

# Perspectives

A VIEW OF FAMILY MEDICINE IN NEW JERSEY

## Helping Parents Choose the Right Extracurricular Activities

What the New Payment Models Mean for New Jersey

**Additional CME Inside:**

**Chronic Obstructive Pulmonary Disease**

**Quality Improvement in the New Primary Care Workspace**



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# IN THIS Issue

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## On the Cover

Many parents encourage their children to become involved in extracurricular activities, which can develop motor skills, improve physical fitness, and build cognitive and social skills. Adults can learn how to make activities more developmentally friendly and appropriate.



# A Season of Change

■ THERESA BARRETT, PHD, CMP, CAE Managing Editor

**I**N ANOTHER LIFE I was part of a transition team that was tasked with bringing together two separate organizations with very different philosophies into a cohesive whole. Those of us on the team received quite a bit of training to help us manage the murky waters ahead of us. One thing that I learned in that time came from change management consultant, William Bridges. He said, "...it is not the change that does you in, it's the transitions."

Change is situational - a quick, one-time event. Transition is psychological. It is the process of coming to grips with the new reality caused by the change. Experiencing transition is like a journey through the twilight zone where the only certainty is confusion, apprehension, and insecurity. Even good change brings on these feelings.

Looking back over the last few months, there have been several of those "one-time events" that have thrown us all into the "Twilight Zone" of transition – new payment models, a presidential election, hospital and health system mergers, and CPC+, just to name a few. Stress and burnout are at an all-time high, or at least people are more willing to talk about them as serious issues. Add in the turmoil of the holiday season and it is a wonder that any of us can function at all.

Change, even when it makes sense, will ultimately succeed or fail based on how people handle the transition. So how do you deal with transition? Very simply (because there is not enough room in this column to go through all the steps) acknowledge the end that the change caused and then find a way to let go of the past; try not to get lost in the "neutral zone" between what was and what is, and celebrate the possibilities that come with new beginnings.<sup>1</sup>

Easy to say that these three things will get you through, but there is more to it than that. Perhaps one of the most important ways to manage transitions is to develop resilience – the psychological strength to cope with change and stress. As with the journey through the twilight zone to get through a transition, developing resilience is also a personal journey.<sup>2</sup> The techniques that help one person build resilience may not work for another. That said, there are some common methods that can be used to build resilience:<sup>2</sup>

- Make connections with people and organizations you care about
- Look beyond the present and see how the future could be different
- Accept that change is a part of life
- Develop realistic goals and take small steps to move toward them
- Take action rather than detaching from problems
- Engage in self-discovery
- Have confidence in your ability to solve problems.
- Keep things in perspective
- Be optimistic
- Take care of yourself

There are several apps that can guide you in developing resilience. One app developed specifically for healthcare providers is *Provider Resilience* (<http://t2health.dcoe.mil/apps/provider-resilience>). While originally developed as a tool for those who care for military personnel and their families, this app features a self-assessment to rate your risk of burnout, as well as a clock showing the time since your last day off, inspirational cards, and even Dilbert comics to encourage you to take restful breaks critical to avoiding burnout. The app also contains videos by service members describing the positive impact healthcare providers have on their lives. *Cleveland Clinic Stress Meditations* app (<https://my.clevelandclinic.org/mobile-apps/cleveland-clinic-stress-meditations-app>) provides

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# The Way Forward

■ ADITY BHATTACHARYYA, MD, FAAFP

**I** BRING YOU GREETINGS from the New Jersey Academy of Family Physicians. This September, I attended the annual Congress of Delegates meeting of the AAFP and wanted to update you on what our national Academy is working on. This was the first time I attended the event and it was a fascinating experience. New Jersey had a few resolutions that were discussed, but as I sat through the workings of quite a few reference committees I found that problems here are not unique to us after all. Many resolutions from other chapters were similar to what we often talk about at our meetings and Family Physicians across the country have similar problems that face our specialty as a whole. Here are some highlights from the event:

The reference committee on **Organization and Finance** had a few interesting resolutions that were discussed and adopted. One was about limit-

olution asking the AAFP to develop a policy statement regarding the pre-authorization process and to continue to educate members about resources available to deal with the problem. I am not sure how much power the AAFP has over insurance companies, but if enough people make noise and are able to lobby Congress, there may be some pressure on the insurance companies to change.

Another adopted resolution from this committee involved asking AAFP to seek a ruling by CMS to stop payments for annual wellness visits that were done outside the patient's primary care physician's office. If CMS adopted this, it would stop all those companies that are sprouting up offering to do these visits, as well as specialists' offices that sometimes bill for them. This may be a long shot. There were also a few resolutions supporting independent practices and increasing primary care reimbursements that were adopted. Our own New

The reference committee on **Advocacy** adopted a few resolutions. A resolution from California asked the AAFP to advocate for Medicaid coverage for emergency contraception and another from New York asked that AAFP advocate for reproductive health care for women in federal prisons. A joint resolution from a few chapters asked our Academy to work on eliminating pain as a fifth vital sign, as well as removing pain control as a determinant for quality of care. Finally, we are talking about an issue that somehow falls in the lap of all primary care physicians. This joint resolution asked the AAFP to advocate for a national database for the prescription drug-monitoring program for controlled substances. This would really help physicians who work along state borders.

Finally, from the reference committee on **Education** there were a few resolutions that we have discussed extensively in our meetings. One was a resolution asking AAFP to develop a campaign aimed at increasing the number of US medical students choosing family medicine as a career path. But they wanted the effort to begin earlier, in colleges and even high schools. There were also a few resolutions that would eventually be lumped together asking the AAFP to advocate for developing Point-of-Care Ultrasound training in all Family Medicine residency programs. This seems to be catching on fast and reimbursements seem good. Another resolution that is relevant to those of us in graduate medical education was advocacy to the Federation of State Medical Boards to increase reciprocity in training licenses across boards. This will help students who choose electives in states other than where they do their residencies. Unfortunately the resolutions on medical student debt/loan forgiveness did not pass.

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**“Family Physicians across the country have similar problems that face our specialty as a whole.”**

ing the amount of paper-based campaigning materials for those running for AAFP board positions to a single page. This resolution was co-sponsored by the NJAfp and will definitely save a lot of trees in the future. Another resolution concerned conducting a study on the nominations and election process for the Board of Directors. It would be nice if our Federal and State governments conducted such a study and cleaned up their respective election processes.

There were a few interesting resolutions from the reference committee on **Practice Enhancement** as well. One that is a big issue for all physicians relates to the hassle factor and time spent in the pre-authorization process for insurance companies. The Congress of Delegates adopted a res-

Jersey resolution requesting CMS increase transparency on how they rate provider performance for MACRA was adopted.

The reference committee for **Health of the Public and Science** had a few resolutions that I found thought-provoking. One of them asked the AAFP to write a letter to the Department of Health and Human Services asking them to develop a comprehensive report on gun violence as a public health issue. This may be the way we can make a dent in this huge problem that plagues our nation. Another interesting resolution asked the AAFP to write a letter to the Department of Agriculture asking them to adhere to recommended dietary guidelines in the Food Stamps program and ban sugar sweetened beverages.

