

New Jersey Immunization Network (NJIN)

VOLUME 13, ISSUE 3 • 2014

Perspectives

A VIEW OF FAMILY
MEDICINE IN NEW JERSEY

A Look Back 2014 SCSA



Dr. Krishna Bhaskarabhatla

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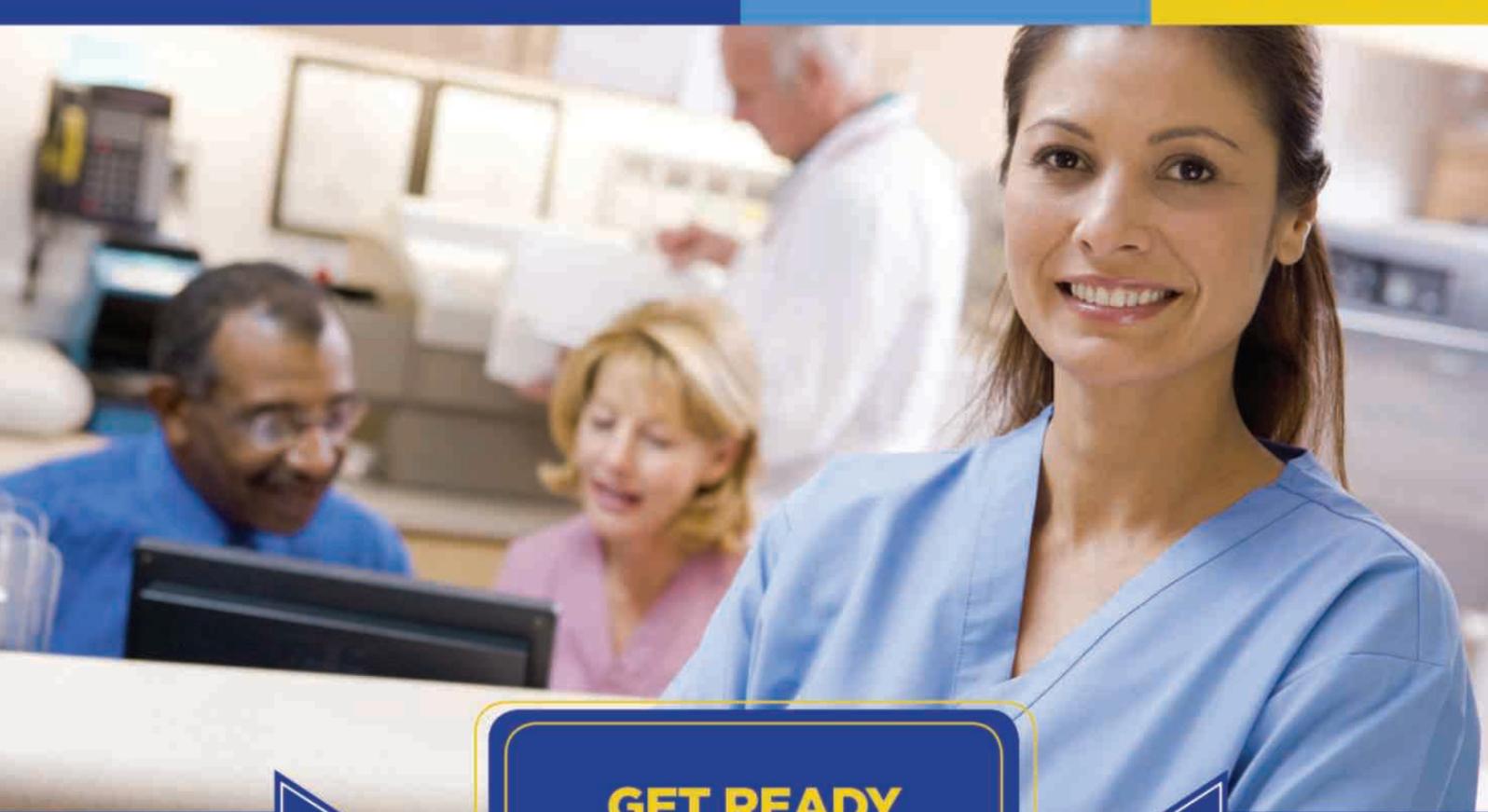
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IN THIS ISSUE

Volume 13, Issue 3 • 2014



On the Cover

Dr. Krishna Bhaskarabhatla is installed as NJAFP President at the 2014 President's Gala. Read all about the highlights from this year's annual meeting in NJ View.

President's View.....	6
Executive Vice President's View	7
Academy View	9
Clinical View.....	12
CME Quiz	15
New Jersey View	16
Practice Management View	21
Government Affairs View	22
Quality View.....	24
Student View	26
Special Projects View.....	27
Foundation View	29
Closing View.....	30

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Apps You Can't Live Without (or Maybe You Can)

In the last edition of *Perspectives*, I shared some of the interesting things that come through my inbox as the NJAFP Meeting Manager. I mentioned that some of the things I come across are the "latest, you cannot possibly live without, apps." Here are a few of the more unique apps that I have found (not that I necessarily use them 😊).

I didn't really think I needed an app to figure out if I should wear pants, but apparently I was wrong. "Should I Wear Pants Today?" is a handy little weather app that not only tells you the humidity, wind temperature, and average temperature, it also tells you how to dress.



And since we are talking about the weather, never have a bad hair day again. "Haircaster" checks the weather for you and tells you how the forecast will affect your hair. Follow this apps advice ranging from "perfect" to "stay home" and you'll never be frizzy in public again.

So you are at a cocktail party, enjoying your favorite beverage and engaging in a scintillating conversation over the latest viral You Tube video, when your companion is pushed from behind and you end up wearing a glass of red wine all over your favorite shirt. You now resign yourself to the fact that you will need to go shopping tomorrow to replace your favorite shirt. But don't despair, there's an app to the rescue. Visit <http://www.clorox.com/mystainapp/> and find the solution to what happens when people, events, and fabrics collide.

Under the "Just Plain Scary" category is Refresh. It was designed to give you insights into people you may be meeting with in order to create better experiences. The app is a social network curator, accessing social networking sites to build profiles for the people you have in your address book. Refresh uses the social information it finds to build a dossier of the person you are meeting with so you will have more information about them. It will also offer you tips about the person. If that person has posted to Facebook that he was in Hawaii, Refresh will tell you. Then when you meet in person, you will have something to talk about. Chances are if it is on the web it will end up in the Refresh dossier. Really scary... and remember other users can build a similar profile about you.

Tired of being surprised by your monthly cell phone bill? Tired of your spouse complaining that you spend too much time on your phone? Check out "Moment" (<http://inthemoment.io/>). This app tracks how much time you actually spend on your phone each day. You set a daily limit and Moment lets you know when you've spent too much time with your phone.

Do you have a favorite, strange, or interesting app that you would like to share with your fellow readers? Send it on to editor@njafp.org. I'll include those apps in future installments of "From My Inbox."

Happy Reading,

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

The Interface of Change

Dr. Krishna Bhaskarabhatla

Dr. Bhaskarabhatla is president of the New Jersey Academy of Family Physicians, has a private practice in Woodland Park, NJ and is Associate Program Director at New York Medical College - St. Joseph's Family Medicine Residency Program in Clifton, NJ.

