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This program is a collaborative effort by the NJAFP and ArcheMedX. It is made possible by an unrestricted educational grant from Takeda Laboratories.

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Questions? Contact Theresa Barrett, PhD at Theresa@njafp.org





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You Want to Meet Where!?

One of my responsibilities at the NJAFP, besides being managing editor of *Perspectives*, is to serve as staff liaison to the NJAFP Education Committee. The committee members work very hard to provide content for the annual Summer Celebration & Scientific Assembly (SCSA), which focuses on the latest developments in therapeutic areas that are relevant to your practice. As the NJAFP meetings manager, I am responsible for the logistics of executing the educational plan, along with lots of assistance from other members of the NJAFP staff.

As a meeting manager, I find that my inbox fills up quickly with a lot of very interesting items. On a daily basis, I receive information about the latest concepts in serving nutritious meals that will help attendees to stay energized throughout the day (sorry, no turkey for lunch); how to choose the right “green” accessories for the meeting; what the latest “must have” app is for planning a successful meeting (more on that later); and, of course, tons of suggestions on where to hold the meeting.

I thought that it might be interesting to explore some of the more unique meeting venues in the world.¹ As you might expect, most of these...well...interesting hotels are in exotic locations. One such location is the Saariselka area of northern Finland (we are talking Arctic Circle country). Here you can view the Northern Lights from the warmth of your very own igloo, which is made entirely of glass, or ice, or both. Though the igloos are supposedly very comfortable, privacy is somewhat lacking.

If Finland is a bit too cold for you, then you might prefer to stay at the Adrere Amellal in Egypt. Built entirely of salt and mud, this eco-lodge is located in the middle of the Saharan oasis at Siwa and is surrounded by shifting sand dunes. It is only an 8-hour drive across the desert from Cairo. Did I mention that there is no electricity? The hotel is lit completely and only by candles.

Not up for globetrotting? There are unique hotels right in our own backyard. Check out Jules' Undersea Lodge, which rests at the bottom of the Emerald Lagoon in Key Largo, Florida. The lodge can accommodate two couples and comes complete with a microwave and a refrigerator. Although the views of the sea life are incredible, the only way to get to the lodge is if you happen to be a scuba diver.

For pet lovers, there is the Dog Bark Park Inn, located in Cottonwood, Idaho. This bed and breakfast is shaped like a giant beagle and can accommodate four people. The best part? Responsible pets that arrive with their well-behaved humans are welcome.

Rounding out the list is Kokopelli's Cave Bed & Breakfast in Farmington, New Mexico. This cave is not like those that you might have explored in your younger days. Although it is 21 meters (about 65 feet) below the surface and accessible only by hiking in, guests stay in a carpeted, fully furnished room dug into a cliff face of 65-million-year-old sandstone. If you are looking for privacy, this is the place.

Even though you will not find undersea accommodations or rooms dug into sand dunes at this year's SCSA, what you will find is a comfortable and welcoming environment that is focused entirely on you. As I write this article, we are putting the finishing touches on an educational program with topics that are built around your clinical practice. You will have time to network and catch up with old friends, and have opportunities to make some new friends and contacts. Read on to discover more about this year's SCSA.

Happy Reading,

Theresa J. Barrett, PhD, CMP, CAE
Managing Editor

P.S. If you want to learn more about the “must have” apps, stay tuned for the next issue of *Perspectives*.

References

1. CNN Travel. (2014). Retrieved from <http://www.cnn.com/2014/04/21/travel/15-quirky-hotels/index.html>

Interesting Times... Thomas A. Shaffrey, MD

Dr. Shaffrey is president of the New Jersey Academy of Family Physicians. He is in private practice in Bound Brook, NJ.

The origin of the expression, "May you live in interesting times," is unknown but the expression seems appropriate for family medicine right now. The challenges are numerous, have been around for some time and, in general, have not changed.

- **SGR (Sustainable Growth Rate) – the formula used to determine Medicare Payments** - Last fall a bipartisan agreement was reached to eliminate it. As the previous adjustment (#16) was about to expire, an agreement (#17) to replace that adjustment with a full year extension to 2015 was substituted by voice vote. At the Family Medicine Congressional Conference (FMCC) most federal legislators were unable to describe how this happened. As a secondary benefit of this fix, the implementation of ICD-10 was also postponed.
- **ACA (Affordable Care Act) and Insurers Terminating Contracts** - At a time when improving access to our services seems essential and logical, just the opposite is happening. Practices have little recourse to prevent this, especially in light of a long history of non-negotiable contracts. A recent article in *NJSpotlight*¹ that New Jersey is among the states where citizens have the greatest difficulty making appointments, and having access to primary care services.

If these issues give you reason to doubt the value of your Academy, I would tell you that such a view would not be worthy of the efforts that have been made on your behalf.

- **Prescription Drug Abuse** - Many states are considering or have already passed legislation which requires physicians to check a prescription data base prior to writing for controlled substances to determine if the patient is receiving such medications from other sources. This approach, while hopefully reducing such prescriptions, does not seem to have measures to deter individuals from attempting to obtain prescriptions from multiple offices.
- **Scope of Practice** - Due to the aforementioned problems with primary care access, there have been multiple proposals to "open" the field of primary care to others in the health-care community, with the argument that with their training, although significantly less than that required of physicians,

other individuals will be able to substitute for a fully trained primary care physician.

- **Payment Reform** - New Jersey is one of the highest ranked cost-of-practice states, yet is ranked near the lowest in payments for primary care services from all sources. This has continued despite practices' investments in Meaningful Use and the Patient-centered Medical Home (PCMH) model. Changing this is vital to preserving the independence of members and their existing practices as well as being able to keep and attract graduating residents. At the recent AAFP Annual Leadership Forum this topic was listed among the top issues in the new Future of Family Medicine project. Resources for members, including information on Direct Patient Care models is available or will become available in the near future.

If these issues, and many others, give you reason to doubt the value of your Academy, I would tell you that such a view would not be worthy of the efforts that have been made on your behalf. These issues are serious, and as such deserve the time and resources of your Academy, which they have received repeatedly. As from my inaugural address, many of these challenges are not really new, just former issues in a new guise. We have been diligent in attempting to educate legislators and regulators about the realities of practicing primary care in this state, which was declared a "Distressed Primary Care Environment" by the AAFP in 2011. Unfortunately, there are still many people who do not understand that not actively supporting primary care will have a significant negative impact on the quality of care in this state in the near future.

The future is not bleak, just the opposite, we have a great deal of potential to put health care in this state back on track. Those members who have given their time and energy to representing you will not be as successful doing so without your support and even more so, your participation in these efforts. As in past years, I ask that you become active in your Academy, let us know of your problems which are likely shared by many of your colleagues, consider becoming a key contact to your legislator as part of the NJAFP's governmental affairs program and actively lend your voice to the efforts to change New Jersey from a "primary care desert" to an oasis.

This is my last article for *Perspectives* as President. It has been an honor to represent the NJAFP. In June, I will turn over the office of President to Dr. Krishna Bhaskarabhatla. I will support him in his efforts to improve the primary care environment in this state. I ask that you do the same. ▲

Reference

1. <http://www.njspotlight.com/stories/14/04/16/jerseyans-find-it-hard-to-find-doctors-who-accept-their-insurance/>



THE GREATEST THING

Raymond J. Saputelli, MBA, CAE

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

If you have never heard of Max DePree, it might be worth a trip to the Internet to find out more about him. He is the guru for what is known as 'relational leadership.' Relational leadership is the relational process of people working together attempting to accomplish change or make a difference to benefit the common good. Perhaps in another column I will talk more about how Max and relational leadership are relevant to our family medicine journey. But for now, I want to talk about the fact that very shortly current NJAFP leaders will come together to do the work the Academy needs to do in order to ensure the future of family medicine. And we are asking you to join us.

The NJAFP House of Delegates, the principal governing body of the Academy, will meet on June 13th at the Sheraton Atlantic City Convention Center Hotel. I know you are asking: "What good would it do for me to be there? Things are what they are." The question is easy to answer. At the risk of being a bit cliché, "If not you, then whom?" Many times I have written to you to say NJAFP is the only organization in the state exclusively dedicated to the support of and advocacy for family physicians and family medicine. There is no other entity that is totally focused on you and your success. True, other organizations represent family physicians, but as part of a larger constituency. None represent you as a family doc without any conflicts. This is not as easy as it sounds. We are not a homogenous group. In fact, I believe that family medicine is among the most diverse of specialties. We serve different cultures and societies. We all work in differing locales, from clinics to solo practice to hospitals, and everything in-between. We have very wide "full-spectrum of family medicine" practices, and more narrowly focused scopes. We are similar, but far from the same. For these reasons, it is critical that we have leadership who can bring diversity to our dialogue to ensure that as we debate issues, strive for change, form opinions, reach consensus, and ultimately make policy, that all perspectives and voices are heard.