# Supporting Family Docs in Payment Reform

■ RAY SAPUTELLI, MBA, CAE

**A**S A PRACTICING family physician in New Jersey – whether you agree with where healthcare payment reform is going or not – it's here, starting in 2017 with the launch of Medicare Access and CHIP Reauthorization Act (MACRA), Merit-based Incentive Payment Systems (MIPS), and Advanced Alternative Payment Models (APMs). The somewhat slow but sure shift from fee-for-service to value-based payments will be a bumpy and winding road for the next several years as we navigate it with an ever-evolving GPS.

In an effort to help physicians prepare for these new requirements and payment models, the Center for Medicare and Medicaid Innovation (CMMI) launched several programs over the past few years designed to support practice transformation – such as the Comprehensive Primary Care Initiative (CPCi), State Innovation Model (SIM), and Transforming Clinical Practice Initiative (TCPI). New Jersey has been a recipient of these programs in some form, and NJAfp has been intimately involved with several, both in New Jersey and Delaware.

New Jersey was chosen as one of seven regions for the original CPC Initiative, which started in 2012 and will conclude at the end of this year. CPCi provided practices with extra funding to support the additional resources needed to transform their IT infrastructure and staffing. NJAfp served as the Regional Learning Faculty (RLF) for the CPCi program, providing both practice coaching and learning collaborative events for over 70 practices across the state. Due to the success of the original program, "CPC+" was created and will begin a five-year program starting in 2017. CPC+ will launch in 16 different regions in the United States including the original seven plus Hawaii, Missouri, Kansas, Montana, Michigan, Pennsylvania, Rhode Island, and Tennessee.

What did we learn over the past four years as a CPCi region?

- Primary care physicians can – and do – have a positive effect on quality of care. New Jersey's

quality scores improved over the course of the program and were consistently high among the CPC regions.

- Primary care physicians can have a positive effect on hospital utilization. Given the right information at the right time, our docs can – and do – keep patients out of the hospital.
- Primary care physicians need trusted and reliable data to drive cost reduction.

More recently, New Jersey was also included in the TCPI program, a four-year, national program with 29 regions designated to create "Practice Transformation Networks" (PTNs) that include non-ACO primary care and specialty physicians. The goal of the PTN program is to prepare practices that are not currently part of an ACO or other Advanced Payment Model to initially build the capacity to succeed in MACRA and MIPS, and ultimately graduate to an Advanced Payment Model relationship. NJAfp has contracted with the New Jersey Innovation Institute (NJII), which received over \$49 million to develop the "Garden PTN" in New Jersey, with an initial lofty goal of reaching

ing primary care practices to succeed in value-based payment models.

So, CMS is changing the way physicians will be paid, and our members need to get ready for it. CMS's approach to helping physicians is to leverage its innovation arm –

CMMI – to put supportive boots on the ground across the country to work with physicians, some with financial incentives such as CPCi and CPC+, and others with only resource support. Has this approach been successful?

Dr. Joseph Schauer III, a family physician at Farmingdale Family Practice, has been in the CPC Program since it began. He is an avid supporter of the CPC Initiative and says that it provides structure and resources for patient-centered care, enhanced care coordination for chronic disease, and patient engagement. Dr. Schauer's practice was accepted into CPC+ and everyone at the practice is incredibly excited to continue with an initiative



## Given the right information at the right time, our docs can – and do – keep patients out of the hospital.

over 11,000 providers across the region. Through this grant, NJAfp's healthcare transformation team is providing much needed technical and process support to physicians across the state.

In addition to our work in New Jersey, NJAfp was chosen as a practice transformation vendor for the State Innovation Model (SIM) grant in Delaware, allowing our healthcare transformation team to provide free practice coaching services to up to 100 primary care practices across Delaware. The goal of the SIM program in Delaware – similar to our programs in New Jersey – is focused on prepar-

that has helped them grow. They wanted to continue the opportunity to contribute to the future of health care and believe that this initiative is going to help improve the coordination of care and patient engagement.

Dr. Lisa LaCarrubba-Blondin's viewpoint – from both a family physician's side as well as a Medical Director at Horizon Blue Cross Blue Shield of NJ – is that CPCi created a space for team-based care that is productive in its outreach to patients.

Given the recent, some might say surprising

*Continued on page 14*



# 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 the 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.

**Do you have a particular interest that you feel needs to be addressed? Think about starting a member interest group!**

**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.

## Interested in Starting a MIG?

Do you have a particular interest that you feel needs to be addressed? Think about starting a member interest group. All you need to do is complete an application (go to <http://www.aafp.org/about/member-interest-groups/mig.html>). Applications are reviewed by the AAFP's Commission on Membership and Member Services (CMMS).

In order for an interest group to be considered, it must be consistent with the AAFP's definition of a MIG (i.e., a forum of AAFP active members who have shared professional interests), further the AAFP's strategic objectives, and must not duplicate groups represented by the current Board-approved member constituencies. For the full list of criteria visit <http://www.aafp.org/about/member-interest-groups/mig.html>.

## CHRONIC CARE MANAGEMENT RESOURCES AVAILABLE FROM AAFP

Are you leaving payment opportunities on the table? Through CPT code 99490, family physicians and other eligible healthcare professionals can be reimbursed by the Centers for Medicare & Medicaid Services for providing chronic care management (CCM) services to their patients. Whether you want to learn more about CCM, are ready to get started, or have had success and need a resource to help manage your CCM patient base, the AAFP can help you start getting paid for services you provide. The CME webcast, *Chronic Care Management: Getting Paid for What We Do Best*, provides insight on implementing CCM from a physician who is currently successfully managing this program in her practice. In addition, the AAFP's Chronic Care Management Toolkit offers a variety of resources for communicating with patients and implementing a workflow in your practice. For more information visit <http://www.aafp.org/practice-management/payment/coding/chronic-care.html>



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## NJAFP Seeks to Expand the Family Medicine Residency Program & Community Health Center Collaborative

The Residency Program & CHC Collaborative started in 2009 and now includes over 30 practices across Pennsylvania. Through management by the New Jersey Academy of Family Physicians, in 2017, the Collaborative will expand to include residency programs and community health centers from New Jersey and Delaware.

The Collaborative is a FREE quality improvement community for primary care residency program practices and community health centers/FQHCs, bringing together primary care practices that serve as both teaching health centers and safety net practices. The Collaborative is committed to implementing the Chronic Care Model, as well as patient-centeredness and process improvement that leads to measurable patient outcomes improvement. Practices sign participation agreements which include a commitment to submit quality data, allowing NJAFP to report practice and patient-level outcomes.

If you are interested in learning more about the Collaborative contact Angie Halaja-Henriques ([angie@njafp.org](mailto:angie@njafp.org)) or Sandi Selzer ([sandi@njafp.org](mailto:sandi@njafp.org)).

### Congratulations to...

Suzanne Hockenberry, who has successfully renewed her PCHH Content Expert Certificate. Those who hold a PCMH CCE certification have a comprehensive knowledge of the requirements, the application process and the documentation of the NCQA PCMH Recognition Program.

Sue is an invaluable member of our NJAFP team, a fantastic resource for our members and clients, (and one of the nicest people you'll meet).



# 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.

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

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

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



For a complete description of criteria and requirements, please contact the NJAfp office at (609)394-1711 or email [Candida@njafp.org](mailto:Candida@njafp.org)

Submission deadline for the 2017 FPOY Award is April 30, 2017.