***"You have to be fast on your feet and adaptive or else a strategy is useless."* – Charles de Gaulle**

IT IS A GREAT HONOR and privilege to be your President. Our Academy is truly a great organization which has demonstrated its leadership and expertise in developing state-of-the-art resources in patient-centered care, continuing education and quality improvement.

We are in the midst of unprecedented changes in the health-care field. As a direct response to the Affordable Care Act, several entities small and big have adapted in new ways. The traditional fee-for-service payment model may soon be a part of history. Only time will tell how successful the new alternative models (pay for performance, bundling, value-based purchasing, and accountable care) will evolve. The time has come to rethink the way we provide care and do business. We all have noticed a large migration of independent practices to integrated or employed models. Caught up in these turbulent times are the small practices, which face immense financial and regulatory burdens.

How long can anyone ignore the mounting evidence of the cost-effective, best quality of care that we family physicians provide?

At the interface of these changes are the family physician workforce shortages, huge medical student loans, and the burden and uncertainty of ICD10 transition. It is troubling to see our well-trained, new graduate family physicians leave to greener pastures. These departures directly impact the best evidence-based primary care prospects in New Jersey.

How are we as family physicians positioned? There cannot be a better time than now to be a family physician! How long can anyone (in health care, business industry, policy making or media) ignore the mounting evidence of the cost-effective, best quality of care that we family physicians provide? We have shown lower mortality rates, lower admission and re-admission rates, and lower episodic care costs. Adopting "best primary care practice" is in our DNA and is a norm. When other specialties are struggling to define primary care, we have shown to the nation what state-of-the-art primary care is through our practices. Whether it is in ambulatory

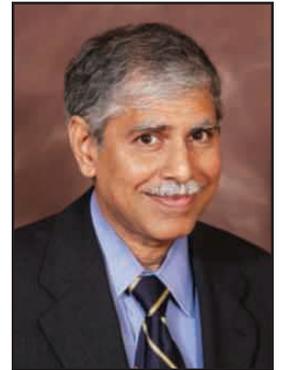
centers, acute hospitals, long term nursing facilities or personal homes, we, family physicians, provide leadership to health teams and deliver appropriate care for our people with multiple complex medical problems. We care for all age groups: whether it is a baby with hyperbilirubinemia in the newborn nursery, the adult diabetic in ketoacidosis on an acute medical floor, or an elderly person battling a cognitive decline in a nursing home. What other primary care physician or sub-specialist (organologist) or physician extender has such a breadth of scope of practice than a family physician? How do we leverage all our strengths so that our specialty maintains its value and stays ahead? It depends upon on how we handle the current challenges and preserve our unique scope and breadth of practice.

What should our Academy do? I propose three "Task-Forces" to work on developing a report to be presented to the Board of Trustees in the following areas:

1. Newer models of communications (blog, social media) and outreach programs (town hall style regional meetings in late fall) so as to communicate more effectively with you, our members and educate our people in the communities. These networking opportunities shall help us understand the issues so that we can shape our Academy's pathways and future directions.
2. Maintaining and enhancing "scope of practice."
3. Preserving small practices.

I invite you all to tap into our Academy's resources and tools and suggest new areas to explore. Your active participation in committees and task forces would provide strength and relevance. I will keep in touch with you on a monthly basis and keep you abreast on what your Board and your staff are doing to advance our Academy's goals. We can work together and unleash the power of digital communication, and social media, in addition to our grassroots networks. This is your Academy and it is my desire that we all strive to further advance Family Medicine. We should use as many pathways as possible to educate our people and community about what Family Medicine is and why everyone needs a family doctor and to have integrated care... because without a family doctor, care is always fragmented!

Please send me your thoughts and ideas so that we all can work together and build on the momentum. Please join me in thanking our amazing, dedicated staff - Theresa Barrett, Cathy Cardea, Robin Comiski, Karen Foster, Pamela Joyce, Claudine Leone, Corrina Lucas, Cari Miller, Tara Perrone, Candida Taylor, and last but not least, Ray Saputelli. ▲



BURNOUT!

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.

I had the most difficult time writing this article. I found myself saying "I don't have anything of value to say." Still, I've said that before and with a little thought and a few deliberate conversations, a topic or a theme made itself clear. This time I found myself saying things like "who wants to hear what I have to say, anyway?" This is a particularly stressful time for me, and I told myself that I just needed some rest and that my batteries would recharge. They always do – or did. A day off, some time alone or at least away from the daily stressors, that's all I needed. So I did that. I took a Sunday and did glorious nothing. I turned off my phone, I locked my computer and my iPad in the desk, slept in, watched some football, and just relaxed. Except I couldn't relax. Suddenly the desire to relax became an additional stressor in itself. Still, I made excuses to myself. Everyone has been there in one way or another, right? Who hasn't laid in bed and had that internal conversation where you say to yourself "if I just fall asleep NOW, I will still get 3 hours." This was no different. I just needed to FORCE myself to relax.

Sound familiar?

I am not a physician. Since coming to organized medicine as a young association executive in 1999, I have told people that I forgot to go to medical school. Still, this was starting to look a lot like burnout. I recognize it in some of the physicians with whom I work, but hadn't seen it in myself.

Sound familiar?

In his blog, *The Happy MD*, Dike Drummond, MD notes that global studies involving nearly every medical and surgical specialty indicate that approximately 1 in 3 doctors are experiencing physician burnout at any given time.¹ Some studies show the prevalence of physician burnout as high as 60%. In a study published in *JAMA* in October, 2012, Shanafelt, et al. concluded:

Of 27 276 physicians who received an invitation to participate, 7288 (26.7%) completed surveys. When assessed using the Maslach Burnout Inventory [MBI], 45.8% of physicians reported at least 1 symptom of burnout. Substantial differences in burnout were observed by specialty, with the highest rates among physicians at the front line of care access (family medicine, general internal medicine, and emergency medicine). Compared with a probability-based sample of 3442 working US adults, physicians were more likely to have symptoms of burnout (37.9% vs 27.8%) and to be dissatisfied with work-life balance (40.2% vs 23.2%) ($P < .001$ for both).²

Burnout in physicians manifests itself in many ways, but some of the most easily recognizable are a downward spiral with three distinct symptoms: physical and emotional exhaustion; depersonalization; and reduced sense of personal accomplishment. Burnout

is more than stress. It's a level of depletion of physical and emotional reserves brought on by work from which you can't recover in your time off. It's an abnormal level of "cynicism, sarcasm, and feeling put upon by your patients." The creators of the MBI describe physician burnout as "...an erosion of the soul caused by a deterioration of one's values, dignity, spirit and will."¹ Pretty serious stuff, with truly dangerous potential consequences for both the physician and the physician's patient. For the physician, the consequences include increased incidence of substance abuse and self-destructive behavior, even increased suicide. For the patient, the impact of physician burnout can be a continuum that begins with a decrease in the physician's professionalism and the quality of care he or she provides and ends with reduced patient compliance and satisfaction. For the system, the consequences include spikes in medical errors, liability claims, higher costs, and even a reduction in an already inadequate physician work force as burnt out physicians contemplate leaving practice.



