are significant and reasonable concerns about the implementation and utilization of telemedicine, there are also potential benefits and, of course, hurdles to be overcome, practice standards and licensure portability being the biggest.[2]

Telemedicine in New Jersey

While New Jersey does not specifically authorize telemedicine in its statutes, existing physician licensing laws when applied to telemedicine require a physician be licensed in New Jersey prior to providing services to a patient in the state (N.J.S.A. § 45:9-6.).[3] There are two minor exceptions to this rule (N.J.S.A. § 45:9-21). Subsection (c) of N.J.S.A. § 45:9-21states a physician or surgeon of another US state who is authorized to practice medicine in that state, is not required to obtain a New Jersey license to practice telemedicine providing the practitioner does not open a practice in the state.[3] N.J.A.C. §§ 13:35-7.1A and -7.5 also indirectly impact telemedicine by requiring all patients in the state to receive a physical exam before medication can be prescribed or dispensed.[3] This regulation would limit telemedicine services, at least to the extent that drug therapy is included.[3]

Legislation to define telemedicine services are under consideration by the New Jersey Legislature (S291/A1464[4]). According to New Jersey's pending legislation:

> *"Telemedicine" means the delivery of a health care service using electronic communications, information technology, or other electronic or technological means to bridge the gap between a health care provider who is located at a distant site and a patient who is located at an originating site, either with or without the assistance of an intervening health care provider, and in accordance with the provisions of this act. "Telemedicine" does not include the use, in isolation, of audio-only telephone conversation, electronic mail, instant messaging, phone text, or facsimile transmission (S291/A1464).*

Broader Perspectives

The American Academy of Family Physicians' (AAFP) defines telemedicine as the "use of medical information that is exchanged from one site to another through electronic communications. It includes varying types of processes and services intended to enrich the delivery of medical care and improve the health status of patients."[5]

According to the AAFP processes and services can include activities such as subspecialists' consults where the subspecialist "sees" the patient in a live, remote visit or the transmission of video or diagnostic images for later review by the specialist.[5] Also considered telemedicine is the use of electronic communication that is used monitor patient vital signs remotely and then transmit them to the physician's office.[5]

Telemedicine in Primary Care

Telemedicine can complement primary care practice by allowing the primary care office to offer expanded services for non-emergency patients who need advice but not necessarily an office visit.[6] The integration of telemedicine services into the primary care office has some promising benefits, though more studies are needed to determine its long-term impact. One thing is known, while telemedicine can be effective as face-to-face care, it will never replace the face-to-face visit. ▲

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Jessica Runyon is a program manager for the Healthcare Transformation and Quality Improvement program for the NJAFP.

Call for 2017 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.

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- 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

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For a complete description of criteria and requirements, please contact the **NJAFP office** at **(609)394-1711** or email ***Candida@njafp.org***

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Medical Practice Targeted by Ransomware

SUSAN B. ORR, ESQ.

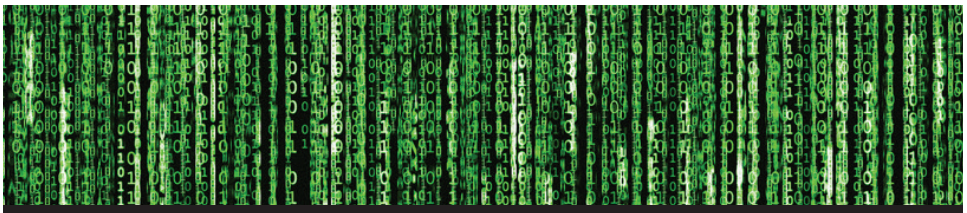
DO YOU HAVE PROTECTIONS in place to prevent this headline from appearing in your local newspaper about your medical practice? One of my clients believed that their IT systems had all of the firewalls, anti-virus, and other bells and whistles needed to prevent any type of cyber hack. They also mistakenly believed that they would never be targeted. Unfortunately, they were wrong. Between 2am and 5am, someone entered one of their servers and encrypted all of their information and then held that data hostage asking for a ransom payment.