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# Perspectives

## A View of Family Medicine in New Jersey

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## A Season of Change *continued*

seven different relaxation techniques designed to help you to feel more in control of stressful emotions and help you to enjoy the present and worry less about the future. *Stop, Breathe, Think* (<https://app.stopbreathethink.org/>) is an app designed to help you practice mindfulness meditation. The app takes you through the basics of meditations, provides guided meditations ranging from 2 to 20 minutes, and allows you to track your progress. Some of the meditation guides are free while others require a small fee.

Regardless of how you choose to journey through the transitions of life, taking care of yourself – whether it is through mindfulness meditation, exercise, or relaxing with friends – is the most important thing you can do. I wish you peaceful journeys and happy holidays. Namaste.

Happy Reading.

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## The Way Forward *continued*

There were fun moments as well and it was nice to hear from the national leaders about exciting things going on in our Academy. Dr. Mike Munger from Kansas City was chosen as the President-Elect and Dr. John Meigs was sworn in as the new President. Some of you may have met them as they attended our annual Scientific Assembly in Atlantic City in the past two years. Though I did not stay for the FMX conference, the inaugural address by Dr. Atul Gawande, a surgeon and prolific writer about our healthcare system was inspirational, as was the speech by our new president and his vision for the future of our specialty.

On the home front, your Academy has been busy setting up an action plan for the year ahead. After our strategic planning retreat in August we aligned our action plan for the upcoming year with the four goals of the Academy which are grouped under “Advocacy,” “Practice Enhancement,” “Membership and Communication.” and “Academy Operations.”

To that end we developed task forces to work on the most pressing issues that impact our practice environment in New Jersey today. One such

task force is working on advocating for a loan redemption program for our medical students and residents to help more students go into careers in family medicine and stay in New Jersey to practice. Along similar lines, the residency directors are looking into keeping Family Medicine residency graduates in New Jersey to increase our primary care work force. Another task force is looking at developing a set of tools and resources for new physicians in practice. The task force on Membership and Communications is working on developing a member needs survey, which I hope you will all participate in. This will help us understand your needs and modify our Academy operations to meet them. As your Academy continues to work on these and many more issues, I will keep you updated with the details.

I want to end by saying that I joined this Academy to have a voice for myself and my specialty. I want to invite you to join us in our work, for united we can solve many more problems together. ▲

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

# Helping Families Choose Age-Appropriate Extracurricular Activities

LINDA ROOKE, PT, C/NDT AND EMMY LUSTIG

Linda Rooke, PT, C/NDT is a certified physical therapist at Pathways Center in Glenview, IL.

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The authors have no relevant financial conflict of interest relative to this article.

**M**ANY PARENTS ENCOURAGE their children to become involved in extracurricular activities as a way to promote their development. Extracurricular activities help children develop motor skills and improve physical fitness, while also building their cognitive and social skills, all of which can enhance children's sense of wellbeing.<sup>1</sup> To help children receive the most benefits from extracurricular activity involvement physically, emotionally, and socially, they should participate in the right amount of activity for their age level and abilities. Adults facilitating children's extracurricular activities can learn how to make the activity more developmentally friendly and recognize when it may not be appropriate for a child.

Research on parents' perceptions of children's extracurricular activity involvement reveals that parents in the United States may be becoming more involved in children's choice of activities and the intensity in which children practice and rehearse. In one study analyzing parents' perceptions of their children's extracurricular participation in Rome, Italy and in Los Angeles, California, both groups of parents encouraged their children to participate in extracurriculars to improve their performance in other activities. For example, families in L.A. and in Rome reported that extracurricular activities helped their children work on executive function skills like successfully managing the time needed to complete schoolwork while also managing time requirements for organized activities outside of school. Parents also believed participation in extracurricular activities helped build their child's self-confidence and assertiveness.<sup>2</sup>

Interestingly, there were some differences between the way Roman parents and parents from

Los Angeles perceive their role in facilitating their child's extracurricular activity participation. Parents from L.A. felt the need to be very involved in the child's choice of activities and training.<sup>2</sup> This correlates with national statistics revealing that 3 in 10 parents coached their child's sports activities in the last year.<sup>3</sup> Parents from L.A. supervised their children closely during activities, whereas parents from Rome had much less involvement in their child's training and did not often emphasize the importance of the child's success in extracurriculars.<sup>2</sup>

In addition to becoming involved in children's choice of activities and training, parents in the United States may also be placing their child in more time-intensive activities that are emotionally or physically demanding. The American Academy of Pediatrics reports this trend may be occurring because:<sup>4</sup>

- Parents feel pressure to build their child's skills and aptitude from an early age to develop a "high-achieving" child.
- The college admission process has become more competitive and children are encouraged to build strong resumes with lots of extracurricular activities.
- Adult expectations are placed on children at an earlier age—children are expected to manage their time commitments for both extracurricular activities and schoolwork.

Involvement in extracurriculars can be beneficial for children when they are pursued in a time appropriate and age appropriate way. In fact, children may receive the most developmental benefits from extracurricular activities when they participate in a diverse range of activities that fit comfortably in the child's schedule instead of focusing intensely on one type of activity. This protects children from activity 'burnout,' and can help reduce unnecessary physical and emotional stress.<sup>2</sup> The American Academy of Pediatrics particularly emphasizes the importance of children engaging in different types of sports to develop a wide range of skills.<sup>5</sup>

Nationally, more children participate in sports activities than other types of extracurriculars.<sup>3</sup> When talking to parents about children's sports, try offering these tips to help parents decide if their child is engaging in the right type of activity and whether it is developmentally friendly for their child's age and abilities:

- Does the child enjoy participating in the sport? Most children (70%) drop out of sports by the time they are 13 because they no longer find the activity fun due to the intensity of practice and lifestyle changes required for participation.
- Make sure the child receives positive coaching that promotes their enjoyment of sports while teaching teamwork and fair play.<sup>6</sup>



- The sport level should be appropriate for the child's age and abilities. For example, have restrictions on the number of pitches a child can throw in a baseball game or set a ratio for the number of practices to games.
- The child's coach should have knowledge about the proper training techniques, equipment needed for participation, and physical and emotional needs of the children participating.
- Coaches should strive to prevent overuse injuries and recognize injuries early.
- Children should never try to 'work through' injuries.

Diversity in extracurricular activities can also benefit children who are not in athletics, as these provide time to socialize with peers and continue building other important skills. With the right mix of activities and an appropriate time commitment, extracurriculars can help children perform better

academically and identify with their school, thereby cultivating a more positive school experience.<sup>7</sup>

Sometimes, parents may be concerned about their child participating in too many activities outside of school. Diversity in extracurricular activities promotes development as long as the child balances activities with the demands of school and family life. Parents can gather tips for choosing activities for their child on the Pathways.org website. Healthcare providers can discuss with parents about the appropriate amount of activity for their child to facilitate a healthy lifestyle. They can also express the importance of children having time for free play while limiting the use of electronic devices to less than two hours a day. Playtime is a great way for families to connect and share quality time together among busy schedules and an abundance of activity options.