Burnout is more than stress. It's a level of depletion of physical and emotional reserves brought on by work from which you can't recover in your time off.

Some of the obvious stressors that lead to burnout include the pressures that a volume-based payment system puts on the physician to see a high number of patients, often leaving the physician (and the patient) feeling that there is too little time to establish and nurture a caring relationship, not to mention simply not having enough time to provide what the physician would consider truly comprehensive care. In a 2012 blog on *Kevinmd*, Rob Lamberts, MD extended this stressor to include the fact that often "good work" is penalized. He notes: "When I do explain things, call people, or just act friendly toward my patients I am rewarded with a lower salary. I constantly have to choose between doing good and getting paid, and that's really lousy."³ Other factors include an absence of work/life balance that begins with training that reinforces what for most physicians are already significant

continued on page 11

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To All Family Medicine Providers: Join NJIN!

John Moore, DO

ACADEMY
VIEW

John Moore, DO is a family physician member of NJAFP and a Patient Management Director for Aetna.

Be a supporter of adult and pediatric vaccination compliance. Contribute to efforts that tell New Jersey legislators that relaxing vaccination state mandates puts all New Jersey residents at risk for vaccine preventable epidemics resulting in potentially serious morbidity and mortality. Assist with guiding communications to health care providers and facilities throughout New Jersey to encourage appropriate vaccination of all New Jersey residents (newborns to seniors) and the healthcare providers who care for these patients. Hear the most current updates from representatives of public health regarding the management of vaccine preventable diseases in New Jersey, as well as the on-going efforts relating to adding patient data to our state registry.

This is what the New Jersey Immunization Network (NJIN) has been doing on a regular basis since it was created in late 2009. The NJIN is a statewide coalition committed to advancing immunization rates throughout the state by providing healthcare providers, the public, and policy makers with the most current scientifically-sound information pertaining to the importance of safely immunizing infants, children, adolescents, and adults throughout New Jersey.

Jointly co-founded and led by the American Academy of Pediatrics New Jersey Chapter (AAPNJ) and the New Jersey Academy of Family Physicians (NJAFP), NJIN has grown to approximately 240 members representing over 132 public and private entities. This statewide alliance is co-chaired by nationally acclaimed pediatric infectious disease specialists Margaret (Meg) Fisher, MD, FAAP and Lawrence Frenkel, MD, FAAP, and vice co-chaired by John J. Moore, DO, FAAFP and Peter Wenger, MD. We have active members who represent state and local health partners, private pediatric practices, private family medicine practices, nurse practitioners, managed care insurers, vaccine manufacturers, pharmacists, retail pharmacies, hospital systems and others who wish to promote improved vaccine compliance rates in New Jersey.

Initially emerging as an offshoot of the 2009 AAPNJ Immunization Congress, NJIN quickly developed the infrastructure and associations essential for positively impacting New Jersey's dire immunization rates. Today, the Network is actively involved in reaching out and attracting an expanding list of key stakeholders, assisting in efforts to accelerate acceptance and participation in the mandated transition to the New Jersey Immunization Information System (NJIS), taking proactive measures to counteract public and legislative efforts to loosen or increase school/child care immunization exemptions, and providing education and resources to healthcare professionals, the media, and the New Jersey Department of Health and Senior Services.

How to Join:

NJIN has monthly meetings from 12:30PM to 2:30PM normally on the 4th Wednesday of each month. We welcome all healthcare

providers to attend in person (come at 12 noon for lunch!) or call in to attend by phone conference. As a member, you also have access to the monthly meeting minutes and other email communications to the group.

NJIN also has subcommittees that address the following topics: Adult Immunization, Education, Interface and Information Technology, and School Immunization. The committees usually meet monthly via teleconference.

One of the greatest success stories in public health is the reduction of infectious diseases resulting from the use of vaccines. The public sometimes questions the need to continue vaccinating people since we rarely see the dire consequences of vaccine-preventable diseases today. This complacency can result in people skipping vaccines or following a delayed schedule.

The good news is that healthcare professionals remain the most trusted source of information and play a critical role in supporting on-time, age-appropriate vaccinations. As a healthcare provider, you have the opportunity to influence patient choices by promoting vaccination as a standard of preventative care across the life span—for infants, children, adolescents, and adults throughout New Jersey. Since you represent a credible source of immunization information, you have the potential to impact not only your community, but the entire state—by joining the New Jersey Immunization Network (NJIN).

To join us, simply email Program Coordinator, Mary Jo Garofoli, mjgarofoli@aapnj.org or call her at 609-588-9988.

New Jersey Medicaid ICD-10 Update

On July 31, 2014 the U.S. Department of Health and Human Services issued a final rule formally establishing October 1, 2015 as the new compliance date for health providers, health plans, and healthcare clearinghouses to transition to ICD-10, the tenth revision of the International Classification of Diseases. ICD-9 codes will continue to be reported through September 30, 2015 as per CMS.

The State of New Jersey Medicaid will follow the CMS guidelines and deny all claims not using the new ICD-10 codes if the service dates are October 1, 2015 or later. All claims with service dates September 30, 2015 or earlier must use ICD-9 codes.

Information concerning ICD-10 and how it affects NJMMIS and your Medicaid Submissions can be found at www.njmmis.com under "Headlines – Web Announcement."

For additional information, please contact Robert Brookwell at robert.brookwell@dhs.state.nj.us

Promoting Breastfeeding in the Healthcare Environment

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

The New Jersey Department of Health is focused on supporting healthy choices for residents that will improve their health and quality of life. An important way we can help build a healthier population is by promoting and supporting new mothers who breastfeed.

For both mother and child, there are many health benefits associated with exclusive breastfeeding. Babies who are exclusively breastfed have a lower risk of obesity, diabetes, asthma, ear infections and sudden infant death syndrome (SIDS). The Centers for Disease Control and Prevention (CDC) estimated that infants who are breastfed for nine months have a 30% reduced risk of being overweight.¹ Moms who breastfeed have a lower risk of Type 2 diabetes, breast cancer, ovarian cancer and postpartum depression.

Despite all the health benefits associated with breastfeeding, New Jersey's rate for mothers who exclusively breastfeed at three months is 32.3%, which is lower than the national average of 37.7% according to CDC's 2013 Breastfeeding Report Card.

Through the New Jersey Baby Friendly Hospital Initiative (BFHI) and new state regulations initiated by the Department of Health, we are seeing significant progress among our hospitals in encouraging and supporting breastfeeding.

More New Jersey hospitals are adopting measures that encourage breastfeeding, including four that have earned "Baby-Friendly" designations, a distinction that requires hospitals to implement policy change and train staff to promote exclusive breastfeeding: Capital Health in Hopewell, CentraState Medical Center in Freehold, Inspira Medical Center in Elmer and Jersey Shore University Medical Center in Neptune gained this status in 2012. As a result, more than 6,800 babies were born in baby-friendly hospitals this year. Another 22 hospitals are currently on the path to earning Baby-Friendly status. New Jersey Baby Friendly Hospital Initiative's is based on a program of the World Health Organization (WHO) and United Nations Children's Fund (UNICEF) launched in 1991.