Things are what they are? Only if we let them be by remaining exactly as we are today. Our work is hard and long and does not make for splashy headlines. That doesn't make it any less critical. We are at a pivotal time in our state, and our country. The delivery and payment for health care is changing. We must change with it. Family medicine is at a potentially precarious juncture, poised on the sharp edge between crisis and opportunity. While many, including me, believe that we are at the beginning of a renaissance for primary care and family medicine, others fear the imminent demise of the discipline. Almost daily there is some reason for each of those opinions to be reinforced.

The NJAFP staff and leaders are working every day to transform our current state into what we want to become... a state where high quality primary care is delivered by well-trained, highly skilled, efficient, effective, satisfied, and happy family physicians. We are dedicated to ensuring the positive outcome for which we all hope, and that we as citizens and at some point patients, deserve.



The work is slow and deliberate. Every time a group of family physician leaders debate an Academy position, reach consensus, and formulate a policy around an issue; each time a family physician leader, or member of the NJAFP staff has a conversation with a legislator about that policy, in each interaction with a member of the media, we take another step forward. For example: A conversation in 2009 about helping family physicians in New Jersey prepare for opportunities to participate in innovative programs designed to change the way primary care is delivered and valued led to the selection of New Jersey as one of the first regions for

"We cannot become what we need to be by remaining what we are." – Max DePree

the roll-out of the Comprehensive Primary Care Initiative, which is still ongoing with over 60 New Jersey practices involved.

We change the way things are. That is the good that it does.

For those of you who may still wonder what happens at the House of Delegates, consider that over the course of the day we will not only debate and formulate policy that will guide the NJAFP's work in the coming year, but also shape our dialogue with the AAFP. We will communicate with leaders from a number of healthcare stakeholder organizations, allowing us to share perspectives, gain new understanding, and perhaps even shape opinions. Guests as of the time of this writing include: AAFP President-Elect Bob Wergin, MD, and representatives from other stakeholders in family medicine.

I encourage you to go to www.njafp.org/SCSA and click on Call for Resolutions and Nominations for more information on

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Perspectives: A View of Family Medicine in New Jersey

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The Dangers of Indoor Firing Ranges

According to Beaucham, et al. (2014), the biggest danger to the employees and customers of indoor firing ranges is not hearing loss, but lead poisoning.¹ According to data culled from the CDC's Adult Blood Lead Epidemiology and Surveillance program from 2002 to 2012, 2,056 persons in the categories of "police protection" and "other amusement and recreation industries (including firing ranges)" were diagnosed with elevated blood lead levels; an additional 2,673 persons had non-work-related elevated blood lead levels that were likely due to target shooting.



In addition to employees of firing ranges, customers and family members of employees also can be exposed to hazardous amounts of lead. According to the National Shooting Sports Foundation, there are an estimated 19 million active target shooters in the United States.² Patients who present with elevated blood lead levels should be asked about their engagement in occupations and hobbies that might involve lead.

The New Jersey Department of Health has a downloadable resource, "Lead bullets and Firing Ranges: Protect Yourself and Your Family." This resource is available at http://www.nj.gov/health/surv/documents/firing_range_fs.pdf

Reference

1. Beaucham, C., Page, E., Alarcon, W. A., Calvert, G. M., Methner, M., & Schoonover, T. M. (2014). Indoor firing ranges and elevated blood lead levels: United States, 2002-2013. *Morbidity and Mortality Weekly Report*, 63(16), 347-351.
2. National Shooting Sports Foundation. The shooting sports, 2014. Retrieved from <http://www.nssf.org/shooting/sports>

What Have You Done For Me Lately?

In an *NJSpotlight* article about the ability of patients to find physicians who accept their health insurance, NJAFP Executive Vice President **Ray Saputelli, MBA, CAE**, was quoted as saying, "The high cost of practicing in the state threatens to make New Jersey a 'primary-care desert.' The academy wants the state government to reduce family doctors' medical school debt, among other steps to encourage them to practice in the state."

NJAFP President **Tom Shaffrey, MD** (Bound Brook); President-Elect **Krishna Bhaskarabhatla, MD** (Clifton); Resident Trustee Gerald Banks, MD (Trenton); and Executive Vice President **Ray Saputelli, MBA, CAE** represented New Jersey at the Family Medicine Congressional Congress held in early April in Washington, DC.

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Update on the New Jersey Department of Health Budget and Key Initiatives

Mary E. O'Dowd, Commissioner, New Jersey Department of Health

The New Jersey Department of Health's (NJDoH) budget of \$1.8 billion reflects Governor Chris Christie's priorities to strengthen the healthcare safety net, build healthier communities, and work smarter.

The budget strengthens our leadership on public health issues. New Jersey was the first state to ban the use of e-cigarettes in public places in 2010 as part of the Smoke Free Air Act. This year's budget proposes tax parity for e-cigarettes. E-cigarette use among middle and high school students doubled between 2011 and 2012, and according to the Centers for Disease Control and Prevention (CDC), increasing prices can be an effective strategy to curb the rate of smoking among our youth. This initiative is about protecting our children from a lifelong addiction to nicotine.

In the area of health care, the budget continues to invest more than \$1 billion in hospitals and federally qualified health centers (FQHCs). To be specific, Charity Care received \$650 million in funding, Graduate Medical Education received \$100 million in funds, and the Delivery System Reform Incentive Payment (DSRIP) program received \$166.6 million in support. The DSRIP is the first state subsidy program to reward hospitals for improving quality. The NJDoH also continues to support FQHCs at the same rate for their care to patients who are uninsured.

In recognition of April as Autism Awareness Month, researchers gathered at the Autism Center of Excellence at Montclair State University on April 9 to discuss how their clinical research can be translated into new ways of preventing, diagnosing, and treating autism spectrum disorders (ASDs). Since 2008, the Governor's Council for Medical Research and Treatment of Autism has provided nearly \$25 million in research grants.

According to the CDC, autism affects 1 in 45 children in New Jersey and 1 in 68 nationally. Fortunately, we have one of the best systems in the nation for identifying, diagnosing, and documenting children with ASDs. Governor Christie's budget has allocated \$135 million to our Early Intervention System, which provides early

identification as well as referral and service coordination for children up to the age of 3 years who have developmental delays and disabilities.

Improving maternal and child health is another critical component of our work. We are collaborating with the March of Dimes and the National Governors Association to reduce premature births and improve birth outcomes. Although the NJDoH is taking the lead, this initiative is a coordinated effort among the Departments of Education, Children and Families, and Human Services. Our progress was recognized when the State was recently awarded a B on the March of Dimes Premature Birth Report Card, up from a D in 2008, and our initiatives were cited as contributing factors.

The New Jersey Department of Education also has collaborated with communities on successful disease prevention and public education efforts. We recently worked with

health agencies. To date, only two states have achieved accreditation.

Under the leadership of the NJDoH, we've also made significant progress in the use of health information technology. Three regional planning teams are merging data from public health agencies and hospitals to improve patient outcomes. These teams are sharing data to identify frequent emergency department users and improve access to primary care to better manage illness and avoid hospitalization. This work will be expanded through the NJDoH's Health Information Network, a statewide exchange that allows healthcare providers, hospitals, and other stakeholders



New Jersey was the first state to ban the use of e-cigarettes in public places in 2010 as part of the Smoke Free Air Act.

Princeton University and other partners to implement infection control activities in a campaign to reduce the risk of meningitis, resulting in more than 90% of students receiving a vaccination against the Serogroup B strain of the bacteria. As another example, the NJDoH worked closely with the Monmouth County Health Department to manage more than 50 cases of mumps in an outbreak last summer that affected the entire state. We worked with local health agencies to monitor for possible new illness and provide vaccinations.

The NJDoH also remains committed to working smarter within our own agency. We are pursuing public health accreditation as part of a national movement to standardize services across local and state

to share patient information securely and in real time.

By sharing data, healthcare providers can view critical information, track patients' medications and test results, avoid unnecessary procedures, and improve patient outcomes. The network allows providers to access immunization status and exchange information statewide. The network connects 62 hospitals, long-term care facility providers, laboratories, radiology centers, and more than 9,000 physicians. The NJDoH used \$11.6 million in federal funds to develop regional health information organizations and connect them through the network. Through all of these efforts, the NJDoH continues to strive to improve and protect the health of our residents. ▲

CME

Mindfulness in Medicine

Jodie Katz, MD

Jodie Katz, MD is a family physician at Valley Health Medical Group, a certified yoga instructor and teacher of Mindfulness-Based Stress Reduction in Walwick, NJ.