*Pathways.org is a national not-for-profit organization dedicated to maximizing children's development by providing free tools and resources for medical professionals and families. Healthcare professionals can contact Pathways.org to receive free supplemental materials to give away at well child visits and parent classes. For a free package of brochures to give away to families, please email friends@pathways.org.*

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# Chronic Obstructive Pulmonary Disease

LAUREN CARRUTH, MD AND THERESA J. BARRETT, PhD

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## Introduction

Chronic Obstructive Pulmonary Disease (COPD) is a debilitating and progressive disease and is the third leading cause of death in the United States. Because the disease progresses slowly and has minimal to no symptoms in its early stages, a significant number of individuals have COPD and yet remain undiagnosed.<sup>1,2</sup> Known to exist since the early 17th century, COPD was originally referred to as "voluminous lungs" and later "emphysema."<sup>3</sup> Today, COPD is known to be the result of inflammatory changes in the lungs that result in persistent limitation of airflow. The disease is progressive, not fully reversible, and largely preventable.<sup>3</sup>

## The Health Burden

COPD presents a significant clinical burden that affects millions of people in the United States. Although many patients with severe COPD are diagnosed early, many individuals who have COPD remain undiagnosed because of the slow

progression of the disease and the lack of symptom recognition among primary care clinicians.<sup>1,2</sup> In a cohort study of 38,859 patients with COPD, Jones et al. discovered 85% of the cohort experienced missed opportunities for diagnosis up to five years prior to the diagnosis of COPD being documented in the patient record.<sup>1</sup>

In 2014, COPD was the third leading cause of death in the United States.<sup>4</sup> Deaths attributable to COPD have fallen among men, from 57.0 per 100,000 in 1999 to 44.3 per 100,000 in 2014.<sup>5</sup> However, there has been no significant change in COPD related deaths among women between 1999 (35.3 per 100,000) and 2014 (35.6 per 100,000).<sup>5</sup>

COPD significantly affects quality of life. As the disease progresses, daily activities, emotional health, and the ability to meet patient action plan goals are all negatively impacted by the disease's symptoms.<sup>6</sup> These can be exacerbated by depression and anxiety.<sup>7</sup>

## The Cost Burden

The cost of COPD and its sequelae in 2010 was estimated to be \$32.1 billion, with absenteeism costs of \$3.9 billion.<sup>8</sup> The cost of care increases as the disease progresses. By 2020, medical costs for COPD are projected to reach \$49.0 billion.<sup>8</sup> Hospitalizations account for the majority of the cost associated with COPD.<sup>9</sup>

## Treatment Status

Patients with COPD have a high prevalence of asthma.<sup>1</sup> COPD and asthma are separate respiratory diseases, yet are often confused because they share similar symptoms, such as shortness of breath, chronic coughing, and wheezing. Phillip Factor, MD, Chief of Pulmonary, Critical Care, and Sleep Medicine at Beth Israel Medical Center said, "Millions of Americans currently have COPD, and they don't know it because they are undiagnosed or are given a diagnosis of asthma or bronchitis."<sup>10</sup> Factor stated that better recognition of the symptoms of COPD, especially in current and past smokers, could get patients into treatment earlier.<sup>10</sup> Early treatment is critical to preserving lung function.

Smoking is a key contributor to the development of COPD, yet many patients with COPD continue to smoke.<sup>11</sup> An analysis of the Behavioral Risk Factor Surveillance System showed that 40% of smokers with COPD have never tried to quit.<sup>11</sup> In a separate study, researchers found that 31% of patients with COPD disagreed or strongly disagreed that smoking was a cause of COPD, indicating a lack of knowledge about their disease and the importance of quitting smoking.<sup>12</sup>

Patients who smoke should be screened regularly for COPD. One study of patients who smoked revealed that 21.5% (N=2961) had no symptoms to indicate the presence of COPD.<sup>13</sup>

However, of this asymptomatic group 69% were in GOLD stage I and II.<sup>13</sup> In a longitudinal observational study of current and former smokers, researchers found that a rapid decline in FEV1 (forced expiratory volume in 1 second) over a 36-month period was a predictor for the future development of COPD among smokers without lung disease at baseline.<sup>14</sup> As the cost of caring for patients with COPD is expected to continue to rise, family physicians should continue to offer interventions to reduce tobacco use, a known contributor to the development of COPD, in order to curb the rising cost of care.<sup>8</sup>

## Screening for COPD

The ability to make an early and accurate differential diagnosis is essential to the proper and cost-effective treatment of COPD. Spirometry is the gold standard for the diagnosis of COPD and is a HEDIS measure for NCQA.<sup>15</sup> According to NCQA, “Earlier diagnosis using spirometry testing could lead to earlier intervention and treatment of adults with COPD, which could prevent costly complications and slow disease progression.”<sup>15</sup> Unfortunately, though it is the most important diagnostic tools for diagnosis of COPD, it is not widely used in clinical practice.<sup>15,16</sup>

Early diagnosis of COPD and early intervention can improve quality of life and physical function.<sup>17</sup> The combination of a screening tool and spirometry can facilitate the early diagnosis of COPD.<sup>17-19</sup> For example, the “Screening, Evaluating and Assessing Rate Changes of diagnosing respiratory conditions in primary care 1 (SEARCH1)” study found that use of the COPD Population Screener (COPD-PS), with or without the use of a hand-held spirometer, resulted in an increased level of COPD diagnosis in primary care.<sup>20</sup> In another study, researchers found that the use of COPD-6 (a portable device to screen for COPD) was a valid and reliable screening tool and resulted in an increase in the diagnosis of the disease.<sup>21</sup>

It is important to note that the United States Preventive Services Task Force (USPSTF) recently reviewed their 2008 recommendations for regarding screening for COPD.<sup>22</sup> They reviewed important factors such as screening tools and their accuracy, whether screening improves preventive services, and the harm that may come from screening and treating mild to moderate COPD.<sup>22</sup> As in 2008, USPSTF found no evidence that screening asymptomatic individuals for COPD improves morbidity, mortality or quality of life.<sup>22</sup>

## Improving the Picture

Primary care physicians provide the majority of care for patients with early COPD, but they do so only when they recognize COPD.<sup>23</sup> Walters et al. found that primary care physicians rely too heavily on clinical symptoms, not spirometry, in diagnosing COPD and, therefore, tend to misdiagnose the condition.<sup>24</sup> Opportunities to diagnose COPD earlier should be incorporated into routine clinical practice.<sup>1</sup> The National Heart Lung and Blood Institute (NHLBI) encourages physicians

to screen for COPD in patients over 40 who have cough or progressive dyspnea, chronic cough or sputum production, decline in level of activity, and/or shortness of breath with or without symptoms.<sup>25</sup> Early diagnosis and aggressive management can improve both length of life and quality of care.<sup>25</sup>

Once identified, current care for COPD is based on a reactive model designed to manage acute exacerbations, usually to the detriment of patient outcomes.<sup>26</sup> It has been shown that using a chronic care model based on the implementation of COPD guidelines (i.e., patient registries) can result in improved patient care and a reduction of inpatient care and emergency room visits.<sup>26</sup>

Patient engagement also improves outcomes for COPD. Long-term adherence to medication is needed for success, yet poor adherence is common.<sup>27,28</sup> Lack of adherence is one of the main reasons that patients fail to meet their treatment goals resulting in an increase in preventable COPD-related hospitalization, unnecessary escalation of therapy, increased morbidity and mortality, and reduced quality of life.<sup>27,28</sup> Inhaled medications are complex and lead to significant non-adherence, both intentional and nonintentional.<sup>29</sup> Teaching patients proper technique for inhaled devices is critical to better outcomes.