This June, I joined more than 200 healthcare professionals representing all 52 of the state's birthing centers at the New Jersey Mother-Baby Summit to discuss the achievements and challenges of the BFHI and explore ways of working together to implement the state's comprehensive hospital regulations to support breastfeeding. This summit was hosted by the New Jersey Hospital Association in Princeton, with the goal of expanding the Baby-Friendly Initiative successes through sharing the designated hospitals' expertise.

The Department has supported maternity hospitals to implement the BFHI since 2010. The initiative has provided funding, training and technical assistance to help New Jersey hospitals progress along the pathway to Baby Friendly designation following the 10-Step guidelines established by the World Health Organization and UNICEF.

Hospital support can have a great impact on a mother's success in breastfeeding. According to the CDC, about one in three moth-

ers stop breastfeeding early without hospital support. Hospitals have the ability to implement practices that can protect, promote and support breastfeeding and improve the success rate among women who choose to breastfeed.

Whether or not hospitals choose to implement Baby Friendly, it is important that they set concrete goals for changing practices. We encourage more hospitals to begin allowing mothers and newborns to sleep in the same room and increase the percentage of mothers who have "skin to skin" contact with their babies during the first hour after birth.

To ensure all hospitals are accommodating new mothers' infant feeding choices, the Department adopted rule amendments in January of this year that support mothers who breastfeed in the hospital and advance the quality of care in New Jersey's hospitals. Specifically, the rulemaking directs hospitals with obstetrics services to implement changes in facility operations that support infant feeding at birth—in accordance with a mother's choice to breastfeed or bottle feed her infant—and requires all hospitals to identify, assess, plan for, and accommodate the breastfeeding needs of a nursing mother and/or child. The goal of these amendments is to increase breastfeeding rates, improve health outcomes for both mothers and infants, reduce childhood obesity rates, contain healthcare costs and establish healthy practices that respect maternal choice. The new policies, adopted as amendments to Hospital Licensing Standards, were developed collaboratively with public health and healthcare experts.

Mothers need information, help and skilled support when they breastfeed—that is why the Department is working with healthcare providers to improve support for breastfeeding mothers and their infants. Healthcare providers play an important role in advising and supporting patients and they can educate women and their partners about how breastfeeding can help improve their child's health. A good resource for providers is the American Academy of Pediatrics' Health Professionals Resource Guide, which is available at: <http://www2.aap.org/breastfeeding/healthProfessionalsResourceGuide.html>. This guide will direct healthcare providers to information, toolkits, publications and other web sites for health professionals about breastfeeding. Information available includes breastfeeding policies, everyday resources for the office or hospital, breastfeeding education for health professionals and resources to support breastfeeding families.

We need all healthcare providers to support new mothers and improve breastfeeding rates in our state so we can give New Jersey's children a healthy start in life and build a healthier population.

Editor's Note:

To learn more about how to receive the "Baby Friendly" hospital designation, please visit <https://www.babyfriendlyusa.org/>

Reference

1. <http://www.cdc.gov/vitalsigns/breastfeeding/>

What Have You Done For Me Lately?

Arnold Pallay, MD (*Montville*) served as the Chair of the Reference Committee on Advocacy during the AAFP Congress of Delegates in Washington, DC this fall.

Arnold Pallay, MD (*Montville*), **Mary Campagnolo, MD** (*Bordentown*) served as the NJAFP Delegates to the AAFP Congress of Delegates held this fall in Washington, D.C. **Terry Shlimbaum, MD** (*Berkeley Heights*) and **Sal Bernardo, MD** (*Freehold*) served as NJAFP Alternate Delegates. **Jerry Banks, MD** (*Trenton*), NJAFP Resident Trustee served as the Resident Delegate to the AAFP Congress of Delegates. **Rodrick Stewart** (*Lindenwold*), NJAFP Student Trustee served as the AAFP Alternate Student Trustee to the AAFP Congress of Delegates.

BURNOUT! continued from page 7

workaholic tendencies.

It would be easy to assume that the current fractured and fragmented system in which physicians work is entirely to blame. The volumes of paperwork that at best are burdensome and time consuming, and at worst are ridiculous examples of out of control bureaucracy; the overly litigious society in which physicians practice; the overload of often incorrect information available to patients that leads to physicians feeling the need to constantly explain why – for example – Jenny McCarthy is wrong and vaccinations are an

important public (and personal) health tool, are all factors that lead to physician burnout. However, the system changes that most agree are necessary to achieve the “triple aim” of improving the patient experience of care (including quality and satisfaction); improving the health of populations; and reducing the per capita cost of health care are not necessarily a panacea for the fight against physician burnout. As Dr. Drummond notes, “being a physician is stressful... period.”¹ Even in the best system, physicians have chosen one of the most inherently stressful careers possible, where “days are filled with intense encounters with sick, scared, or hurting people...”¹ and where even if tomorrow we were able to throw a switch and convert to a fully team-based system that rewards value over volume, physicians would too often find themselves in leadership roles for which their training was woefully inadequate.

Simply put, the current system contributes to the high levels of burnout. Yet, that isn't the sole factor. It is critical that we begin to recognize both the causes and symptoms of physician burnout, as well as tools that the individual physician and the system might implement to reduce the number of physicians who fall victim to burnout and to lower existing levels of burnout. In future issues I will highlight some of those tools and resources that leaders in the field suggest in the fight against physician burnout. In addition, the NJAFP will continue to provide connections to resources through our educational offerings, on NJAFP.ORG, and here in *Perspectives*. On behalf of your entire academy, I remain committed to your health and success, and thank each of you for the work you do, and sacrifices you make, on behalf of your patients each and every day. ▲

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Breastfeeding

Sara Leonard, MD and Theresa J. Barrett, PhD

Dr. Leonard is family physician in Freehold and a trustee of the NJAFP. Dr. Barrett is the Deputy Executive Vice President for the NJAFP

Dr. Leonard has no relevant financial relationships related to the content of this article. Dr. Barrett is an employee of the New Jersey Academy of Family Physicians and has no conflicts relevant to the content of this article.

Learning Objectives:

At the conclusion of this activity, the learner should be able to:

1. Follow the AAFP and the AAP policies on breastfeeding
2. Discuss the benefits and risks of breastfeeding

The American Academy of Pediatrics (AAP) policy statement on Breastfeeding and the Use of Human Breast Milk states that “Breastfeeding and human milk are the normative standards for infant feeding and nutrition. Given the documented short- and long-term medical and neurodevelopmental advantages of breastfeeding, infant nutrition should be considered a public health issue and not only a lifestyle choice.”¹

Family physicians have a great deal of influence over a mother’s decision to breastfeed her infant. To effectively promote breastfeeding, family physicians need to educate themselves and their patients about the benefits, and the potential risks, of breastfeeding and then engage in shared-decision making to make the right choice for mother and baby.