What is mindfulness, and why is it important to patients and physicians alike? First, let's start with what mindfulness is not. It is not trying to achieve a special state of mind or going into a trance. It is not about thinking positive thoughts, or imagining yourself to be someplace other than where you are right now.¹ According to Jon Kabat Zinn, Professor of Medicine Emeritus and founding director of the Stress Reduction Clinic and the Center for Mindfulness in Medicine, Health Care, and Society at the University of Massachusetts Medical School, mindfulness is paying attention in a particular way, intentionally, in the present moment and non-judgmentally.² It is paying attention to the present moment with non-preferential curiosity and a willingness to be with the experience as it unfolds.

Mindfulness training develops a nonjudgmental, nonreactive attention to the present moment experience that allows practitioners to see their habitual patterns of thought and reactivity as they occur. In turn, this attention allows other possible new and creative responses to be recognized. Such attention often results in a greater sense of equanimity and well-being.

Unlike other animals, we human beings spend a lot of time thinking about things not actually going on around us; instead we remember events that happened in the past and concern ourselves with what might happen in the future. When used intentionally, this uniquely human capability allows us to learn from the past and plan for the future. However, it also is the "default mode network" of the mind, or "mind wandering." This mind wandering is stimulus independent and is what the mind defaults to when it is not engaged in anything in particular.

Killingsworth and Gilbert conducted a study to investigate the emotional consequences of mind wandering. They determined that in their sample group, the participants' minds wandered frequently, in fact, nearly 50% of the time, and that the individuals were less happy than when they were fully engaged in their present moment experience.³

It appeared that what an individual was doing was a weaker determinant of happiness than whether or not the individual was fully engaged in the activity. The researchers concluded, "A human mind is a wandering mind, and a wandering mind is an unhappy mind. The ability to think about what is not happening is a cognitive achievement that comes at an emotional cost."³

Mindfulness practice counteracts this tendency towards proliferative, non-engaged thinking by continually bringing the practitioner back to awareness of the direct, present moment experience.

It is important to recognize that this tendency of the mind also has physiological consequences. All animals with a central nervous system have a stress response that involves the sympathetic component of the autonomic nervous system and the hypothalamic-pituitary-adrenal axis. However, what triggers that response varies considerably by species. For instance, sympathetic arousal in reptiles is precipitated only as the result of hunting for food, running from a predator, or experiencing actual physical injury. In mammals, it also can be evoked by emotional stress, such as the threat of an outside male coming too close to the territory of a rival.

It is important to note that both of the aforementioned physical and emotional stressors are events occurring in the present. The stress response ends when the precipitating event has resolved, at which point a parasympathetic tone predominates and the physiology returns to its resting state. Because the human species is uniquely capable of remembering the past and projecting into the future, we are the only animals who can actually create a stress response all day long. In other words, the stress response system that evolved to respond to imminent, life threatening events can be triggered by a human mind thinking about credit card debt. This is what we think of when we talk about "chronic stress."

It can be easy to think that all stress is detrimental, but this is not the case. In fact, we enjoy some forms of stress and do not think of them as stress. Instead, we refer to them by such terms as excitement, challenge, or interest. Typically, this form of stress is generally of short duration; of moderate degree; perceived as being manageable by the individual; and often associated with growth, accomplishment, and reward. This form of stress involves a mild-to-moderate sympathetic response as well as dopaminergic pathways and endorphin release.

Chronic stress is very different. Its defining characteristics are a lack of long-term support for the individual, with the sense of no escape, no physical release, and no sense of control. Investigations into the effects of chronic stress have shown a substantial negative impact on physical and mental health.^{4,5}

Examples of chronic stress include conflict-laden family relationships, childhood abuse, adverse physical or social conditions, and stressful life events. Such stressors can actually impact brain structure, particularly in areas associated with emotional regulation, anxiety, and executive function such as the hippocampus, amygdala, and prefrontal cortex.⁵ These alterations can affect "patterns of emotional expression and regulation, stress reactivity, recovery,

and coping, and perhaps even the rate of bodily aging.”⁵

However, research into neuroplasticity has shown the brain's ability to change its structure in response to environmental stimuli. These changes in the brain might be, at least in part, reversible.⁵ Studies of patients and healthy volunteers have shown that meditation impacts brain function. Research into one particular program, the “Mindfulness-Based Stress Reduction Program (MBSR)” has shown a positive impact on depression, anxiety, and pain perception, and a decrease in psychological distress.^{6,7}

Other studies have shown changes in brain activity using functional neuro-imaging methods.⁸ One study showed that after participating in an 8-week program, the individuals exhibited increased cortical thickness in the left hippocampus, posterior cingulate cortex, and temporal-parietal regions of the brain. The results suggested that participation in the MBSR was associated with changes in gray matter concentration in brain regions involved in learning and memory processes, emotion regulation, self-referential processing, and perspective-taking.^{9,10} The results from these studies supported Treadway and Lazar's premise that mindfulness meditation training induces changes in emotion, awareness and attention that can be identified and assessed at subjective, behavioral, and neurobiological levels.¹¹

Physicians are not exempt from the stress of daily life and might even experience greater-than-average stress as the result of daily exposure to patients in distress and escalating pressures from a healthcare system in the midst of dramatic change. Being unable to cope successfully with the demands of medical practices can have cascading consequences that can affect a physician on personal levels (emotional, spiritual, and physical health) and professional levels (diminishing the quality of the doctor/patient relationship).¹² ‘Burnout,’ defined as emotional exhaustion, depersonalization (treating patients as objects), and low sense of accomplishment, is a component of stress and is experienced by up to 60% of practicing physicians.¹³ Evidence has suggested that burnout affects the quality of patient care.¹⁴ Despite the prevalence of burnout, few interventions for clinicians have been shown to improve work-life balance.

In 2009, Krasner, et al. demonstrated that a 12-month program incorporating mindfulness, narrative medicine, and appreciative

inquiry was able to decrease burnout among the study participants significantly. Several other studies of interventions for healthcare providers, including a recent study of a condensed mindfulness intervention,¹⁵ have shown that shorter interventions also improve markers of physician well-being. Thus, mindfulness training and practice might be of benefit to patients and clinicians in living with the life challenges that face us all.

References

1. Bauer-Wu, S. (2011). *Leaves gently falling*, Oakland, CA: New Harbinger Press.
2. Kabat-Zinn, J. (1994). *Wherever you go, there you are: Mindfulness meditation in everyday life*. New York, NY: Hyperion.
3. Killingsworth, M. A., & Gilbert, D. T. (2010). A wandering mind is an unhappy mind. *Science*, 330, 932.
4. Thoits, P. A. (2010). Stress and health: Major findings and policy implications. *Journal of Health and Social Behavior*, 51(5), S41-S53.
5. McEwen, B. S., & Gianaros, P. J. (2010). Central role of the brain in stress and adaptation: Links to socioeconomic status, health, and disease. *Annals of the New York Academy of Science*, 1186, 190-222.
6. Bohlmeijer, E., Prenger, R., Taal, E., Cuijpers, P. (2010). The effects of mindfulness-based stress reduction therapy on mental health of adults with a chronic medical disease: A meta-analysis. *Journal of Psychosomatic Research*, 68, 539-544.
7. Reibel, D. K., Greeson, J. M., Brainard, G. C., & Rosenzweig, S. (2001). Mindfulness-based stress reduction and health-related quality of life in a heterogeneous patient population *General Hospital Psychiatry*, 23(4), 183-192.
8. Keng, S. L., Smoski, M. J., & Robins, C. J. (2011). Effects of mindfulness on psychological health: A review of empirical studies. *Clinical Psychology Review*, 31(3), 1041-1056.
9. Hölzel, B. K., Carmody, J., Vangel, M., Congleton, C., Yerramsetti, S. M., Gard, T., & Lazar, S. W. (2011). Mindfulness practice leads to increases in regional brain gray matter density. *Psychiatry Research: Neuroimaging*, 191(1), 36-43.
10. Lazar, S. W., Kerr, C. E., Wasserman, R. H., Gray, J. R., Greve, D. N., Treadway, M. T., ... Fischl, B. (2005). Meditation experience is associated with increased cortical thickness. *Neuroreport*, 16(17), 1893-1897.
11. Treadway MT, Lazar SW. The neurobiology of mindfulness, in C Treadway, M. T., & Lazar, S. W. (2009). *The neurobiology of mindfulness*. In F. Didonna (Ed.), *Clinical handbook of mindfulness*. New York, NY: Springer *Clinical Handbook of Mindfulness*, F. Didonna, (Ed.) (2009). New York, NY: Springer.
12. Shapiro SL, et al. Mindfulness-based stress reduction for healthcare professionals: Results from a randomized trial. *International Journal of Stress Management*, 2005. 12(2):164-176.
13. Krasner, M. S., Epstein, R. M., Beckman, H., Suchman, A. L., Chapman, B., Mooney, C. J., & Quill, T. E (2009). Association of an educational program in mindful communication with burnout, empathy, and attitudes among primary care physicians. *Journal of the American Medical Association*, 302(12), 1284-1293.
14. Shanafelt, T., & Dyrbye, L. (2012). Oncologist Burnout: Causes, Consequences, and Responses. *Journal of Clinical Oncology*, 30(11), 35-1241
15. Fortney, L, Luchterhand, C, Zakletskaia, L, Zgierska, A, Rakel, D. (2013) Abbreviated mindfulness intervention for job satisfaction, quality of life, and compassion in primary care clinicians: a pilot study. *Annals of Family Medicine* 11(5) 412-420.