Ransomware attacks are becoming rampant. So what is ransomware exactly? It is malicious software used by hackers to deny access to systems or data. The hacker holds the data hostage until the ransom is paid. After the initial infection, the ransomware can spread to shared storage drives and other accessible systems. If the ransom is not paid, the system or encrypted data remains unavailable or it may be deleted. The problem with ransomware is that it is extremely difficult to determine whether the information has been viewed. Even after a forensic analysis is performed, IT experts cannot say with 100% certainty whether the data has been viewed. As a result, one must assume the worst and look at this as a HIPAA breach of protected health information.

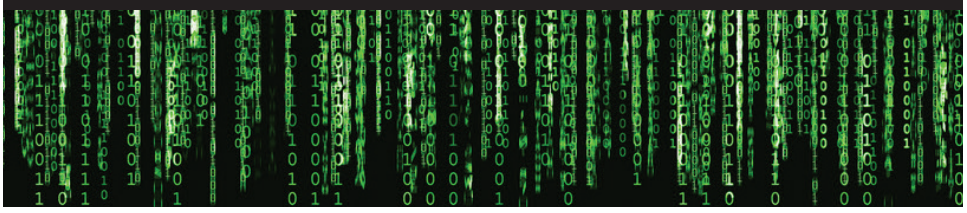
My client was fortunate in that they had backed up all of their data the evening before so the data wasn't lost to them nor did they have to pay the hackers. However, this ransomware attack cost them thousands of dollars and they are still not done yet.

As soon as the ransomware was detected, the client's IT company was brought in to investigate the extent of the ransomware attack and to put in place various software programs to protect their current data. Following this, an extensive risk assessment was done by another IT company that specializes in breaches. They reviewed policies/procedures and made further recommendations to plug any additional vulnerabilities they identified.

While this was being done, we engaged a company to send out letters to almost 13,000 patients to inform them of the potential breach, to set up a call center for patients to obtain additional information, and to arrange for patients to receive free credit reporting. Letters had to be developed (one for minors, one for adults, one for those living in states requiring certain other information to be included), a list of patients had to be created and address verification had to be done. A media consultant was engaged to handle the newspapers and television reporters calling for information. A press release was issued to the newspapers and placed on the client's website. The breach was reported to the Department of Health and Human Services, Office of Civil Rights, and finally to the FBI. There were many pieces that had to be handled and they all had to be handled quickly and efficiently.



One of my clients believed that their IT systems had all of the firewalls, anti-virus, and other bells and whistles needed to prevent any type of cyber hack. They also mistakenly believed that they would never be targeted. **Unfortunately, they were wrong.**



To make matters worse, my client did not have cyber insurance to cover any of these expenses. By the time this process is over, my client will have spent somewhere between $50,000 and $75,000 in dealing with this ransomware attack. This does not include the staff time spent in handling the attack. We are currently waiting to hear from the Office of Civil Rights, which we anticipate will be visiting to verify everything that has been done.

Don't let this happen to you. Make sure you have engaged a reputable IT company to manage your systems, do daily backups of your data, and purchase cyber insurance, just in case.

For more information or assistance with a breach or possible breach, please contact Susan Orr, Esq. 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.

There and Back Again

A Residents Tale: Report on the 2016 AAFP National Conference for Residents and Students

KRISHANNA EOLANI TAKEMOTO-GENTILE, MD

SLEEPING IN WHEELCHAIRS at 2:00 am on a Friday in a Chicago airport was not exactly what we had in mind when we booked our trip to Kansas City for the National Conference. Navjot Narula, MD, the newly elected junior resident trustee, and I, the senior resident trustee, were both post 24-hour call, delusional, and stranded. We were eagerly waiting to get on a standby flight to Kansas City after our initial flight was so delayed we missed our connections. After some creative re-booking, we finally made it to the Kansas City Convention Center.

> The median education debt for 2012 medical school graduates is $170,000. Medical school tuition has quadrupled in the past 20 years.

The enthusiasm among the participants was contagious as we sat down next to our "New Jersey" sign, suddenly wide awake and ready to begin the session. The reports given by resident representatives from the many committees were both humbling and inspiring. Family medicine residents have strong voices across the nation and amidst the larger medical community. The "hot topics" for the congressional sessions started to become evident. These included student debt reform, gun violence, loan forgiveness, resident wellness, LGBT health, women's health, global stewardship/health, and Medicare issues - both old and new.