To improve patient adherence, physicians must be prepared to partner with their patients and communicate the benefits and risks of treatment and promote the need for optimal self-management.<sup>28,30</sup> Glenn et al. found that patient engagement was a predictor of better functioning and symptom outcomes making patient engagement of critical importance.<sup>31</sup>

## Summary

COPD is a common and largely preventable respiratory disease. COPD is either misdiagnosed or not diagnosed until late in the course of the disease resulting in poor outcomes. Effective medications exist to treat the disease, however a lack of adherence to guidelines and recommendations for smoking cessations, along with lack of patient engagement lead to sub-optimal care and poor patient outcomes resulting in a failure to meet ACO quality and HEDIS standards. Using spirometry and other screening tools can help family physicians facilitate a diagnosis of COPD early in the course of the disease and to differentiate it from asthma. Employing shared-decision making tools can also help patients understand their disease and its treatment, thereby improving outcomes. ▲

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# Quiz

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**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.

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1. *True or False:* Many parents feel the need to be involved in their children's activities, yet only 5 in 10 parents coached their child's sports activities in the last year.
2. *True or False:* Children may receive the most developmental benefits from extracurricular activities when they participate in a diverse range of activities rather than one focused activity.
3. *True or False:* Life style changes and the intensity of practice do not seem to affect whether children remain involved in a sport after age 13.
4. *True or False:* The right mix of extracurricular activities with the appropriate time commitment can help children perform better academically.
5. *True or False:* COPD was the third leading cause of death in the United States in 2014.
6. *True or False:* 31% of patients with COPD disagreed or strongly disagreed that smoking was a cause of COPD.
7. *True or False:* Hospitalizations account for the minority of the cost associated with COPD.
8. *True or False:* COPD is mostly preventable.
9. *True or False:* The gold standard to diagnose COPD, spirometry, is consistently used in practice.
10. *True or False:* The use of EHRs is the biggest impediment to successful QI Projects.

## In the News

**Robert Eidus, MD** (*Jersey City*) was quoted in a *MedPage Today* article focused on soaring drug prices. Dr. Eidus was the author of a New Jersey resolution on the high cost of life-saving medications which was presented to the AAFP Congress of Delegates in September. To read the full article to go <http://bit.ly/EidusMedPage>.

**Ray Saputelli, MBA, CAE** (*Trenton*) was quoted in a *NJ Biz* article, commenting on a TD Bank survey regarding the financial pressures faced by physicians. The article can be accessed at [http://bit.ly/Saputelli\\_NJBiz2016](http://bit.ly/Saputelli_NJBiz2016).

**Jeff Rosenberg, MD** (*Berkeley Heights*) was featured in an *NJ.com* article on physicians assistants and their evolving role in medical practice. Read the article at [http://bit.ly/Rosenberg\\_NJcom2016](http://bit.ly/Rosenberg_NJcom2016).

## CPC+ coming to New Jersey

**N**J AFP is pleased to report that New Jersey will retain its position as one of 14 regions selected for participation in the CMS Comprehensive Primary Care Plus (CPC+) initiative, scheduled to launch in January, 2017. CPC+ is an advanced primary care medical home delivery and payment model that builds on the Comprehensive Primary Care Initiative (CPCI) program, which began in 2012 and concludes at the end of this year. NJ AFP has served as lead faculty for the New Jersey CPCI region since October 2012, and provides program support and education to 70 primary care practices throughout the state.

Fundamentally restructuring how we pay for primary care is an important step towards our goal of reforming the healthcare system to one that is foundational in primary care. The underlying policies of the CPC+ program are consistent with the AAFP policies on primary care delivery system and payment reform, and the AAFP welcomed the announcement of the new program.

CPC+ has been identified as an Advanced Alternative Payment Model (Advanced APM) under the Medicare Access and CHIP Reauthorization Act (MACRA) meaning that practices participating in the CPC+ program will be eligible to receive a 5 percent bonus payment on their Medicare allowable charges starting in 2019. This is an opportunity for NJ AFP members and their practices to engage in a payment model that is supportive of advanced primary care functions while also providing an alternative to the MIPs program.

## Supporting Family Docs *continued*

outcome of the national elections, it's not an understatement to say that things are somewhat uncertain as to the direction the new administration may take the healthcare discussion. Some priorities are certain to change. Still, it would seem that the move towards value-based payment, which has always had bi-partisan support, will continue even as other models (for example, Direct Primary Care) are perhaps given greater emphasis. NJ AFP and AAFP will certainly continue to advocate aggres-

sively for that critical shift from our fee-for-service past, and position our resources to assist practices as they prepare not only for the changes we know are coming, but even those we can imagine might lie ahead. The work that family physicians and the primary care community have done in New Jersey to this point clearly demonstrates the value that we add, and the NJ AFP stands ready to continue our work to help each of you navigate both the certain and less-than-certain changes that are coming.

## With Sympathy

The NJ AFP offers its condolences to the families and friends of those family physicians who have passed away.

**Ken Van Dyne, MD** (*Flemington*) was a longtime supporter of NJ AFP and a frequent attendee at the NJ AFP Scientific Assembly. He passed away on October 24, 2016.

**William D. Ryan, MD** (*Whitehouse Station*) passed away on November 22, 2016

**Victor J. Irmiere, MD** (*Wayne*) passed away on September 5 2016.

## WHEN ONE PERSON CARES ENOUGH TO MAKE THEIR VOICE HEARD, THE WORLD CAN CHANGE

Join the change...submit a resolution to help shape the course of the Academy or consider nominating yourself or a colleague to serve on the NJ AFP Board of Trustees.

For information visit:  
<http://www.njafp.org/content/house-delegates>

I remain positive about the role of family physicians in New Jersey, and their opportunity to not only survive, but thrive. Please feel free to contact me or any member of the professional staff at NJ AFP whenever we can be of service. ▲

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.



## NJAFP Supports First Responder Education

**N**JAFP worked with the NJ Office of Emergency Medical Services to provided education to New Jersey's first responders at the NJ Statewide Conference on EMS, held this November in Atlantic City. Over 800 people representing EMTs, paramedics, law enforcements agencies, emergency room physicians, and hospital systems came together over the three-day conference.

One of the Keynote speakers for this year's conference was Marilyn Franchin, a Prehospital Emergency Physician for the Fire Brigade of Paris. As one of the first responders to the 2015 Paris Bombings, Dr. Franchin shared the horror of the first terrorist attack in the city since World War II. Multiple bombings and shootings occurred in a span of thirty minutes that left 130 people dead and 352 people injured. The worst situation was at Bataclan, a concert hall, where 82 people died in an execution-style shooting.

The city felt they were prepared for an attack of this nature because in 2007, Paris created an emergency response plan to be implemented if a mass casualty situation occurred. The plan, called "Alpha Red Plan," had three main objectives: 1) Survival of the wounded, 2) Controlled personal exposure, and 3) Continuation of mission. However, the vast nature of the tragedy exposed weak points in the plan. The medics working at Bataclan ran out of stretchers for the victims so they had to improvise, using the barriers that were placed by the building as a means to transport patients. After receiving

calls from victims, police closed down the roads around Bataclan to keep citizens safe but at the time didn't realize that it would create problems when trying to bring in ambulances for the victims.

The city of Paris is using what they learned during the bombings to better prepare for the future attacks. For example, they have increased the number of tourniquets and flexible stretchers they carry, and have added damage control kits to their ambulances. They also created classes for the citizens of Paris so that they could be educated on tactical emergency casualty care, which have been incredibly successful.