NJAFP offers CME online

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

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





COMMUNICATION DELAYS: Common Misconceptions

Virginia Li

Virginia Li is a communications associate at Pathways.org, a national not-for-profit organization dedicated to providing free resources and information for health professionals and families on children's motor, sensory, and communication development.

Popular misconceptions regarding communication delays in boys, bilingual children, and younger siblings may prevent these groups of children from getting the help they need. All children who show the early warning signs of a delay should immediately be referred for a developmental screening by a speech-language pathologist. Developmental screenings are typically free and last approximately 15 minutes. Early detection and treatment give children with communication delays a greater chance of improving with speech therapy.

Misconception #1: *It is normal for boys to show delays in speech and language.* While boys tend to acquire communication skills at a slower rate than girls, they should still fall within the typical age range for major milestones.^{1,2} Any signs of a communication delay in both boys and girls should be addressed in a timely manner.

Misconception #2: *Bilingual children talk later than monolingual children.* Bilingual children will reach communication milestones at the same pace as their monolingual peers, with first words appearing around 11 to 14 months.^{3,4} Total vocabulary growth is the same between typically developing bilingual and monolingual children when every language is taken into account.

Misconception #3: *Younger siblings talk later because their older siblings talk for them.* All children are motivated to communicate their own needs and wants as soon as they can. Studies have shown that there are no differences in general communication development between first-born children and later-born children.^{5,6}

Communication delays, ranging from hearing and oral-motor issues to difficulties with language comprehension and production, can be detected within the first year. If an infant does not seem to respond to sounds or faces, or is not producing age-appropriate coos, babbles, or words, refer him or her for a screening. Pediatric therapy clinics typically offer free developmental screenings to help all children reach their fullest potential.

Additional information regarding communication delays can be found at Pathways.org, or you can email friends@pathways.org, or call our toll-free parent-answered hotline at 1-800-955-CHILD (2445).

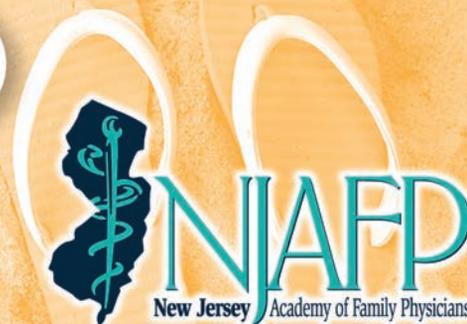
References

1. Özçalskan, S, Goldin-Meadow, S. Sex differences in language first appear in gesture. *Developmental Science*. 2010; 13(5): 752-760.
2. Huttenlocher J, Haight W, Bryk A, Seltzer M, Lyons T. Early vocabulary growth: relation to language input and gender. *Developmental Psychology*. 1991; 27(20): 236-248.
3. Petitto, LA., Holowka, S. Evaluating attributions of delay and confusion in young bilinguals: special insights from infants acquiring a signed and spoken language. *Sign Language Studies*. 2002; 3(1): 4-33.
4. Werker, JF, Byers-Heinlein, K. Bilingualism in infancy: first steps in perception and comprehension. *Trends Cogn Sci*. 2008; 12(4): 144-151.
5. Oshima-Takane Y, Goodz E, Derevensky J. Birth order effects on early language development: do second born children learn from overheard speech? *Child Development*. 1996; 67(2): 621-634.
6. Tomblin, JB. The effect of birth order on the occurrence of developmental language impairment. *Br J Disord Commun*. 1990; 25(1): 77-84.

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CME QUIZ

Instructions: Read the articles designated with the  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 8 Prescribed credits by the American Academy of Family Physicians. AAFP certification begins January 1, 2014. Term of approval is for two years from this date. Each issue is approved for 1 Prescribed credit. Credit may be claimed for two years 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: Mindfulness is about thinking positive thoughts.
2. True or False: Through the practice of mindfulness, practitioners develop a nonreactive, nonjudgmental attention to the present.
3. True or False: The unique human capability to remember what has happened and anticipate what may happen allows us to learn from the past and plan for the future.
4. True or False: A study by Killingsworth and Gilbert showed that when people's minds wander, they are actually happier than when their minds were fully engaged in the present moment.
5. True or False: In humans, the stress response, which involves the sympathetic component of the autonomic nervous system and the hypothalamic-pituitary-adrenal axis, can be generated even after the precipitating event has ended.
6. True or False: Stress can also be synonymous with excitement, interest, and challenge.
7. True or False: Studies have shown no structural changes in the brains of those individuals practicing "Mindfulness Based Stress Reduction."
8. True or False: Bilingual children will develop speech capability at a slower rate than monolingual children.
9. True or False: Children communicate their own needs and wants as soon as they can, regardless of whether or not they have older siblings.
10. True or False: Within the first year of a child's life it is possible to recognize communication delays, ranging from hearing and oral-motor issues to difficulties with language comprehension and production.

ANSWERS ON PAGE 23

In the News...

Executive Vice President, Ray Saputelli, MBA, CAE (*Trenton*), was quoted in an *NJSpotlight* article that commented on the ability of New Jersey patients to find physicians who will accept their insurance. He highlighted the fact that the primary care environment in the state does not support family medicine and that "the ACA, as hopeful as it might be in terms of covering people, is going to expose and exacerbate the creation of that desert pretty quickly if we don't change some things." To read the article, go to <http://www.njspotlight.com/stories/14/04/16/jerseyans-find-it-hard-to-find-doctors-who-accept-their-insurance/>

In a separate *NJSpotlight* article, Mr. Saputelli spoke about the trend toward retail clinics in pharmacies. Referring to this growing trend, he stated, "The danger to it in my mind is that in the attempt to make the model convenient, which is a good thing, we could further fragment an already broken system." To read the full article, go to <http://www.njspotlight.com/stories/14/03/06/pharmacy-based-clinics-present-opportunities-challenges-in-primary-care/>

Sloan Robinson, MD (*Marlton*), and his practice, Meeting-house Family Physicians, were featured in a *Philly.com* article focused on their quest to incorporate electronic medical records into their practice. To read the article, go to http://articles.philly.com/2014-04-18/business/49217436_1_doctors-struggle-emr-robinson

Jeff Brenner, MD (*Camden*), blogged about the state of health care and what must be done to transform the current systems. The blog, *A World of Darkness: What If Thomas Edison had to Write Grant Proposals to Invent the Light Bulb?*, can be found on the Health Affairs website at www.healthaffairs.org

NJAFP Wins Membership Awards

The NJAFP received an award from the AAFP for the highest percentage increase in active membership as of December 31, 2013. The NJAFP also received an award, Chapters at 100% for Resident Membership for 2013-2014, based upon its standing as of March 31, 2014. The chapter was recognized for these achievements at the ALF/NCSC luncheon held Friday, May 2, in Kansas City.

Congratulations to all NJAFP members!

Experience the MDD Virtual Classroom

ARCHEMEDX AND THE NJAFP have launched the first-ever virtual course with educational activities that carry a total of 5.25 AAFP Prescribed credits. The virtual course is being offered in conjunction with an NJAFP-developed program on major depressive disorders that is taking place in seven state Academy chapters.