There were many other issues brought to light in the resolutions - 66 resolutions to be exact. One resolution in particular resonated with us, which also happens to be one of the major issues keeping young family medicine physicians out of New Jersey: Student Debt Reform. This resolution stated that the current national student loan debt is $1.4 trillion and the median education debt for 2012 medical school graduates is $170,000. The current debt reflects the fact that medical school tuition has quadrupled in the past 20 years. Debt burden is further compounded by average student loan interest rates of 7%, or 7.9% in my case. By 2020 it is projected that the shortage of primary care physicians will be 20,400. The debt burden is expected to be an obstacle for both medical students pursuing primary care and for primary care physicians treating patients with low insurance reimbursement rates, like Medicare and Medicaid. The resolve clause for the resolution called for the American Academy of Family Physicians to use its legislative advocacy to urge the U.S. Congress to reduce the debt burden, curb the growth of tuition, and discount loan interest rates for medical students going into family medicine.

This reform is vital for our future in recruiting medical students into family medicine; keeping residents in New Jersey after graduation; serving the primary care needs of our population; and providing the high quality, comprehensive, cost efficient medical care found in family medicine to our patients. This reform might be the start to increasing the numbers of family physicians in the Garden State.

New Jersey did have a few family medicine programs exhibiting in the EXPO hall. However, it took us about two laps before we found our state's corner. While we understand that the cost often outweighs the yield for recruiting for many programs, it was still a reminder to us how important our job is as residents in working towards making our state more family medicine friendly.

The high energy and welcoming feel in the EXPO hall, where programs from across the country were recruiting, carried over into the lectures, workshops and evening social events. Friday night was topped off with the National Conference Celebration with an impressive live band in the historic Midland Theatre. There it was evident that family physicians do have more fun. The trip to Kansas City turned out to be better than we expected, especially after our rough journey there. For both resident delegates and NJAFP student trustee, Michael Cacoilo, the conference was inspirational, educational, and reminded us why we are committed to this field and why we must remember to ask ourselves (to paraphrase a common sentiment) 'ask not what family medicine can do for us, but what we can do for family medicine.' ▲

Attending the conference from NJ are (l to r): Student Trustee, Michael Cacoilo; Resident Trustees, Navjot Narula, MD and Krishanna Takemoto Gentile, MD.

Dr. Takemoto-Gentile is the Senior Resident Trustee for the NJAFP and a PGY3 at CentraState Medical Center in Freehold, NJ.

CME Quiz ANSWERS:

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

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Family Physician Educates Others through Media

THE PATH THAT LED Jennifer Caudle, DO, a board-certified family physician, to family medicine was not a straight one, nor was it a conventional one. However, despite the twists and turns, Dr. Caudle's experiences have led to a passion for medicine and health education.

While attending Princeton University, the accomplished cellist learned about the Miss America Organization and the scholarship assistance available through participation. Dr. Caudle, in search of scholarships, not only participated in a pageant, she went on to win the title of Miss Iowa 1999 and competed for the title of Miss America.

Although she didn't win the crown, the pageant world introduced Dr. Caudle to public speaking, cameras, and how to use the media to get a message across. The experiences gleaned through the Miss America Organization stuck with Dr. Caudle, and she kept them in her back pocket for the future.

Fast-forward a few years, Dr. Caudle entered medical school at the University of Medicine and Dentistry of New Jersey – School of Osteopathic Medicine. During her third year, like many medical students, Dr. Caudle struggled with picking a specialty.

"I think it's really about who you are as a person - it's a personality decision," she says. "Do you only want to listen to hearts all day? Do you want to spend all day in the operating room, or do you want variety?"

After self-reflection, Dr. Caudle decided on family medicine, despite it not being considered one of the "cool specialties," because she couldn't imagine a more perfectly suited specialty for her.

"In family medicine, we're dealing with different patients of all ages – those who are sick, but also those who are healthy. You get to stay ahead of problems by educating and counseling patients," she says.

Dr. Caudle says she has no regrets with choosing Family Medicine, despite its challenges.