PTSD was a very real concern for those personnel that went through the crisis. All 840 members of the Parisian Fire Brigade and other first responders met with a psychiatrist or psychologist to be screened for any signs of trauma. Forty percent of those who were screened were affected by the events and needed long-term professional care. The most frequent cause for care was related to seeing victims dying, feelings of failure, and fear of danger for themselves. Paris is still recovering from the fear and terror that struck last year, but as Dr. Franchin said, they will keep on going and keep on living their lives.

EMS personnel touch all of our lives every day, even though we don't realize it. NJAFP will continue to support First Responders and their education as the world changes and lifesaving technologies advance. Through our involvement in the NJ Statewide Conference on EMS, we help to fulfil our mission to improve healthcare for all New Jerseyans. ▲

## Transform your practice through industrial strength

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# Law Authorizing Physicians to Sell Nutritional Supplements

CLAUDINE M. LEONE, JD

**G**OVERNOR CHRISTIE signed a bill into law that authorizes physicians to sell/dispense nutritional supplements in their practices.

This new law, which became effective in 2016, permits physicians and podiatric physicians to dispense nutritional supplements to their patients. This created an exception to a law that previously prohibited physicians from dispensing more than

saw the need for parity and pursued changing the law restricting physician practices from offering supplements to patients. There was also a strong argument made by the sponsors that physicians, who know their patients' health history and current medications, are in a better position to recommend supplements to their patients over that patient simply walking into a vitamin store and purchasing a supplement. Often times the patient fails to share the fact that they purchased and are actively taking a supplement with their physician. They also recognized that compliance with a physician's recommendations for supplements is likely to improve when the patient can leave the practice with the product in hand. Of course, the original law was put in place because of concerns of conflict of interest and profiteering in physician practices. These historical concerns remain, but the parity arguments and the potential benefits to pa-

tient care/compliance outweighed those concerns in the Legislature and with the Governor.

In my history of working with NJAfp there are mixed opinions on whether this law is appropriate in a family medicine practice, so the NJAfp did not take a position on this legislation as it went through the legislative process. Whether you choose to incorporate this into your practices or not, it is up to you! ▲



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



a seven-day supply of drugs or medicine to patients and imposing no more than a 10 percent administrative fee on the cost of the medicine. The law previously only exempted chiropractic physicians from the restrictions when dispensing certain nutritional supplements. To be clear: the day supply and administrative fee still applies to medications dispensed by physicians – just no longer to nutritional supplements.

The sponsors of the legislation recognized that private practice physicians are operating in a different healthcare environment compared to when the original restrictions were put in place. With the increased presence of retail health clinics operating in drug store chains and patients "shopping" after a healthcare visit at the retail clinic, the sponsors

## P.L.2015, c.296

### Current law with highlighted new provision provides:

A physician shall not dispense more than a seven-day supply of drugs or medications to any patient. The drugs or medications shall be dispensed at or below the cost the physician has paid for the particular drug or medication, plus an administrative cost not to exceed 10% of the cost of the drug or medication.

The provisions of this section shall not apply to a physician:

- a. who dispenses drugs or medications in a hospital emergency room, a student health center at an institution of higher education, or a publicly subsidized community health center, family planning clinic or prenatal clinic, if the drugs or medications that are dispensed are directly related to the services provided at the facility;
- b. whose practice is situated 10 miles or more from a licensed pharmacy;
- c. when dispensing allergenic extracts and injectables;
- d. when dispensing drugs pursuant to an oncological or AIDS protocol;
- e. when dispensing salves, ointments or drops; or
- f. when dispensing a drug or medicine delivered to the eye through a contact lens.

The provisions of this section shall not apply to a licensed physician, podiatric physician or chiropractic physician who dispenses food concentrates, food extracts, vitamins, minerals, herbs, enzymes, amino acids, tissue or cell salts, glandular extracts, neutraceuticals, botanicals, homeopathic remedies, and other nutritional supplements.



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## CALL FOR RESEARCH POSTERS

Present original research and be eligible to win a prize!

A Call for Research Posters is being issued for presentation at the NJAFP 2017 Scientific Assembly. This event will provide an opportunity to exhibit a research project to approximately 200-250 family physicians attending the scientific assembly. The research must be of interest and educational value to the specialty of family medicine and conducted by an NJAFP physician member, a New Jersey Family Medicine resident, or a New Jersey medical student.

Those wishing to submit a poster for consideration must be registered to attend the 2017 Scientific Assembly. Awards will be presented to original completed research in the physician and resident categories.

For application and instructions, visit [www.njafp.org](http://www.njafp.org) and follow the links from the 2017 Scientific Assembly.



## CALL FOR RESOLUTIONS

Let your voice be heard at the  
2017 HOUSE OF DELEGATES

NEW JERSEY is a cauldron of issues and NJAFP needs your voice to help us to craft a message that will resonate with our colleagues to improve the delivery of healthcare for patients and physicians everywhere. Quality of care and better outcomes should generate acceptable reimbursement models. New physicians need loan reimbursement programs that make staying in New Jersey a viable and attractive option.

Share your ideas and help us cut through the bureaucracy of medical red tape. Consider writing a resolution and plan to attend this year's House of Delegates. The HOD will convene at 8:00am on Friday, June 9, 2017 at Caesars Atlantic City. Visit [www.njafp.org](http://www.njafp.org) for information and regular updates.

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# Teaching Quality Improvement to the New Primary Care Workforce

■ SANDRA SELZER, MSHQ AND ANGIE HALAJA-HENRIQUES

Sandra Selzer, MSHQ is the VP of Healthcare Transformation for the NJAFP.

Angie Halaja-Henriques is a Program Director with NJAFP.

**L**EARNING THE SCIENCE of quality improvement is not easy, certainly not in the context of your average busy day in a family medicine office. If you are the only person trying to learn and implement quality improvement in a practice, it is almost impossible. It is especially difficult if you are not supported by the physicians and care teams around you. The only way to address this hurdle is by teaching the newest members of the primary care workforce - residents.



One of the most effective and popular elements of The Collaborative is peer interaction – time to talk with other practice teams about an intervention and brainstorm implementation.

This idea drove a handful of residency directors and AFP staff to create a learning collaborative of family medicine residency programs seven years ago in Pennsylvania. At the time, residency program curricula on quality improvement was non-existent, and residency practices weren't practicing QI in a meaningful way. The goal of the learning collaborative was to teach and practice QI in family medicine residency clinics and graduate residents who could work in or lead QI teams in their own practices.

"We knew we couldn't continue graduating residents with no experience in QI, and we couldn't wait for curriculum reform," explains William Warning, MD, program director at Crozer Key-

stone Family Medicine Residency Program in Pennsylvania, PA.

Over the course of its seven years, The Collaborative grew to include community health centers, and ultimately became the largest single-state residency program collaborative in the country. In 2016, NJAFP assumed management of The Collaborative and plans to expand its reach to include residency programs and community health centers in New Jersey and Delaware.

While the Collaborative's operating model is a learning collaborative supported by the Model for Improvement, the overriding "change package" is the Chronic Care Model and most importantly, patient-centeredness.