The virtual course, which is powered by ArcheMedX, offers members of each participating state chapter an entirely new way of

connecting learning to practice as they dive deeper into the topic of treatment of major depressive disorder through a curriculum of self-directed lessons and collaborative learning activities that re-create the critical elements of small, problem-based workshops in a secure online setting.

Attendees of the NJAFP Scientific Assembly will gain exclusive entrance into this virtual course. Plan to join us in Atlantic City to learn more. Sign up now! www.njafp.org/SCSA

With Sympathy...

The NJAFP extends condolences to the family of NJAFP staff member **Cari Miller**. Her brother, Darin Miller lost his battle with ALS and passed away in April.

Congratulations

David E. Swee, MD (*New Brunswick*), received the Excellence in Medicine Award for Outstanding Medical Educator. Dr. Swee is the associate dean for Faculty Affairs and Development, the associate dean for Education, and a professor of Family Medicine and Community Health at Rutgers Robert Wood Johnson Medical School. The Excellence in Medicine Awards are named after Edward J. Ill, MD, a New Jersey physician who was a pioneer in promoting continuing education in ways that set the national standard.

Karen Lin, MD (*New Brunswick*), has assumed the position of assistant dean for Global Health at Robert Wood Johnson Medical School. She will be working with Dr. Javier Escobar, associate dean for Global Health, to continue expanding the school's liaisons overseas, many of which Dr. Lin started.

Barbara Jo McGarry, MD (*New Brunswick*), associate professor of Family Medicine and Community Health, has been named program director for the RWJUH Family Medicine Residency.

Have you registered for the 2014 Summer Celebration & Scientific Assembly (SCSA)?

You still have time to register for the 2014 SCSA.

There is a lot going on this year, so you won't want to miss it! Check out these highlights:



NJAFP Poster Contest

Family physicians, residents, and students will be presenting the latest research focused on family medicine in New Jersey.



Resident Knowledge Bowl ▲

Last year featured 11 residency teams and three mystery judges. What will this year hold? You won't know unless you are there.



President's Gala ▲

Join the Academy in honoring incoming president, Krishna Bhaskarabhatla, MD; new members of the board of directors; and NJAFP award winners. Dance the night away to the incredible music of Kenny I.

Time to grab your flip flops and head to the shore:

2014 Summer Celebration & Scientific Assembly

June 13-15 • Atlantic City, NJ

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Exhibit Hall ▼

The Exhibit Hall will host more than 35 exhibitors from all facets of family medicine and industry. Drop by to say, "Hi" and "Thank you." The exhibit hall helps to make the SCSA possible.



SAM Study Hall

Don't forget that you can complete your SAM with a passing grade by joining your colleagues in the SAM Study Hall. This year's topic is Congestive Heart Failure. The study hall will be moderated by family physician, Ryan Kauffman, MD.

To register for the meeting, go to www.njafp.org/SCSA, and follow the links.

**Join us for the Pre-Conference Symposium -
Advanced Topics in Healthcare Delivery 2014:
Ensuring a Viable Practice Using Patient-
Centered Approaches**

Thursday, June 12

Go to www.njafp.org/SCSA and follow the links to the Advanced Topics Symposium.

Earn up to 14.5 Prescribed Credits in One Weekend

The NJAFP Education Committee has developed an educational program designed to improve your knowledge and skills in important areas of clinical practice. Check out what's in store.

Influenza, More Than You Think (*William R Sonnenberg, MD*)

Think that influenza is just another respiratory illness? Think again. Explore the history of the 1918 influenza pandemic, the worst pandemic in history. Explore the diagnosis and recognition of influenza, and find out ways to differentiate it from other respiratory infections. Conclude the session with a discussion around the influenza vaccination, especially for you and your office team.

Burnt! (*Chantal Brazeau, MD*)

You go through each day trying to do the best for your patients, your staff, and your family, but each day is harder than the last, and the joy that you used to find in being a family physician is elusive. Attend this session to learn to recognize the symptoms of physician burnout and ways to deal with it.

You Want Me To Do What? Motivational Interviewing for Weight Loss (*Frank Domino, MD*)

How often have you heard that from those patients you counsel to lose weight? In this session, you will learn how to meet patients where they are in their readiness to change and then work together using motivational interviewing to develop plans that meet the needs of patients.

Protect Your Patients' Bones: An Update on the Prevention, Diagnosis, and Treatment of Osteoporosis

(*Jeff Levine, MD, MPH*)

As the U.S. population ages, so, too, does the prevalence of osteoporosis. Unfortunately, we might not even realize that a patient has osteoporosis until we are confronted with a broken hip or wrist. This session will provide an update on the evidence-based recommendations for the prevention and screening of osteoporosis, along with the latest treatment options to prevent osteoporosis-related fractures.

The Perfect Storm (*Peter Anderson, MD*)

The era of Obama Care could see the salvation of primary care in the United States, or it could mean the extinction of the family physician. In this session, family physician and author Peter Anderson describes the sea change in healthcare reform and offers his unique perspective on the ways in which team care medicine can help family physicians to survive the storm.

Dementia: Preserving Future Memories

(*William R Sonnenberg, MD*)

Dealing with dementia is challenging from diagnosis and into the future. Can you recognize Alzheimer's disease and differentiate it from other forms of dementia? This session will explore the world of dementia, available treatments, and possible prevention strategies.

The Changing Landscape of Outpatient Detox, Behavioral Health, and Primary Care (*Ken Faistl, MD*)

Patient-centered care for those suffering from substance abuse needs to encompass a full range of services. Family physicians can manage the care of patients suffering from substance abuse by creating clinical frameworks and partnering with organizations that can support these high-risk patients on the road back to health. Dr. Ken Faistl presents a real world case study being implemented in Monmouth County to ensure that these patients receive care in the least expensive and most successful settings.

BLITZ! Everything You Need to Know Right Now

Chronic Kidney Disease (*Bennett Shenker, MD*)

Acne and Rosacea (*Everett Schlam, MD*)

Top 10 Evidence-Based Changes to My Practice in 2013

(*Frank Domino, MD*)

This session will cover some of the practice-changing papers published in the last year. Information will cover a range of pediatric and adult topics that include the feeding of infants, the use of contraception by adolescents, obesity, and the overuse of some tests.

***Major Depressive Disorder in the Patient-Centered Medical Home** (*Richard Sadovsky, MD*)

Writing about his own experience with depression, Leon E. Rosenberg, MD said, "I couldn't sleep, I couldn't eat, I couldn't teach. I became convinced that death would be preferable to being brain dead." Stories such as this testify to the psychological and emotional burden that depression can place on individuals, but depression's impact extends beyond the mind: It also affects a person's entire physiology. This session will explore the complexities of major depressive disorder.

Family Medicine in the Era of the ACA: The Frank C. Snope, MD Keynote Lecture (*Robert Wergin, MD*)

AAFP President-Elect, Robert Wergin, MD, will discuss the latest developments in the world of health care and their impact on family physicians, as well as other emerging issues that affect family medicine.

Cases from the Family Medicine Files (*Everett Schlam, MD*)

Join Ev Schlam as he takes you on a journey through case files from family medicine that are focused on the latest evidence-based practices in family medicine.

The Mine Field That Is Pain Management (*Nitin Sekhri, MD*)

The management of pain in the family medicine practice is like navigating through a minefield. You need to watch every step you take and proceed around obstacles with great care, lest your good intentions to help your patients backfire. This session will provide guidance in managing pain in your office.

**Don't forget to check out the virtual course room*

The Current Standards of Care and Treatment of Diabetes

(Marc Sandberg, MD)

The world of diabetes management is constantly changing, with new understandings of disease etiology and new and emerging treatment options. This session will present the latest advances in the management of diabetes.

Men: Healthy at Any Age (Richard Sadovsky, MD)

According to the CDC, over 12% of men 18 years of age and older are in poor health, 33.9% are obese, and 31.7% have hypertension. How can you help your male patients stay healthy, no matter what their age? This presentation will explore ways to keep your male patients in the best of health.

Contraception Across the Ages (Aditya Bhattacharyya, MD)

Contemporary females have a wide array of contraceptive options available to them, but how do you determine what the right option is for a particular patient? This session will review common contraceptives to help you to choose the right therapy based upon each patient's age and lifestyle.

Static on the Line: Peripheral Neuropathy (John Ruiz, MD)

The peripheral nerves comprise the sensory communication network of the body. When peripheral neuropathy arises, it is like static on a telephone line, distorting and interrupting messages between the brain and the body. The symptoms of peripheral neuropathy can range from annoying to extreme. Join this discussion to learn how you can help your patients to quiet the static on the line.