"Yes, I wish I had more time with patients and less paperwork, but it's so rewarding. We become a partner on life's journey – we know patients inside and out and what's going on in their lives. We're not treating just one facet of the patient, we're treating the entire patient and part of that is who the patient is and what's going on with them," she says.

"In family medicine, we're dealing with different patients of all ages – you get to stay ahead of problems by educating and counseling patients."

More importantly, she has found ways to integrate her profession with some of her own passions, creating a rewarding and fulfilling life.

The daughter of two educators, it was a natural progression for Dr. Caudle to incorporate education into her role as a family physician. Following her residency (UMDNJ/SOM Kennedy Memorial Hospital, Our Lady of Lourdes), Dr. Caudle immediately entered the academic world.

"Teaching is just a natural part of what I should be doing," she says.

As an osteopathic physician and assistant professor in the Department of Family Medicine at Rowan University School of Osteopathic Medicine and third-year clerkship director, her daily interaction with medical students helps them to navigate the medical field, which keeps her stimulated and motivated.

Drawing on the lessons learned through her experiences with the Miss America Organization, Dr. Caudle also uncovered how to use her voice as a physician to educate those outside of the classroom or medical office.

Dr. Caudle

"The people who talk about medicine should be the same people who participate in medicine," says Dr. Caudle. "We all should be actively participating in the dialogue of health."

Today, Dr. Caudle serves as a regular on-air health expert for local and national news networks. She appears on CNN, The Dr. Oz Show, FOX News, CBS Philly 3 News, PBS and many others. Her health articles have appeared on The Daily Beast, CNN.com, DoctorOz.com, ABCNews.com and she has been quoted by The Huffington Post, among many other outlets.

Dr. Caudle considers her health communication work a calling, just as much of a calling as practicing medicine.

"Medicine wants all of us. It's easy to give everything to it and forget who we are," she says. "As physicians, we need to find creative ways to fulfill our passions and use our skills. We can't forget who we were when we came into this profession." ▲

To learn more about Dr. Caudle, visit www.jennifercaudle.com or follow her on Twitter and Instagram @drjencaudle.

Goodbye Dear Friend:

A Tribute to Michael J. Doyle, MD

Michael Joseph Doyle, MD, FAAFP was a family physician to four generations of patients during his fifty-five year private practice in Neptune, NJ. Born in Newark – he lived, worked and enjoyed life as a "Jersey Boy" for all of his 83 years – with the exception of attending Loyola University's Stritch School of Medicine after graduating from Seton Hall University to embark on his career as a young "family practitioner" in post WWII New Jersey. Captain Dr. Doyle also served as a post surgeon at Camp Kilmer before completing his internship at Monmouth Medical Center.

Eager to make a difference in the field of medicine, Dr. Doyle joined the New Jersey Academy of Family Practitioners on May 1, 1964. Just 15 years young at the time, the Academy welcomed one of its most passionate and influential family physicians it would be privileged to have in its ranks. And so Dr. Doyle began to make his mark. Putting community first, Dr. Doyle was a founding director of the Jersey Shore Medical Center's Physician Emergency Service (circa 1969). During his tenure with the NJAFP, Dr. Doyle generously gave of his time to mentor and help young resident physicians as they plowed through grueling active duty on call hours of their family medicine (or family practice – as it was called in the early days) residency programs. Many of these family physicians wrote to us about this time and the wonderful impact that Dr. Doyle had on them and their careers (see side bar – *"Remembering Mike Doyle"*).

To add to his community work, Dr. Doyle also served his Academy very well. He was elected and served as NJAFP President from 1983-1984 and AAFP Director from 1991-1994. He received the Degree of Fellow from the AAFP in 1993. In recognition of his volunteerism and community efforts, he was awarded the New Jersey Family Physician of the Year Award in 1992; the NJAFP Chair Award in 1997; and the NJAFP Philanthropist of the Year in 2006.