Epidemiology

The Centers for Disease Control and Prevention (CDC) analyzed National Immunization Survey data to determine breastfeeding trends from 2000 to 2008 and found that overall breastfeeding is on the rise (Table 1).²

Table 1: Breastfeeding Trends 2000 to 2008

	Infants born in 2000	Infants born in 2008
Ever breastfed	70.3%	74.6%
Breastfed for 6 months	34.5%	44.4%
Breastfed for 12 months	16.0%	23.4%

By race and ethnicity, over the same time period, breastfeeding prevalence increased among blacks (47.4% to 58.9%), whites (71.8% to 75.2%) and Hispanics, although the increase among Hispanics was not statistically significant (77.6% to 80.0%).² Duration of breastfeeding – from 6 months to 12 months increased

across all three populations, with the gap narrowing between black and white breastfeeding. However, black infants still had the lowest prevalence of both breastfeeding initiation and duration, indicating a need for intervention to support and promote breastfeeding in the black community.²

Recommendations

The American Academy of Family Physicians Policy on Breastfeeding recommends:

“...all babies, with rare exceptions, be breastfed and/or receive expressed human milk exclusively for the first six months of life. Breastfeeding should continue with the addition of complementary foods throughout the second half of the first year. Breastfeeding beyond the first year offers considerable benefits to both mother and child, and should continue as long as mutually desired.”³

The American Academy of Pediatrics also recommends exclusive breastfeeding for about six months, and continued breastfeeding as complementary foods are introduced into the infant’s diet. Breastfeeding can be continued for one year or longer as desired by mother and child.¹

Benefits of Breastfeeding

Studies have shown a 72% decrease in hospitalizations for lower respiratory tract infections in the first year of life when an infant is breastfed exclusively for more than four months.^{4,5} When compared to commercial infant formula feeding, any amount of breastfeeding has been shown to reduce incidence of otitis media (OM) by 23%, while exclusive breastfeeding for longer than three to six months reduced the risk of OM by 50%.⁴ Infants who were breastfed exclusively until age four months and partially breastfed thereafter showed a significant reduction in both gastrointestinal and respiratory infections.⁶

Rates of obesity are significantly lower in breastfed infants than their non-breastfed counterparts.¹ Three good and moderate quality meta-analyses showed an association between a reduction in the risk of obesity in adolescence and adult life and breastfeeding compared to individuals who were not breastfed, although caution should be used in interpreting these associations due to the possibility of residual confounding.⁴ Studies have also reported a 30% reduction in Type 1 diabetes for infants who were breastfed exclusively for at least three months, thereby avoiding exposure to cow milk β-lactoglobulin, which stimulates an immune-mediated process cross-reacting with pancreatic β cells.^{4,7} It has been postulated that this exposure is the putative mechanism in the development of Type 1 diabetes. In addition, a 40% reduction in the

incidence of Type 2 diabetes has been reported which could reflect the positive long-term effect of breastfeeding on weight control and feeding self-regulation.⁸

Breastfeeding also benefits the mother. In women without a history of gestational diabetes, breastfeeding is associated with a longer life expectancy, as well as a reduced risk of developing Type 2 diabetes.⁴ Women who breastfeed their babies also have a reduced risk for the development of breast cancer and there is some evidence that may suggest an association between breastfeeding and a decreased risk of maternal ovarian cancer.⁴

Contraindications for Breastfeeding

True medical contraindications to breastfeeding are rare but they do exist. Infants with classic galactosemia, a metabolic disorder, should not receive breast milk.¹ However, if appropriate blood monitoring is available, infants with other metabolic disorders, such as phenylketonuria, can be fed by alternating breast milk with modified or special protein-free formulas.¹

Certain maternal conditions are also contraindications to breastfeeding. Mothers who have active herpes simplex lesions on their breasts or infectious, untreated tuberculosis should not breastfeed, however they can use expressed breast milk as there is no risk of passing the infectious organisms to the infant through the milk.¹ Mothers who have untreated brucellosis⁹ or who are positive for human T-cell lymphotropic virus type I or II¹⁰ should not breastfeed, nor should they provide expressed milk to their infants. A full review of the contraindications to breastfeeding can be found in the AAP Policy Statement Breastfeeding and the Use of Human Milk.¹

Breastfeeding and Legislation

One provision of the Affordable Care Act (ACA) was an amendment to the Fair Labor Standards Act (FLSA) which requires an employer to provide reasonable break time for an employee to express breast milk every time there is a need to do so, for one year after the birth of the child. While the employer is not required to compensate the employee, the employer must provide a place, other than the bathroom, for the employee to express breast milk (an employer that employs fewer than 50 employees is exempt for

this requirement).¹¹ New Jersey law states that “a mother shall be entitled to breastfeed her baby in any location of a place of public accommodation, resort or amusement wherein the mother is otherwise permitted.”¹²

Conclusion

The AAFP states that family physicians should have the knowledge to promote, protect, and support breastfeeding.³ Research shows that the prevalence of breastfeeding is increasing,² and there are clear benefits for both the infant^{1,4-8} and the mother.⁴ However, fewer than half of the infants in the CDC survey² were still being breastfed at 6 months. Mothers who choose to breastfeed their infants need ongoing support to continue breastfeeding and family physicians are in the best position to offer this support and education.

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Introducing Solid Food

Heidi Sloan, MA, CCC-SLP, C/NDT

Ms. Sloan is a speech-language pathologist with Pathways.org. Ms. Sloan has nothing to disclose relevant to this article.

Learning Objectives:

At the conclusion of this activity, the learner should be able to:

1. Recommend the best time to introduce solid food to an infant's diet

Parents often rely on their child's healthcare provider for information and support regarding infant feeding practices and nutrition. The American Academy of Family Physicians recommends introducing solid food to an infant's diet around 6 months of age.¹ However, the results of a 2013 survey, which included 1,334 new mothers, indicated that 40% of respondents introduced solid foods to their infants much earlier – prior to 4 months of age.² Given the short-term and long-term risks associated with early solid food introduction, it is essential for healthcare providers to give clear and accurate feeding recommendations at early well-child visits.

Every infant develops at his or her own pace and parents should be instructed to watch for the following signs of solid food readiness near 6 months of age:³

- Able to hold his or her head up when sitting
- Opens mouth when food approaches
- Able to move food from a spoon or fork into throat

Infants can start their transition to solid food with thinly pureed fruits and vegetables, such as bananas, peaches, and squash, as well as single-grain cereals mixed with breast milk or formula. Particular foods should be avoided for the first year, including honey,

cow's milk, salt, and artificial sweeteners. Honey contains spores that can cause infant botulism, and infants' digestive systems cannot process the protein present in cow's milk.⁴

Parents may be tempted to start solid foods early if their infant seems particularly fussy or hungry. They may also follow the common misconception that consuming solid foods before bedtime helps an infant sleep through the night; research shows that there is no evidence to support this claim.⁵ Healthcare providers can encourage a healthy transition to solid food by communicating the risks associated with starting too soon. Introducing solid food too early may:

- Cause an infant to choke – in their first few months, infants cannot hold their heads up in a sitting position and have not yet developed the coordination needed to swallow food
- Result in stomach aches, gas, and constipation – an infant's digestive tract is not prepared to process solid foods until closer to 6 months of age
- Replace breast milk or formula with food that may not meet an infant's nutritional needs – breast milk or formula should remain an integral part of an infant's diet until the first birthday
- Increase the risk of obesity and diabetes^{6,7}

Founded in 1985, Pathways.org empowers parents and health professionals with free educational resources on the benefit of early detection and early therapy for children's motor, sensory, and communication development. For more information, visit www.pathways.org or emails friends@pathways.org. Pathways.org is a 501(c)(3) not-for-profit organization.