NASH: A Silent Killer (Charissa Chang, MD)

Nonalcoholic steatohepatitis (NASH) is a common and often "silent" liver disease. Most people with NASH are unaware that they have a liver problem because they feel fine, until it is too late. It is suspected that both NASH and non-alcoholic fatty liver disease are becoming more common, possibly because of the high number of Americans with obesity. Learn about the intricacies of this condition, which could be affecting more of your patients than you realize.

AAFP Chapter Lecture Series: Human Papillomavirus (HPV)

(Louis Kuritzky, MD)

Join your colleagues for a discussion about the diagnosis and management of HPV and ways to improve vaccination rates within the patient-centered medical home model. (Note: This CME activity is funded by an educational grant to the AAFP from Merck.)

Evaluation and Injection of the Knee (Alan Remde, MD)

Knee evaluation and joint injection is a procedure easily performed in the family physician's office. Attend this hands-on workshop to improve your skills in this important area.

Cardiovascular Controversies "JNC8" and Cholesterol Treatment Guidelines (Seth Martin, MD)

New treatment algorithms, new therapy recommendations, new goals... There have been important, and controversial, changes made in the world of cardiovascular health. Plan to attend this session so that you are up-to-date on the latest.

To register for the 2014 SCSA, go to www.njafp.org/SCSA, and follow the links to the registration site.

Don't forget the Preconference!

Advanced Topics in Healthcare Delivery 2014: Ensuring a Viable Practice Using Patient-Centered Approaches

The topics for the preconference have been selected based upon the NJAFP's extensive experience with patient-centered medical home (PCMH) and practice transformation concepts and feedback from more than 500 clients whom we have assisted in becoming PCMH-recognized and in using a variety of innovative ideas to transform into medical homes.

It is paramount that patient-centered practices have the knowledge, resources, and access to best practices necessary to ensure the success of practice transformation.

Go to www.njafp.org/SCSA, and follow the links to the preconference page.

The Greatest Thing

continued from page 7

the agenda, guests, resolutions, and other activity scheduled for the House. If you plan to join us you might also wish to take part in the Town Hall Forum on Thursday evening June 12, from 7-9pm where we will be hosting a discussion on *Risk Mitigation Strategies to help practices meet the needs of patients with high deductible insurance plans*. At the Town Hall, NJAFP members can engage in dialogue with leaders from both NJAFP and AAFP on this trending issue.

Finally, one of our most important activities at the House of Delegates is the election and installation of new leaders for the coming year. This year the Delegates will elect a new slate of officers, and five new physician members of the NJAFP board. New this year, the resident and student trustees were nominated by the Resident and Student Caucus and will be presented to the House of Delegates.

According to Max DePree, "The greatest thing is, at any moment, to be willing to give up who we are in order to become all that we can be." I ask you to join us at the House of Delegates as we undertake this challenge. Join us. Be a leader. We've never needed you more.

I hope to see many of you shortly in Atlantic City. ▲

Advanced Topics in Healthcare Delivery 2014: Ensuring a Viable Practice Using Patient-Centered Approaches

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224 West State St
Trenton, NJ 08608

The New Jersey Academy of Family Physicians invites you to our second annual one-day symposium – *ADVANCED TOPICS IN HEALTHCARE DELIVERY*. The sessions will focus on critical topics necessary to enhance and foster delivery of advanced patient-centered care models and feature key presentations and speakers.

Topics have been selected based on NJAFP's extensive experience with Patient-Centered Medical Home and practice transformation concepts, and feedback from more than 500 clients we have assisted with practice transformation or PCMH recognition.

LEARNING OBJECTIVES:

- Describe how additional disciplines can be integrated into primary care practices
- Explain legal considerations regarding integration of additional disciplines in a practice
- Refine and demonstrate application of teach-back techniques
- Implement readiness for change assessments to determine patient's likeliness for behavior modifications and follow-up to referral services and support
- Identify best practices and potential sources and costs for shared decision tools
- Explain innovative practices regarding electronic communications with patients
- Describe legal considerations regarding social media communications between staff and patients
- Describe new transition codes and the documentation needed to use the codes for reimbursement

TOPICS:

Integrating Additional Disciplines into a Primary Care Practice

Evaluating, Communicating, and Motivating Patients for Change: A Primer on Readiness Assessments, Teach Back, and Motivational Interviewing

Shared Decision-Making Tools

Technology: Tips, Tricks, and Troubleshooting

Using Transition Codes: Facts, Myths, and Necessities

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Providers Beware ACA Grace Period Provision May Lead to Uncompensated Care

Susan B. Orr, Esq.

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A provision of the Affordable Care Act (ACA) related to grace periods for participants in subsidized Qualified Health Plans may pose payment problems for physicians. The rule provides for a ninety (90) day grace period before termination for non-payment of premiums is permitted, during which time insurers are only obligated to pay costs incurred for services rendered during the first thirty (30) days.

By way of background, Qualified Health Plans (QHPs) are health plans that are offered in a government-sponsored health insurance exchange. QHPs must provide essential health benefits, and are subject to the ACA market reforms, including the restrictions on annual and lifetime limits. QHPs must be certified as being compliant by the health insurance exchange within which they operate.

Individuals obtaining QHP coverage may be eligible to receive government assistance to defray the costs of acquiring the same. Generally, individuals making up to 400% of the federal poverty level are eligible for government subsidies in the form of premium

following a patient's premium default, they have no obligation to pay for claims designated as pending during the next sixty (60) days, if the plan is terminated at the end of the ninety (90) day period.

The new regulatory scheme places the majority of the risk of loss associated with QHP non-payment grace periods on providers. In response, medical trade associations, including the American Medical Association, have encouraged their members to implement policies and practices to mitigate loss inherent to providing care during grace periods, primarily through patient education and diligent monitoring of insurance status. Further, these groups have called for greater clarification with respect to the insurer notice provision.

Specifically, concern has been voiced with respect to the provider notification provision due to its lack of a finite notification time frame. Stakeholders have lobbied the Obama administration to clarify when and how notice must be provided, recommending that it be mandated within the first month of the grace period. It is



Although insurers are responsible for paying providers for medical services rendered during the first thirty (30) days following a patient's premium default, they have no obligation to pay for claims designated as pending during the next sixty (60) days, if the plan is terminated at the end of the ninety (90) day period.

tax credits. Persons eligible to receive the credit have the option of: (1) having the entire sum advanced and allocated evenly across all premium payments, (2) having part of the credit advanced and applied across premium payments, with the balance being refunded as part of his/her tax return, or (3) receiving the entire credit as part of his/her income tax return.

Specific to government-subsidized QHPs is a ninety-day "grace period" related to termination for non-payment of premiums. Under the final regulations, a "QHP issuer must provide a grace period of three consecutive months if an enrollee receiving advance payments of the premium tax credit has previously paid at least one full month's premium during the benefit year." During the grace period, the QHP issuer must:

1. Pay all appropriate claims for services rendered to the enrollee during the first month of the grace period **and may pend claims for services rendered to the enrollee in the second and third months of the grace period;**
2. Notify HHS of such non-payment; and,
3. Notify providers of the possibility for denied claims when an enrollee is in the second and third months of the grace period.

In other words, although insurers are responsible for paying providers for medical services rendered during the first thirty (30) days

CMS' expectation that issuers will provide this notice within the first month of the grace period and throughout months two and three. Issuers can opt to provide this notice by several means, however, they are encouraged to provide this notice whenever responding to an eligibility verification request from a health or dental care provider. Although CMS' position aligns with that of interested stakeholders, its guidance may be inadequate as it fails to set forth any binding norms.

Overall, risks related to the grace period rule can be mitigated in a few ways. Some providers may choose not to furnish care to participants in a QHP. Alternatives may include reaching out to QHP issuers regarding automatic electronic notification techniques. Although largely contingent on the technological capabilities of the issuer, with the proliferation of electronic health records (EHR) and health information exchanges (HIE), such an arrangement is not beyond the realm of possibility. Further, providers should diligently check insurance status before conducting major procedures or providing expensive services. Finally, in non-emergency situations, providers should consider requiring cash payment up-front.

For more information, contact either Susan B. Orr, Esq. at Rhoads & Sinon LLP at 610-423-4200 or sorr@rhoads-sinon.com or Nicole Radziewicz, Esq. at 717-231-6623 or nradziewicz@rhoads-sinon.com.

Get Ready for New Prescription Blanks – Again; Reminder on how to E-Prescribe controlled substances

Claudine M. Leone, Esq.

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

It seems like the State changes your prescription blanks format in the name of fraud every couple of years. But when I looked back, the last change was in 2004. Either way, we are there again for 2014.