In special recognition of Dr. Doyle's lifetime dedication and commitment to New Jersey's Family Medicine residents, the NJAFP recently renamed the Resident of the Year Award in his honor – the NJAFP Michael J. Doyle, MD, FAAFP Family Medicine Resident of the Year Award. Dr. Zeeshan Khan from CentraState Family Medicine Residency Program in Freehold, NJ became the first recipient of this newly renamed award. We are most thankful that Dr. Doyle was able to attend the President's Gala this past June in Atlantic City to make remarks about the value and importance of encouraging our family physician residents to stay here in the Garden State to strengthen our primary care delivery system. Family Medicine resident physicians are the future of the discipline – we must support them in their careers and continue to provide resources to make New Jersey one of the finest states in the country to work as a family physician.

In special recognition of Dr. Doyle's lifetime dedication and commitment to New Jersey's Family Medicine residents, the NJAFP recently renamed the Resident of the Year Award in his honor

Dr. Doyle passed away peacefully at home on July 22 surrounded by his loving family. He is predeceased by his wife of forty years Teresa Healey Doyle, his sisters Ann Behan and Mary White.

He is survived by his wife Mary Frawley Ring and his six children, Michael (Lesa) of Tampa, FL; Kathleen Whelply (Frederick) of Bayonne, NJ; Kevin (Maria) of Point Pleasant, NJ; Sean of Huntington, NY; Sharon Arndt (David) of Fairfax Station, VA; and Kieran (Cecilia) of Clark, NJ; and sixteen grandchildren (Michael, Kelly, Sean, Heather, Alicia, F. Grant, Emily, Kara, Ryan, Turner, Maggie, William, Timothy, Stephen, Teresa and Oliver), his sister Ellen Conry of Belmar, NJ and his two sisters in law Delores Kolodjeski of Interlaken, NJ and Ann Dlouhy of Denville, NJ. Mike is also loved by Mary's six children and her fifteen grandchildren.

A Mass of Christian Burial was celebrated on July 27 at Sacred Heart Church in Bay Head, NJ. After a military honor guard, burial was at St. Anne's Cemetery in Wall, NJ.

The NJAFP Foundation was very important to Dr. Doyle. He often spoke with his dear friend, Theresa Triebenbacher, who passed away in September, 2006 – of the goals the Foundation could achieve if the resources were in place. To that end we thank the many kind and generous individuals who have recently donated to the NJAFP Foundation in memory of Dr. Michael Doyle to ensure that his legacy will live on in the hearts and minds of all family physicians – both resident and attending – to continue to build the best quality healthcare delivery in the state of New Jersey. ▲

To make a donation in memory of Dr. Doyle or any loved one - please send your donation to the New Jersey Academy of Family Physicians Foundation, 224 West State St., Trenton, NJ 08608 with a note stating your intention, including the name and address of the individual(s) you would like us to notify.

The following is merely a fraction of the outpouring of heartfelt remembrance that so many of Mike Doyle's colleagues and friends sent to us upon learning of his passing.

…our loss of a NJ treasure. Mike mentored a number of us who came to family medicine in NJ in the 1980s "second generation" of the specialty. I recall his hospitality in opening his office and home to us for various NJAFP and Foundation meetings. He was always a role model, and a positive voice for family medicine, and our organizations; dedicated to his patients, teaching and mentoring other physicians.

– Mary Campagnolo, MD

Mike had an impact on my life that's incredible. He and George T (Triebenbacher) took me under their wing when I was a first year resident and guided me on my journey through multiple positions involving the AAFP and eventually to chairman of the ABFM in 2006. On a personal note, he was an important factor in the adoption of my second son, Michael. He was the epitome of a Family Physician, gentleman, and friend. He will be missed by many. RIP.

– Frank Kane, MD

I echo everyone's sentiments on the passing away of a true Family Physician both as a personal physician for all of his patients in Monmouth County and as a leader in the Family Medicine movement which started in the 60's and which many of us became involved in through his mentoring in the 70's. His wisdom and energy will be sorely missed but not forgotten.

– Joe Schauer, MD

I want to thank all of you for providing Mike and his family the opportunity to honor him at the Annual Meeting. I know personally how happy his last days were because of the recognition. He was the epitome of a Family Medicine physician and I know how much I will miss his presence and wisdom. He was a good man and friend.

– Ken Faistl, MD

Mike was a legend for NJAFP. He will be remembered always... a true gentlemen and a mentor for most every one of us. The recent honor afforded him was so well deserved and will stand as a testament to his impact on future family physicians in New Jersey.