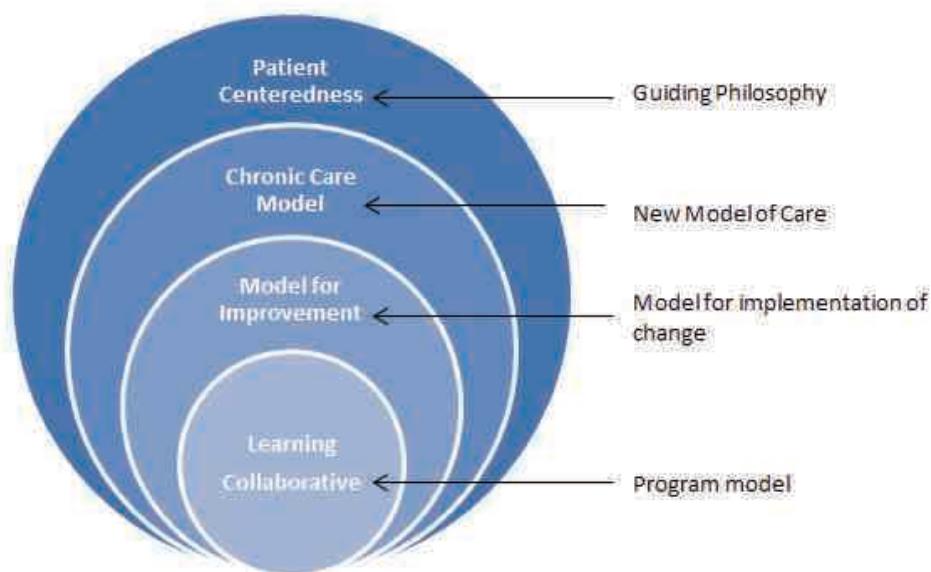
Evaluations and conversations with participants reveal that the Collaborative provides something special that practices and residents cannot get anywhere else – a platform to congregate with peers in similar practice types to learn, share ideas, and then work together on implementing those ideas.

The activities are similar to other improvement model learning collaboratives: two annual face-to-face events and monthly webinars. However, this

is not just a CME initiative, each practice develops their own Plan-Do-Study-Act (PDSA) template during the live learning session and heads back to the office to implement that plan.

The success or failure of that change is carefully measured. Successful PDAs should result in improved patient outcomes measured by data that is reported out of the practice EHR. Data is measured and reported regularly throughout the year. The Collaborative selects one or two clinical topics each year for its focus. In 2016, the Collaborative worked on adult prevention and looked at cumulative influenza and pneumococcal rates and monthly colorectal cancer (CRC) screening numbers.

For the past seven years, EHRs were the biggest barrier to QI work and it remains so. Practices can weather staff issues like retirement, illness or pregnancy. They can even work around unwillingness to change among staff, but others that cannot get their data out of the EHR, or don't trust the data they get, resort to chart pulls or eventually give up. This year's data submissions revealed three Pennsylvania residency clinics from big health systems with serious EHR data reporting issues – e.g., one





system doesn't provide access to CRC data; another no longer provides influenza data; and a third provides basically no access to practice-level data. The NJAFP has EHR experts on staff to help practices run reports and get their data. Staff are able to do work-arounds and find some type of data for the practice to use to guide their QI work. However, this is a perfect example of why our healthcare system needs EHR reform in order to move the needle on outcomes.

The addition of New Jersey and Delaware residency programs is the next chapter in the Collaborative's legacy. Participation has remained steady to date because it is a community, not just another project. Over the years, some practices have taken a break to address major issues, such as changing EHRs, the loss of multiple staff or a change in ownership/leadership, but the door is open and they come back. Collaborative staff and faculty are already onboarding New Jersey and Delaware programs, some of whom joined the Fall 2016 learning session in Harrisburg. The Spring 2017 learning session will officially kick off the new "**Tri-State Collaborative**" with teams from all three states and a new curriculum focusing on major depressive disorder. ▲

*If your residency program or community health center is interested in joining the Tri-State Collaborative, please contact Angie Halaja-Henriques at [angie@njafp.org](mailto:angie@njafp.org).*



Teams at the Collaborative's Fall 2016 Learning Session work on a PDSA.

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# Non-Discrimination in Health Care

SUSAN B. ORR, ESQ.

**O**N MAY 18, 2016, the U.S. Department of Health and Human Services (HHS) published a final rule implementing Section 1557 of the Affordable Care Act to advance health equity and reduce healthcare disparities. Under the rule, individuals are protected from discrimination in health care on the basis of race, color, national origin, age, disability and sex, including discrimination based on pregnancy, gender identity, and sex stereotyping.

The rule became effective July 18, 2016. Among other requirements, the Rule requires covered entities to post notices of nondiscrimination and taglines that alert individuals with limited English proficiency to the availability of language assistance services by October 16, 2016.

## Who are covered entities?

Section 1557 applies to healthcare providers, including physicians who participate in the Medicaid program.

## Notice and Tagline Requirements

The final rule generally requires each covered entity to **post a notice** stating that the covered entity:

- Does not discriminate on the basis of race, color, national origin, sex, age, or disability in its health programs and activities;

- Provides appropriate auxiliary aids and services, including qualified interpreters for individuals with disabilities and information in alternate formats, free of charge and in a timely manner (as well as how to obtain these aids and services); and
- Provides language assistance services, including translated documents and oral interpretation, free of charge and in a timely manner (as well as how to obtain these services).

In addition, depending on the notice or communication, covered entities **must post taglines** to their notice or communication that alert individuals with limited English proficiency to the availability of language assistance services in the top 15 languages spoken by individuals with limited English proficiency in New Jersey.

## Where to Post the Section 1557 Notice and Taglines

In general, the rule requires these notices and taglines to be posted in:

- Significant publications and significant communications targeted to patients and other members of the public;
- In the medical practice office where patients can view the notice; and

- A conspicuous location on the covered entity's website accessible from the home page of the covered entity's website.

Covered entities must also post grievance procedures for patients to follow.



## Copies of Sample Notices

Copies of sample notices and grievance procedure are available in the Final Rule. The sample notices are provided in a variety of languages along with a listing of the top 15 languages spoken by individuals with limited English proficiency for the 50 states, District of Columbia, and U.S. territories.

To obtain more information contact Susan B. Orr, Esq. at Rhoads & Sinon, LLP, [sorr@rhoads-sinon.com](mailto:sorr@rhoads-sinon.com), or by telephone: (610) 423-4200. You can also find the sample notices, policies and the translations by going to the HHS website under Civil Rights. ▲

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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 NJAHP Scientific Assembly.



# It's All About Attitude and Perspective

**NJAFP** board member Michael Cascarina, MD believes himself to be the luckiest guy in the world.

The self-described “crazy happy guy” has built a thriving privately owned, three-physician practice in Brick that enables Dr. Cascarina to practice medicine the way he enjoys – treating patients in a caring environment while developing strong bonds.

Like many family physicians, Dr. Cascarina treats patients of all ages – newborns to seniors – and has patients with two, three or even four generations of family members coming to the practice.

“Every day is different. We do pap smears, minor office procedures and joint injections, and even the occasional home visit,” he says. “The variation in the practice is what keeps things interesting.”

A mainstay in the community, Dr. Cascarina and *Our Family Practice* have called their Brick location home for 20 years, allowing Dr. Cascarina and his staff to develop relationships with neighboring businesses and residents.

“Our neighbors have become a second family,” says Dr. Cascarina. “We frequently visit each other’s businesses and talk about what’s been going on around town. A couple years ago, one of my patients who lives in the neighborhood behind the office was rebuilding an old car so I stopped to chat. Now, I spend most Friday afternoons in the summer working with him on his car.”