Acting Attorney General, John Hoffman announced as part of the state's fight against black-market sale of prescription painkillers that state-approved vendors that manufacture the prescription blanks used by New Jersey doctors will soon be required to add new print-based security features. The security enhancements will include color-changing ink, 0.5-point micro-printing, and a hollow "VOID" hidden word feature, among others.

The new, secured prescription blanks will be phased in during the next six months. **No later than May 18, all State-approved vendors of prescription blanks must stop selling, printing, or delivering the old-form blanks and must exclusively provide the new version. No later than August 18, all State-licensed prescribers must stop using their supply of the old blanks, and must exclusively use the new ones.**

The Division developed the new regulations and prescription blank format after conducting research into the prescription security measures used in other states, and discussions with the State-approved printing vendors that currently supply prescription blanks.

More changes to come... The Acting Attorney General has stated that this is the first in a two-stage change to the blanks. The Division of Consumer Affairs intends to further amend its rules, and ultimately require security measures that would be embedded in the paper itself.

Of course, this new requirement only applies to the use of paper prescription blanks. It does not change the state or federal requirements that pertain to electronic prescriptions. On that note there continues to be confusion about whether you can e-prescribe controlled substances since implementation of federal and state regulations authorizing it have been inconsistent with prescribers, pharmacies, EHRs and other vendors.

To be clear, Federal law authorizes prescribers and pharmacists to use electronic prescriptions for ALL CDS medications through a secure system that has been tested by a DEA-approved expert. New Jersey regulations also authorize electronic prescriptions for ALL CDS or non-CDS drugs, only when they comply with Federal Drug Enforcement Administration (DEA) requirements, as well as requirements adopted by the state.

So what does that mean? We are reprinting part of a previous article from *Perspectives* on this topic as this issue comes up a great

deal with members. I would greatly appreciate feedback from practices on their experiences e-prescribing CDS in New Jersey as, I believe the transition has been a process for all parties concerned.



What Physicians Must do to E-Prescribe ALL Controlled Substances (2013)

In 2010, the DEA approved interim rules finally authorizing e-prescribing for Schedule II CDS. These rules, however, also developed a new certification process for e-prescribing of all CDS. This is now referred to as EPCS: E-prescribing Controlled Substances. That interim federal rule is now being implemented across the country and is causing some of the changes you may be seeing with acceptance of e-prescribed scheduled drugs at your pharmacies and with your application vendors.

Simply put, while these federal rules now permit the e-prescribing of all scheduled drugs, the federal regulations require prescribers, prescriber software vendors, pharmacies and pharmacy software vendors to complete certain steps to meet the DEA's requirements for EPCS.

This is, again, for all scheduled drugs. So, even though NJ law previously permitted you to e-prescribe Schedule IV drugs, for example, without this certification, the DEA is now requiring it for all EPCS. If you are experiencing rejections of e-prescriptions for any scheduled drugs right now, what is likely happening is that someone in the e-prescribing chain hasn't completed their "step." Let's make sure it isn't family physicians!

For each provider in your practice who wishes to send prescriptions for ALL controlled substances electronically, there are steps you must complete to comply with the federal requirements:

- 1. Verify EPCS is legal in your state** YES – confirmed by NJAFP.
- 2. Ensure that your e-prescribing software is certified for EPCS:** Check directly with your software vendor.
- 3. Receive an audit report generated by your software vendor indicating compliance with the DEA Interim Final rules (IFR).** You must get this directly from your software vendor.
- 4. Adhere to ID verification procedures and access controls: ID Proofing, Two- Factor Authentication, Digital Signing.** The DEA expects your application providers will work with CSPs

The new security measures required by the regulations include:

- Thermochromic ink, which changes color in response to body heat. The heat-activated ink will appear in a small Rx logo on the front of the prescription blank. It will fade when touched, and return to its original color when it cools.
- Microprint, of 0.5-point type or smaller. The front of each prescription blank will include a line of microprint that is readable when viewed at 500% magnification, but becomes illegible when scanned or photocopied.
- A hollow "VOID" hidden word feature that is invisible on a genuine prescription blank, but should appear in illegally scanned or copied versions.
- A unique 15-digit identification number for each prescription blank. The alphanumeric code will identify the vendor that created the blank, the vendor's order number, and a six-digit serial number for each separate prescription blank.
- A barcode matching the prescription blank's unique 15-digit identification number. The barcode will enable pharmacists to scan prescription data into the New Jersey Prescription Monitoring Program (NJMPMP). The NJMPMP, maintained by the Division of Consumer Affairs, records all prescription sales in New Jersey of Controlled Dangerous Substances and Human Growth Hormone (more information: www.NJ-ConsumerAffairs.gov/pmp).
- A complete list of all security features will be printed on the back of the prescription blank.
- The new prescription blanks will be green on the front and blue on the back. This will enable them to be more easily distinguished from the old blanks, which are blue on the front and green on the back.

(approved credential service providers) or CAs (certification authorities) to direct you to one or more sources of two-factor authentication credentials that will be interoperable with their applications. You should contact your application provider to determine which CSP or CA your provider recommends. NJAFP has been told the ID verification process will take about 15 minutes.

Now with all of this said, the federal regulation on EPCS is voluntary. The DEA did not mandate that all prescribers and pharmacies e-prescribe CDS and accept e-prescribed CDS. So, you may find some of the small independent pharmacies may choose not to certify under these rules and will not accept EPCS, at all. The larger retail chain pharmacies are all working through the process.

The Federal Department of Justice site also has a great Frequently Asked Questions Section on EPCS: http://www.deadiversion.usdoj.gov/e-comm/e_rx/faq/practitioners.htm#individual

I can be reached at (609) 394-1711 or claudine@njafp.org for any questions or comments.

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

Reflections of My Board Service

Chelsea Brower



Chelsea Brower is a 4th-year medical student at Rutgers New Jersey Medical School in Newark and a student trustee for the NJAFP.

As I near the end of my term as the student trustee of the New Jersey Academy of Family Physicians (NJAFP), I have been reflecting on the many unique opportunities that I have had over this year. Thanks to the NJAFP, my knowledge of family medicine extending beyond direct patient care has increased tremendously this year. I have had many incredible experiences because of the NJAFP, but I want to focus on my three favorites in this article.

My first exposure to the NJAFP was when I volunteered at the Scientific Assembly last June. I was initially nervous to run for the position of student trustee, but was immediately comforted by the uniform encouragement and enthusiasm for family medicine. The physicians whom I met were extremely candid about the current challenges and struggles facing family physicians, but they also shared a realistic optimism about the future of family medicine. It was incredible to hear President-Elect of the American Academy of Family Physicians (AAFP) Reid Blackwelder, MD lead an open discussion about current issues and then have the opportunity to meet him. I learned so much at this conference by attending informative sessions and speaking to knowledgeable and inspirational family physician attendees.

Serving as the NJAFP student delegate at the AAFP's national conference was a once-in-a-lifetime experience! It was inspiring to meet such accomplished peer medical students who were enthusiastic about becoming family physicians. As a student delegate, I also found it enlightening to learn about the proceedings of the student congress as well as ways in which to write resolutions that could potentially influence AAFP policy. I teamed up with another student-

trustee, Monali Desai, and another medical student to draft a resolution encouraging the inclusion of humanities in medical education. I learned skills during this conference that will help me as I pursue future involvement in policy development and leadership.

Advocating for a primary care loan redemption bill was another highlight of my term as student trustee. Claudine Leone, Esq., the NJAFP's government affairs director, was instrumental in developing a bill that would help to relieve the student debt burden of future primary care doctors who care for underserved patients. I immediately supported this bill because I believe that carrying enormous student loans is one of the major factors influencing highly qualified students to choose specialized medical fields that have higher compensation or move to other states that recruit primary care physicians. I believe that a successful loan redemption program could encourage the best and the brightest medical students to pursue careers in primary care and remain in New Jersey. I spoke in support of the bill in front of a committee of state senators and assembly members. The assembly and senate members approved the bill, but unfortunately, it was pocket vetoed. I remain hopeful that a modified loan redemption bill will be passed in the near future to signify support for primary care in New Jersey.

I am thankful to have served on the NJAFP board this year with such passionate family physicians and professional staff. I would highly recommend that any student interested in family medicine reach out to the NJAFP to learn about opportunities to become involved. The board has been and continues to be extremely supportive of the ideas and initiatives that medical students and residents have put forward. Although I am very excited to start my residency this year at Lancaster General Hospital in Pennsylvania, I am sad to leave the state of New Jersey but hope to return in the near future! ▲



AAFP President-Elect, Reid Blackwelder, MD installs the NJAFP 2013-2014 Board.