– Arnie Pallay, MD

Mike was one of the truly great NJ Family Physicians over many years. His influence extended far beyond our borders and his care and devotion to the field knew no bounds. He will be truly missed.

– David E. Swee, MD

I too am saddened by the loss to the Academy, the specialty, and all of us who he mentored and encouraged to become the best physician, family doctor, and person that we could be. Will we miss you Mike.

– Marty Sweinhart, MD

What a staggering loss! A great friend, model Family Physician, educator, and Pillar of the Community - irreplaceable! Our thoughts and prayers go out to his friends (many) and family.

– Joe Lieberman, MD

It was really great to have seen him and honor him at the NJAFP meeting.

– Bob Gorman, MD

Sad to get this news today. He contributed greatly to the Family Medicine movement locally and nationally. He was a mentor and friend to me, always. A classical Family Physician in every sense.

– Tom Ortiz, MD

I am very sorry to hear but I am happy that Mike was around when the first Michael J. Doyle award was done.

– Bob Eidus, MD

Mike was a friend for so many years. Kenny Faistl, Joe Schauer, Rich Cirello, Frank Kane and myself went through those five years in the 90's occupying the NJAFP President position, but in reality all working together to bring our state academy to a different place than it had been in, as an independent academy instead of a vassal of MSNJ. Mike was an ever present advisor helping us in all those decisions. Fast forward a few years to when I had the audacity to believe someone from NJ could actually run for and win a position on the national AAFP Board. I spoke with Mike since he had been there and done that. We had a good talk and he finally said to me that if someone like him could do it, certainly someone like me, who was much smarter than him, could do it too! I suspect he gave me more credit than I deserved - or gave himself less than he deserved. In the end, he convinced me to run and we did, indeed, elect another NJ candidate to the AAFP Board. No small help from Mike. I will always be thankful to him for that and for the years of subsequent advice. RIP, Mike.

– Butch Pallay, MD

Mike is both a huge professional loss to the academy and Family Medicine and a personal loss to me. Mike was one of my mentors when I first joined the academy and really helped with directing my career. He was also a source of support and help during my tougher times. I will always treasure his guidance, and his friendship. I'm glad we were able honor him as we did at the last meeting.

– Jeff Zlotnick, MD

Very sad to hear that this great Family Physician has passed away.

– Krishna Bhaskarabhatla, MD

He mentored me through the election process. I will never wear a name tag without remembering Mike and the fact that it should be on the right lapel only. His lifelong contributions will long be remembered.

– Rich Corson, MD

Learning From Muhammad Ali's Final Fight

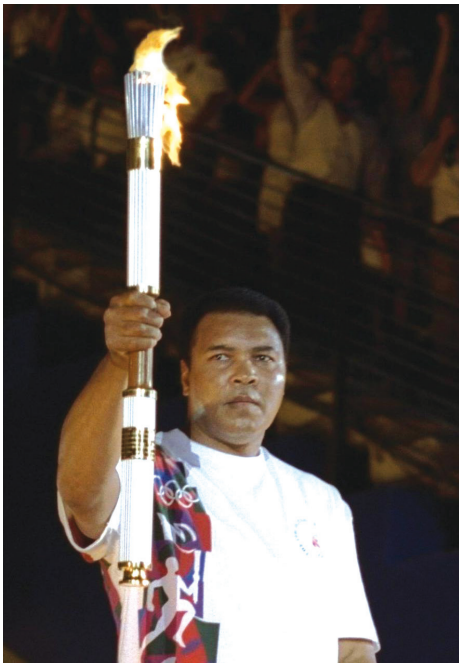
RAMY SEDHOM, MD

RECENTLY MANY HAVE rightfully celebrated the life of Muhammad Ali. He was a great athlete, entertainer, and political advocate. He was a fearless fighter, as seen in the 1996 Olympics in Atlanta, when he courageously confronted his humbling disease of Parkinson's publically. We saw the former champ vulnerable with his physical symptoms on display to the international community. He was an example to us all that our physical limitations are not something to shy away from.

Muhammad Ali did not only live like a champion – he also died like one.