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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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Members – To obtain credit:

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

Nonmembers – To obtain credit:

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

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

Name: _____ AAFP Membership Number: _____

Street Address: _____

City/State/Zip: _____

Email Address: _____

Phone: _____ Fax: _____

1. True or False: Breastfeeding should be considered a public health issue, not a lifestyle choice.
2. True or False: There are no medical risks to breastfeeding.
3. True or False: The rate of breastfeeding remained constant from 2000 to 2008.
4. True or False: Black infants have the lowest prevalence of breast-feeding initiation and duration.
5. True or False: It is recommended that babies be breastfed exclusively for the first six months of life.
6. True or False: Breastfeeding has not been shown to have an impact on either gastrointestinal or respiratory infections.
7. True or False: Mothers who have active herpes simplex lesions on their breasts or infectious, untreated tuberculosis cannot use expressed breast milk to feed their babies.
8. True or False: Recommendations state that solid foods should be introduced at 6 months, however up to 40% of new mothers start feeding solid foods to their babies prior to 4 months of age.
9. True or False: Foods to be avoided during the first year of life include cow's milk and honey.
10. True or False: Until one year of age, breast milk or formula should be a part of an infant's diet.

ANSWERS ON PAGE 19

Research Poster Contest Winners for 2014

First Place in the Physician category went to “Comparing the accuracy of internet search engines, pill identification databases, and image recognition technology in medication identification,” by **Bennett Shenker, MD** with co-authors, **Ujjwala Kalangi, MD; Joan Medina, MD; Philip Manners, MD; Akshat Jain, MD; Simone Singh, MD; Galina Feldman, DO** from the CentraState Family Medicine Residency program in Freehold.

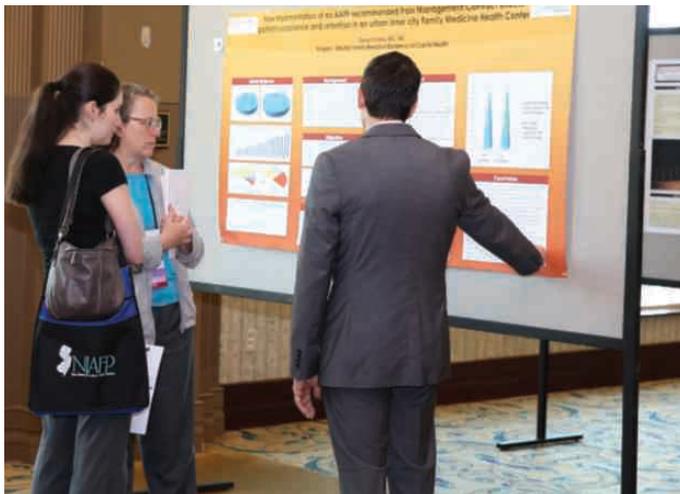
Second Place in the Physician category went to “How to identify and best evaluate inflammatory back pain in primary care among chronic back pain patients,” by **Palanipriya Kalyan, MD** from Valley Health Medical Group and Rutgers in Fairlawn and co-author, **Barbara Jo McGarry, MD** from the RWJMS Family Medicine Residency at RWJUH in New Brunswick.

First Place in the Resident category was awarded to “How implementation of an AAFP recommended pain management contract affects patient compliance and retention in an urban inner city family medicine health center,” by **Gerald Banks, MD** from Capital Health in Trenton.

Second Place in the Resident category went to “How does adherence to office policy for recommended follow up and patient compliance affect control of hypertension in a model family practice office?” by **Adrienne Salerno, MD** with co-authors **Daniel Cruz PhD; George Miller, MD; Kenneth Faistl, MD** from the Hackensack UMC Mountainside Family Medicine Residency Program in Verona.

Degree of Fellow Awarded

Special Congratulations to Geronima Alday, MD and Kevin Berg, MD (both from CentraState in Freehold) who received the AAFP Degree of Fellow by Dr. Robert Wergin at the House of Delegates.



Gerald Banks, MD (r) explains his poster to reviewers, Lauren Carruth, MD (l) and Kathy Saradarian, MD.

In the News...

Sal Bernardo, MD (Freehold), NJAFP Board Chair, was interviewed by radio station 101.5FM about the new strain of influenza B. To listen to the interview go to <http://nj1015.com/new-flu-shows-up-in-nj-audio/>

NJ EVP **Ray Saputelli, MBA, CAE (Trenton)** was interviewed by *NJSpotlight.com* about the number of family doctors in New Jersey as compared with other specialties and practice areas. <http://www.njspotlight.com/stories/14/04/27/the-list-how-nj-stacks-up-against-other-states-in-medical-specialists/>

Jeremy C. Hewens, MD (Milford) was featured in the *Hunterdon County Democrat* as the 2014 Family Physician of the Year. http://www.nj.com/hunterdon-county-democrat/index.ssf/2014/06/milford_physician_named_the_fa.html

NJAFP Government Affairs Director, **Claudine Leone, Esq. (Trenton)** was featured in *NJSpotlight* regarding awareness of naloxone. Read the article at <http://www.njspotlight.com/stories/14/07/21/survivors-of-overdose-victims-call-on-doctors-to-prescribe-opioid-antidote/>

Robert Gorman, MD (Verona) NJAFP President-Elect, was interviewed by *The Star-Ledger* about the importance of vaccinations on overall health. http://www.nj.com/healthfit/index.ssf/2014/08/doctors_say_vaccines_are_crucial_to_staying_healthy_over_a_lifetime.html. Dr. Gorman also spoke with a reporter from *Inside Jersey* magazine about the impact of ACA on physician practices and patients. Article is slated to run in the Top Docs edition of *Inside Jersey*.



Dr. Wergin (l) and new Fellows, Drs. Alday (c) and Berg (r).

2014 Summer Celebration & Scientific Assembly Highlights

The 2014 Summer Celebration & Scientific Assembly was filled with lots of learning and fun. Check out the highlights for the meeting at <http://njfamilydoc.org/>



NJAFP Past Presidents congratulate Deputy Executive Vice President, Theresa Barrett, PhD at the President's Gala on receiving her Doctorate in Adult Education this year.



The RWJ team at the Resident Knowledge Bowl (RKB).



RKB Master of Ceremonies, Dr. John Ruiz.



Attendees pause to chat with Dawn Romond of Partners in Care on the Exhibit Floor.



Dancing to the fun sounds of the Kenny I Orchestra.

Actions of the House of Delegates

The 2014 House of Delegates (HOD) convened on Friday, June 13 at 8am. Delegates were present from the following counties: Atlantic/Cape May, Bergen, Burlington, Essex, Hunterdon, Mercer, Middlesex, Monmouth, Morris, Ocean, Passaic, Somerset, and Sussex.



NJAFP President, Tom Shaffrey, MD addresses the 2014 House of Delegates.