E-Cigarettes

Do You Have the Information to Inform Your Patients?

Richard Feldman, MD

Richard Feldman, MD is the program director at the Family Medicine Residency Franciscan St. Francis Health, Indianapolis. He is also the Former Indiana State Health Commissioner.

Electronic cigarettes, commonly known as 'e-cigarettes,' are skyrocketing in use. Whereas 50,000 of these little devices were sold in the U.S. in 2008, sales reached 5 million in 2012. Manufacturers and other purveyors of e-cigarettes claim that they are either safe or abundantly safer than smoking tobacco. Most mainstream public health advocates flatly discourage their use because of potential dangers. Still other public health and medical professionals, some from prominent academic institutions, see the e-cigarette as a legitimate harm-reduction strategy and possible aid to cessation for current smokers. So what does one make of this relatively new nicotine product?

E-cigarettes are handheld electronic devices consisting of a rechargeable battery and a cartridge containing nicotine, propylene glycol, glycerin, flavorings, and other known and unknown ingredients. When the user inhales air through the device, it activates the battery that heats an atomizer to vaporize the nicotine and other compounds producing a white aerosol. Since there is no combustion, the user inhales vapor, not smoke, and what is exhaled dissipates quickly and does not produce the offensive

about 20% of what cigarettes place in the air. The very limited evidence available suggests that there are far fewer identified compounds in e-cigarettes compared to tobacco, and that they generate and deliver fewer toxic substances to the user (other than nicotine) compared to tobacco combustion.

There is also little evidence that e-cigarettes are a convincingly effective tobacco cessation aid. Relatively few smokers utilize e-cigarettes for complete cessation. They often continue to use them indefinitely, use them in combination with tobacco smoking, or revert exclusively back to smoking. A recent *Lancet* journal study demonstrated e-cigarettes to be about as successful for tobacco cessation as conventional pharmaceutical nicotine replacement patches.

E-cigarettes may deplorably lure children into a life of nicotine addiction. They are cheaper than cigarettes and are available in flavors (including cherry, chocolate, and bubble gum) that appeal to youth. Usage of e-cigarettes among youth has doubled in recent years.

The most immediate issue is the fact that these devices are currently unregulated. The Federal Food and Drug Administration has signaled its intention to regulate them as tobacco products



Although e-cigarettes might be a less-toxic alternative for smokers, they are addictive and potentially harmful.

lingering, smelly, and irritating smoke of combusted tobacco.

Are they harmful? There is a stark lack of good scientific studies; the data just doesn't exist to conclusively say one way or another. The few investigations that have been conducted generally demonstrate potential for harm. A Harvard study determined acute pulmonary effects including airway constriction and inflammation which could lead to chronic pulmonary disease. Importantly, long-term cardiopulmonary health effects and cancer risks are completely unknown.

We do know from an FDA study and a few other investigations that cartridge samples contain a highly toxic substance called diethylene glycol and a number of carcinogens including nitrosamines. A German study showed that e-cigarette secondhand emissions contained toxins and carcinogens including acetone, isoprene, formaldehyde, acetic acid, and acetaldehyde averaging

since their nicotine is derived from tobacco but has yet to assert its Congressional-granted authority.

Regulation is needed. Studies have demonstrated that e-cigarettes have poor quality control, design flaws, incomplete and inaccurate labeling, variable amounts of nicotine concentration from what is claimed on the label, and no assurance that undisclosed ingredients or unintended contaminants are not present.

Public health professionals fear that the rise in e-cigarette smoking-like behavior may undo decades of efforts to reduce smoking and "re-normalize" smoking in our culture. Although e-cigarettes might be a less-toxic alternative for smokers, they are addictive and potentially harmful. From a policy standpoint, their use must be discouraged. From a purely medical perspective, e-cigarettes should be exclusively reserved for those already hopelessly addicted despite all best tobacco-cessation interventions. ▲

Reprinted with permission from Dr. Feldman's Health Care and Public Policy Blog, <http://richardfeldmanblog.wordpress.com/2014/04/>

A Physician's Guide to Thriving and Surviving Amid Changes

Julio Hip-Flores, MD

Dr. Julio Hip-Flores is a general internist in Bound-Brook, NJ.

Reports of the death of private practice have been greatly exaggerated, to borrow from the famous quote by Mark Twain. Although we have certainly seen a decline in the number of independent practices, many of us are not only surviving but also doing well. This is not to say that there are not challenges, because there are. The world of health care has changed significantly since I began my primary care practice in 1980, and it is continuing to change very quickly. Nonetheless, despite the issues, plenty of opportunities and resources exist to help small, independent practices thrive.

If you, like me, enjoy the freedom and independence of running your own practice, but are worried about whether you can sustain and thrive in this increasingly complex environment, I argue that you can and that it is not as difficult as you might think. Although I do not purport to have everything figured out, I can tell you that I run two very busy practices that are doing well and I'm still having fun! A big part of why I am still having fun is because I do not try to manage things that are outside of my expertise. To that end, I took two very practical steps that have made a big difference in my revenue, my patient care, and my sanity.

First, I joined New Jersey's oldest physician-owned provider network and healthcare management company, Partners In Care, a highly innovative and very effective independent physician association (IPA). The beauty of this 450-plus provider network is that I do not pay it; instead, it pays me. There are no sign-up fees or dues, and as a network provider, I am paid for coordinating the care of my patients by participating in the organization's Care Coordination, Population Health, and Accountable Care programs.

I have earned more than \$10,000 annually from participating in these programs, and the potential exists to generate even more. Most importantly, these programs have made a measurable impact on the health outcomes of my patients and have made my practice more efficient. The Partners In Care clinical team members provide my practice with support for case management, disease management, patient scheduling, and other medical care. They identify gaps in care and work with me to ensure that my patients, including those who are chronically ill, are getting needed follow-up care and regular preventative screenings, which helps me to provide better care and run my practice more efficiently. As a bonus, many of the clinicians are multilingual, which is definitely beneficial, given the diversity of our state.

Partners In Care offers me yet another opportunity to increase my revenue via its Medicare ACO. As a participant, I am afforded shared savings earning potential in addition to my regular fee-for-service and care coordination payments without increasing my overhead or my headaches. I see a high percentage of senior patients, so joining

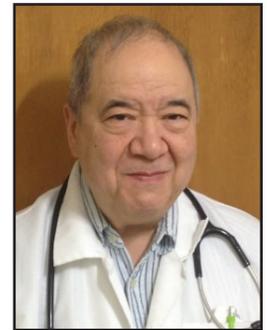
the ACO made a lot of sense clinically and financially. I'm optimistic that the organization's 19 years of experience will continue to benefit my practice and keep me ahead of the curve on all Medicare changes.

Lastly, having the network negotiate group contract rates with health plans on my behalf adds to my bottom line as well as my peace of mind. I could go on and on, but the point is that aligning with Partners In Care has given me the benefits of being part of a large organization while allowing me to maintain full autonomy over my practice and patient care.

The second step that I took was to outsource my billing, which has improved my cash flow and quality of life. It is not a secret that billing can be a major source of pain and that it can literally sink a practice. Consequently, I did not make my vendor selection based upon the lowest cost; rather, I chose the best vendor with the best track record. Although using a professional billing company is not an inexpensive proposition, the price of not using one can be much higher. When I had an employee managing billing, I still had to manage the employee and the overhead for that employee. Billing companies specialize in billing, and although I still have to monitor them, it requires far less of my time to do so. Ultimately, time is a physician's most valuable commodity.

As changes and challenges persist, the prevailing narrative is that in order to make money or have security, you need to sell your practice or join the staff of a hospital. However, as some of my colleagues have learned, the grass is definitely not always greener. Yes, many physicians have sold their practices to hospitals and are doing fine, but the fact remains that other physicians have not fared well. Recently, a colleague of mine sold her practice, which was profitable, out of concern about all of the impending mandates. She discovered very quickly that she had traded one set of regulations for a different set of regulations and difficulties. Ultimately, they parted ways. Some colleagues have had their contracts terminated when their services were no longer needed, and other independent colleagues struggle with the transition from employer to employee and the associated issues with lack of autonomy and patient scheduling. The bottom line is that selling a practice is not without its own inherent issues, and contrary to popular opinion, it is not the only option.

The steps that I have taken to enhance my practice as well as my quality of life might sound simple, but sometimes, the little things make all the difference. The nature of private practice has changed and will continue to change, but contrary to reports of its demise, it is alive and still paying well. ▲



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