The death of Muhammad Ali has been described as "a very peaceful passing." He died surrounded by his family. His last breath was ventilator free and his heart stopped naturally, without violent compressions or electrical shocks.

After leading a most exceptional life, Ali's encounter with death made him appear once again, a champion – this time for the neglected and forgotten in our medical community – those who have no voice when faced with death. The transformation of the former boxing legend, the perfection of human physique, to a frail elder struggling with chronic disease is a process that most of us cannot evade. Yet, despite this obvious life fact, advanced care planning is limited for sick elderly patients. Too many die devoid of personal dignity. They lay naked when they take their final breath, surrounded by medical staff eager to perform an often-vain attempt to sustain life. When a physician officially declares them dead, they are intubated, with pads on their chest, and several lines in their body.



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Hearing a code blue called overhead is a routine occurrence in the hospital. And while there are few things in medicine more satisfying than bringing someone back from a reversible cause of death, there's nothing more depressing than coding a person whose chance of survival is limited—and whose chance of a healthy life is almost impossible.

Statistically, most patients aged >75, with underlying medical illness, have less than a 10% chance of surviving CPR[1]. For those living in skilled care facilities with comorbidities that later develop septic shock (which Ali developed), the survival rate is less than 2%. By 85 years of age, such patients have less than a 1% chance of survival.[1] Those that do survive inevitably die on a respirator after prolonged stays in intensive care units. Yet, many patients will still die 'full code,' without any comfort measures. Statistically, our sickest patients are more likely to have a heart stimulant enter their bloodstream as the last substance, rather than a medication to ease pain and suffering just prior to death.

I recently attended a grand rounds at the University Medical Center of Princeton at Plainsboro that highlighted cultural shifts of medicine over the past fifty years. Death, over time, has become a medical event. This is a paradigm shift from the time when chest compressions were first described in the medical literature. The initial authors stated that CPR should be performed only on those whose deaths would be "sudden and unexpected." They wisely advised, "…the patient should not be in the terminal stages of a malignant or other chronic disease, and there should be some possibility to a functional existence."[2]

Since these words were published in *JAMA* in 1961, CPR has become the default during cardiac arrest. Because of this, patients and families must explicitly opt out of CPR, rather than opt into it. We have all seen families and individuals struggle with this choice in the final days leading up to a loved one's death. Understandably, some struggle with an innate sense of guilt, unsure if forgoing CPR is somehow equivalent to "giving up."

I wonder what it was that led Ali's family to the decision that quality of life, peace, comfort and dignity outweighed adding days to his life. I wish that we could find a way to extend that comfort in decision-making to all of our patients and their families. I know it is how I would want to go.

I hope we can one day redefine what "doing everything" means. For Muhammad Ali and his family, everything meant not engaging in a fight he could not win. Instead, it was allowing him, one last time to walk out of the ring on his terms. This time, his opponent was death and he won on his own terms. I'd like to think that he passed, spirits high, celebrating in the protective arms of his loving and dedicated family. ▲

Reference

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The CDC estimates that each year over 24,000 cancers could be prevented with HPV vaccines.

Six things you can do to prevent cervical cancer and other devastating HPV-related diseases in your patients:

1. Know your numbers - Assess HPV vaccine coverage for each provider in your practice
2. Work as a team – Involve all members of your care team including receptionists, nurses, and providers in developing an office-wide strategy to improve HPV immunization rates
3. Make a strong, effective recommendation for HPV vaccination as cancer prevention
4. Use a reminder/recall system to make sure your patients get all 3 doses of HPV vaccine
5. Check out *www.ImmunizeNJ.org/resources* for great strategies on talking with parents about HPV and cancer prevention
6. Learn more about HPV and cancer prevention at: *www.CDC.gov/cancer/hpv/*

Average number of cancers and genital warts per year in the U.S. attributed to HPV infections

	PENIS	VAGINA	JUVENILE-ONSET RRP*	VULVA	ANUS	OROPHARYNX	CERVIX	GENITAL WARTS
FEMALES		500		1,600	2,900	1,500	11,500	180,000
MALES	400				1,600	5,900		160,000
BOTH			820					

Source: President's Cancer Panel Annual Report 2012-2013
*recurrent respiratory papillomatosis