Actions of the House of Delegates

The following resolutions were adopted:

NJAFP 2014 Resolution #1

Proposed by Kathy Saradarian, MD

RESOLVED: that the Board of Directors of the NJAFP recommend that the Government Affairs Committee research the need for the revision of laws or the creation of new legislation that would enable direct primary care in New Jersey;

RESOLVED: that the NJAFP develop a tool for NJ Family Physicians that spells out what practice structures are legal in the state of New Jersey.

NJAFP 2014 Resolution #2

Proposed by Kathy Saradarian, MD

RESOLVED: that the NJAFP approach, specifically, the Department of Human Services-Division of Developmental Disabilities offering to help them upgrade their forms and requirements be in alignment with current USPSTF recommendations and guidelines, and be it further;

RESOLVED: that the NJAFP create a pre-employment physical form that follows current USPSTF recommended guidelines, keep it updated, and investigate the feasibility of using the form as a revenue generator by offering it to employers for purchase.

NJAFP 2014 Resolution #3

Proposed by Kathy Saradarian, MD

RESOLVED: that the NJAFP Board of Directors be tasked with developing a method to allow for virtual participation and voting at business meetings of the Board of Directors, House of Delegates, and/or committee meetings, and be it further;

RESOLVED: that the NJAFP bylaws be rewritten to allow the same if necessary.

NJAFP 2014 Resolution #5

Proposed by Max Burger, MD

RESOLVED: that the NJAFP submit a resolution to the 2014 AAFP Congress of Delegates (COD) with resolved clauses that instruct the AAFP to educate the public and lawmakers on the use of high deductible insurance plans offered by insurers within and outside the ACA, and to vigorously advocate for alternatives to high deductible plans; and that the AAFP monitor the impact of this practice of health insurers on physicians and patients reporting back to the COD.

The following resolutions were not adopted:

NJAFP 2014 Resolution #4

Proposed by Thomas Shaffrey, MD

RESOLVED: that the NJAFP reaffirm that the patient-physician relationship, not the insurer-patient relationship, is the fundamental foundation of providing healthcare; and be it further

RESOLVED: that the NJAFP seek federal and state regulatory relief from the restrictive insurance practices of selectively applying deductible requirements on patients for care delivered by non-contracted physicians and be required to reimburse the patient, or their designated agent, that portion of the incurred expense at a minimum of local Medicare rates, for any medical service provided by the patient's chosen physician, and to do so without a discriminatory deductible or co-pay; and be it further

RESOLVED: that the NJAFP delegation to the AAFP Congress of Delegates present a resolution with corresponding resolved clauses to the 2014 Congress in Washington, DC this October.



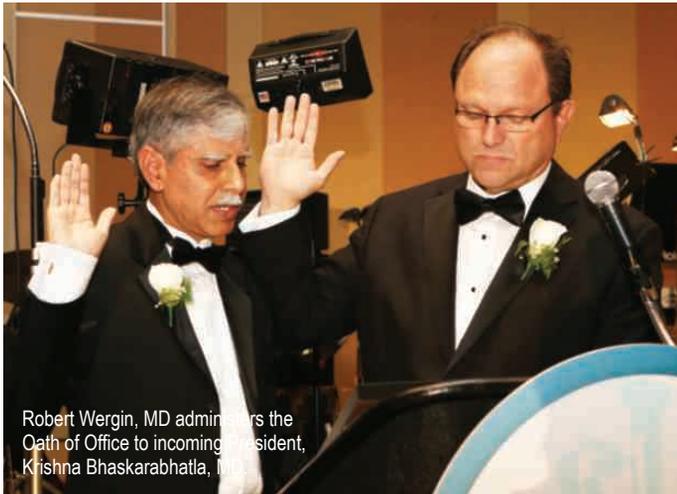
NJAFP Honors New Board Members

THE INSTALLATION of the NJAFP Officers and Board of Trustees is the highlight of the NJAFP year. We were honored to have AAFP President-Elect Robert Wergin, MD as our officiating representative. Dr. Wergin performed in the installation ceremony for the new officers and trustees and for NJAFP incoming president, Krishna Bhaskarabhatla, MD. Please congratulate our new board:

President: Krishna Bhaskarabhatla, MD (Woodland)
President Elect: Robert Gorman, MD (Verona)
Vice President: Adity Bhattacharyya, MD (Trenton)
Treasurer: Peter Louis Carrazzone, MD (North Haledon)
Secretary: Lauren Carruth, MD (Linwood)
Board Chair: Thomas A. Shaffrey, MD (Bound Brook)

New Trustees:

Thomas S. Bellavia, MD 2015 (*Voting Past President*)
Salvatore Bernardo, Jr., MD 2015 (*AAFP Alternate Delegate*)
Mary F. Campagnolo, MD 2015 (*AAFP Delegate*)
Robert Kruse, MD 2016 (*Resident Trustee*)
Sara B. Leonard, MD 2016 (*New Physician Trustee*)
Lisa W. Lucas, DO 2016 (*New Physician Trustee*)
Anthony G. Miccio, MD 2017 (*Board Trustee*)
Cheryl Monteiro 2015 (*Student Trustee*)
Arnold I. Pallay, MD 2016 (*AAFP Delegate*)
Jeffrey S. Rosenberg, MD 2017 (*Board Trustee*)
Rodrick L. Stewart 2015 (*Student Trustee*)
Joseph W. Schauer, III, MD 2015 (*Voting Past President*)
Kelly G. Ussery-Kronhaus, MD (*Board Trustee*)
Terry E. Shlimbaum, MD 2015 (*AAFP Alternate Delegate*)



Robert Wergin, MD administers the Oath of Office to incoming President, Krishna Bhaskarabhatla, MD.



The new Board members and officers of the NJAFP, with AAFP President-Elect, Robert Wergin, MD (l) after the installation. (from l to r) Robert Gorman, MD; Adity Bhattacharyya, MD; Peter Carrazzone, MD; Lauren Carruth, MD; Robert Kruse, MD; Cheryl Monteiro; Rodrick Stewart; Mary Campagnolo, MD; Terry Shlimbaum, MD; Sal Bernardo, MD

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

A Special Congratulations to all 2014 Honorees



Robert Gorman, MD was recognized for his work as the 2014 Annual Meeting Chair.



NJ Family Physician of the Year, Jeremy Hewens, MD is flanked by his nominator, Terry Shlimbaum, MD (l) and NJAFP Past President, Tom Shaffrey, MD (r).



Sal Bernardo, MD (l) receives the President's Award from Dr. Shaffrey.



Resident of the Year, Donna Kaminski, DO, MPH with Somerset Program Director, John Bucek, MD.



Dr. Al Tallia (r) receives the NJAFP Chair Award from Dr. Tom Shaffrey (c) with new NJAFP President, Dr. Krishna Bhaskarabhatla.



Resident Knowledge Bowl – 2014 Champions
Inspira Family Medicine Residency Program at Woodbury

The Inspira team proudly displays "The Coveted Cup" as our esteemed judges look on.

How Secure is Your Mobile Device?

Susan B. Orr, Esq.

Susan B. Orr, Esq. is a health law attorney with Rhoads & Sinon LLP in Exton, PA.