Patients and neighbors aren’t the only people who Dr. Cascarina has built relationships with during his 20 years. He often welcomes residents, medical students, physician assistants, and nurse practitioners into his office to gain some hands on experience.



**“Most of my patient visits are equal parts social and medical. I spend all day talking with patients.”**

“It is amazing to be around people with such enthusiasm to learn,” he says. “They have very positive, engaging personalities.”

Dr. Cascarina is very much a people person and admits he likes to chat, which is an important attribute for family physicians. “Most of my patient visits are equal parts social and medical. I spend all day talking with patients – I know who just got a job, whose kid is going to college,” says Dr. Cascarina. “I can spend time with a patient who I’ve been seeing since he was child and we can catch up on the local election and then I can see an 85-year-old patient and we’ll laugh through most of the visit.”

When confronted with difficulties, it’s Dr. Cascarina’s positive outlook that keeps him upbeat.

“When the economy was bad, yes it hurt. When malpractice rates increased in the 1990s, that didn’t feel so good either. An insurance company may not compensate us as much as we’d like, but how much can I complain about? Overall, we’re doing well,” he says.

Through and through, Dr. Cascarina couldn’t be happier to be a family physician. Each day brings something different, but he can always count on seeing the familiar, smiling faces of patients, coworkers and neighbors.

“While I am a family physician by trade, part of my job has nothing to do with medicine. I listen to my patients and build meaningful relationships with them,” says Dr. Cascarina. “In terms of importance, if the practice is doing well, money is way down the list. I just want to make people happy and healthy.” ▲



**Quiz ANSWERS:** 1. False; 2. True; 3. False; 4. True; 5. True; 6. True; 7. False; 8. True; 9. False; 10. True

# Direct Primary Care

## The Best Kept Secret for Primary Care Physicians

■ DR. AUREN WEINBERG

**M**OST PRIMARY CARE physicians today, especially those who operate a practice independently, are frustrated by declining reimbursements, piles of endless paperwork, rushed appointments, too many patient visits a day, and returning calls to people they feel they barely know. Many feel like they have lost control, that they work for the insurance companies instead of patients, and many are considering giving up the practice of medicine because they cannot make a meaningful impact with patients.

Direct Primary Care (DPC) can change all of that. DPC puts the physician back in control of patient care and running a practice, while giving the physician the time and resources to deliver better care and improved patient outcomes. It is medicine the way it should be.

DPC is a growing trend nationwide, and the New Jersey State Health Benefits Program recently launched a statewide Direct Primary Care Medical Home Pilot Program. This program provides DPC as a free enhanced benefit option for public sector employees and their family members who are enrolled in the State Health Benefits Plan (SHBP) and School Employee's Health Benefits Plan (SEHBP). There are close to half a million SHBP/SEHBP members across the state who are eligible for the program. The goal of the Pilot Program is to enroll 60,000 of these members in a Direct Primary Care Medical Home within three years. R-Health is one of two vendors who have been chosen to implement the DPC Pilot Program. The interest in DPC is expected to continue to grow as physicians and patients seek more quality care with convenience and accessibility.

Dave Chase of *Forbes* notes, "In my study of disruptive innovation in health care, I haven't seen anything come close to DPC in its positive impact on what health care works call the 'Triple Aim' (improved patient experience, health of the population and per capita costs)."<sup>1</sup>

DPC redesigns health care by liberating pri-

mary care from the bureaucratic headaches and cost burden of fee-for-service insurance billing. Instead, a reasonable monthly membership fee is paid directly by either the patient or the patient's employer. There are no co-pays, deductibles, insurance claims or collection headaches, just great patient-physician relationships and predictable cash flow. By changing the revenue model, physicians can have financial success while caring for fewer than half the number of patients seen in the fee-for-service model.

Employers who choose DPC for their employees reduce overall employee healthcare costs and increase employee productivity. A study by Qliance indicates that employers save about 20 percent in healthcare costs by providing DPC as a benefit.<sup>2</sup> Having a trusting, personal relationship with a physician leads to much lower healthcare costs and fewer missed days at work. The patient-primary care doctor connection eliminates unnecessary procedures, emergency department and urgent care visits, admissions, and readmissions. These cost savings more than offset the reduction in physician panel size, while improving patient health, and outcomes, along with both patient and physician satisfaction.

**D**PC physicians deliver comprehensive primary, preventive, urgent, and chronic care management while coordinating specialist care when needed. The model emphasizes strong doctor-patient relationships through convenient, accessible, affordable care, recognizing this relationship is the key to improving health and reducing overall healthcare costs. With DPC, the physician can regain the time and financial security to focus on delivering outstanding care for patients.

*The American Academy of Family Physicians* recently endorsed DPC as "a significant and positive contributor to expanding access to primary care for millions of patients, improving the quality of care provided by family physicians and increasing patient and physician satisfaction."<sup>3</sup>

DPC physicians are no longer driven by perverse incentives to see more patients, but instead

are allowed to focus on the quality of care provided to each individual. The combination of eliminating fee-for-service, reducing the patient panel size, and reemphasizing the physician-patient relationship, gives DPC physicians:

- More time with patients (the average visit time is 35 minutes compared to 8 minutes in the fee-for-service model)<sup>4</sup>
- Increased practice revenue
- Decreased practice overhead
- Need for fewer administrative office staff
- Less paperwork, including reduced insurance filings
- Fewer medical errors and thus, less risk exposure

The model eliminates time and resources wasted on insurance billing procedures and collections. With lower business overhead and dramatically less paperwork, primary care physicians are no longer forced to squeeze in an unmanageable number of patients and can instead take the time necessary with each patient to deliver high-quality, personalized care.

"I love getting up and going to work each day," says Dr. Steve Horvitz, R-Health's DPC Medical Director and a practicing DPC physician in Moorestown, New Jersey. "How many docs can say that?" ▲

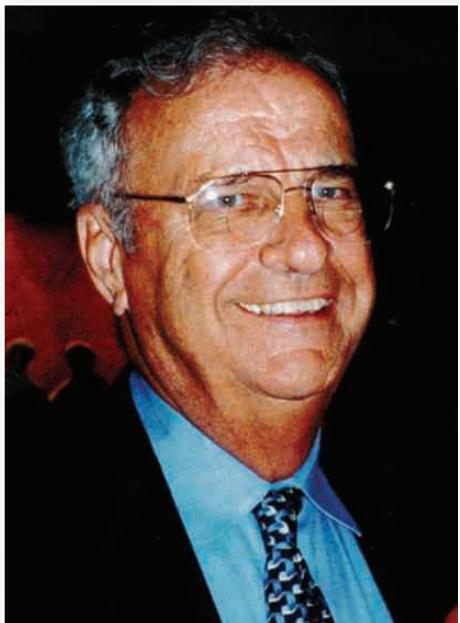
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Dr. Auren Weinberg is the founder of Lower Bucks Pediatrics and Vice President, Clinical Strategy and Network Development at R-Health ([www.R-Health.md](http://www.R-Health.md)).

# Thank You To All Who Contributed to the Foundation in Memory of Dr. Doyle



**M**ichael 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. Dr. Doyle joined the New Jersey Academy of Family Practitioners on May 1, 1964 and became one of its most passionate and influential members. Thank you to all those who made a donation to the NJAfp Foundation in Dr. Doyle’s name. ▲

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