Published by the New Jersey Immunization Network, a program of the New Jersey Chapter of the American Academy of Pediatrics: *www.ImmunizeNJ.org.*

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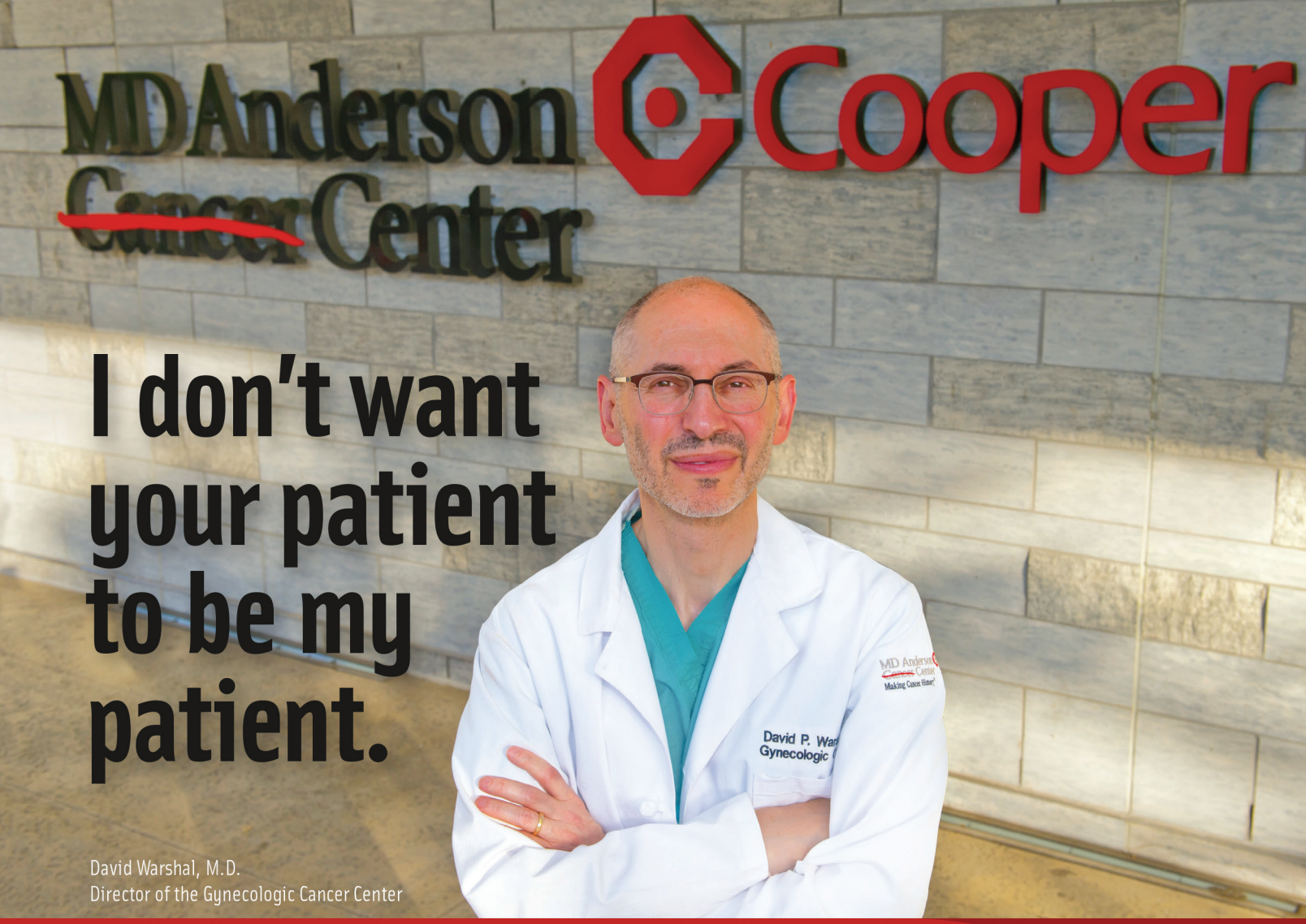

Immunize girls and boys with all doses of HPV vaccine before age 13.