Communicating with patients and other physicians using mobile devices such as iPhones, iPads, or smart phones is a fast growing trend among physicians. Eighty-three percent of physicians use some type of mobile device to collect, store or transmit patient information. However, 49% do nothing to protect their device from unauthorized access to patient information. Because physicians use their personal mobile device rather than that of their employer, they rarely use passwords to access patient information or install an encryption program to protect the electronic protected health information (ePHI). The risk of unauthorized access to ePHI on a mobile device is further compounded as data is actually stored in the device itself via either internal memory or a memory chip.

Mobile devices are particularly vulnerable to unauthorized access as they are small, portable, and easily visible, making them easy targets for would-be thieves. In addition, ePHI stored on the device may be accessed if ePHI is transmitted through an unsecure Wi-Fi or cellular network.

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") Privacy and Security rule requires covered entities ensure the confidentiality, integrity, and availability of all ePHI the covered entity creates, receives, or transmits and to protect the ePHI against any reasonably anticipated threats or hazards to the security or integrity of such information and any reasonably anticipated uses or disclosures of such information. Therefore, physicians as covered entities are accountable for any breach of ePHI that may occur as a result of their failure to adequately secure their mobile device.

Failure to adequately secure the ePHI on a mobile device can have significant ramifications for physicians in the event of a breach.

To meet this requirement, physicians should take the following steps: (a) conduct a risk analyses of the potential threats and vulnerabilities to ePHI maintained on mobile devices; (b) develop policies and procedures that outline the administrative, physical and technical safeguards needed to protect ePHI; and (c) train staff on the use of mobile devices. The Office of the National Coordinator for Health Information Technology has outlined tips to protect and secure information when using a mobile device, as follows:

1. Configure your mobile device to require a password or pin or other type of user authentication.
2. Install and enable encryption on mobile devices that store or access ePHI. Some mobile devices have built-in encryption capabilities, but if yours does not, buy and install an encryption program for your device.

3. Install and activate remote wiping or a remote disabling to erase or delete the data in your mobile device or to lock or completely erase data stored on a mobile device if it is lost or stolen.
4. Disable and do not install or use file sharing applications to reduce the risk to data.
5. Install and enable a firewall to block unauthorized access.
6. Install and enable security software to protect against malicious applications, viruses, spyware, and malware-based attacks.
7. Keep your security software up-to-date so you have the latest tools to prevent unauthorized access to health information on or through your mobile device.
8. Research mobile applications (apps) before downloading. Use known websites or other trusted sources that you know will give reputable reviews of the app.
9. Maintain physical control to prevent the loss or theft of the device and to limit unauthorized users' access, tampering or theft of your mobile device.
10. Use adequate security to send or receive health information over public Wi-Fi networks or better yet, do not send or receive ePHI when connected to a public Wi-Fi network, unless you use secure, encrypted connections.
11. Delete all stored health information before discarding or reusing the mobile device by using software tools that thoroughly delete (or wipe) data stored on a mobile device before discarding or reusing the device.

The use of mobile devices can certainly enhance the efficacy and convenience of accessing and transmitting health information to patients, other physicians, and pharmacists. However, failure to adequately secure the ePHI on a mobile device can have significant ramifications for physicians in the event of a breach. Theft of a mobile device is the most frequent cause of a HIPAA security breach that can result in significant penalties. In 2014, two healthcare organizations paid the U.S. Department of Health and Human Services Office for Civil Rights (OCR) \$1,975,220 collectively to resolve violations of the HIPAA Privacy and Security Rules resulting from the use of unencrypted laptop computers and other mobile devices. Susan McAndrew, OCR's deputy director of health information privacy, summed up OCR's position on mobile devices by stating: "Covered entities and business associates must understand that mobile device security is their obligation. Our message to these organizations is simple: encryption is your best defense against these incidents."

For questions regarding the security of mobile devices please call Susan B. Orr, Esq., Rhoads & Sinon LLP at 610-423-4200 or email her at sorr@rhoads-sinon.com ▲



CALL TO ACTION:

Family medicine practices needed to apply as host sites for NJ's Primary Care Loan Redemption Program *Claudine M. Leone, Esq.*

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

NJAFP has known for some time that the current NJ Primary Care Practitioner Loan Redemption Program (LRP) is lacking something. We have heard that there is low awareness of its existence from medical students and residents and we have heard that there are not enough sites or practices to place those eligible participants that actually want to work through this program. A third reason may just be that primary care practices simply don't have the resources to hire new full time physicians.

If you are not familiar with the Loan Redemption Program, it provides \$120,000 of loan redemption over four years of employment working in a medically underserved community in New Jersey. But this has nothing to do with you as a prospective practice site or employer to these participants.

NJAFP has investigated this for some time with our partners, NJ Council of Teaching Hospitals and MSNJ, and we recently tried to "fix," through legislative action, what we believed was limiting the access and effectiveness of LRP. The legislation was well received, generally, but was stalled in the final hours of the legislative session that ended in January 2014 for reasons I can't possibly explain in a *Perspectives* article!

We were advised to work directly with the staff and management of the LRP and representatives of the Higher Education Student Assistance Authority, which oversees the Program. That meeting, which occurred this summer, resulted in NJAFP's conclusion that we need to get sites to apply to the Program to "test" its current process of site approval.

While we generally still believe there are some other problems with the LRP that may need tweaking, it appears at this time that it simply doesn't have enough qualified sites to hire its eligible participants. They have new physicians approved through the Program, who want to stay in NJ, but have nowhere to go!

We are calling on all family medicine practices (private, hospital-owned, clinics or otherwise!) to apply to qualify as an eligible site under LRP and let NJAFP help you get over the hurdles in the application process.

There are some basic site eligibility criteria for you to consider, and I encourage you to think broadly. They need primary care sites.

1. Practice Location: There is an approved list of medically underserved municipalities found at www.nj.gov/health/fhs/professional/documents/njmmu99.pdf to guide you initially as to whether you can easily pass the first test. However, there are exceptions. Practices not located in designated medically underserved areas are asked to submit additional documentation identifying their

patient population in order to determine if they qualify. You will need to contact the program directly if you are not located in one of the listed underserved municipalities.

- 2. Sliding Fee Scale:** Your practice must have a sliding fee scale or if you do not, must develop one to submit with your placement site application with the LRP. Not sure? A sliding fee scale is a tool used to determine how much to bill uninsured, low-income patients for services rendered based on the family size and income level. For guidelines on establishing a sliding fee scale, contact the LRP office. They have samples and can help with this requirement.
- 3. Insurance:** Your practice must accept Medicare, Medicaid and Medicaid Managed Care plans.
- 4. Underserved Population:** Sites must demonstrate that they provide services to an underserved population based on the percentage of medically underserved patients served in the county. This can be the tricky one, and you are not supposed to know this. I would submit an application and the LRP will figure this out with the practice information you provide to them.

Keep in mind that you can use the program's pool of candidates to interview or find your own eligible participant. Once you are an "approved" site, you are in and the process to hire can move forward. ▲



GENERAL INFORMATION ON THE PROGRAM:

General guidelines can be found at http://rbhs.rutgers.edu/lrpweb/placement_sites/index.htm. Requests for site eligibility, site applications, and/or technical assistance should be directed to the LRP office directly at <http://rbhs.rutgers.edu/lrpweb/contact/index.htm>.

For questions on the application or about the following criteria, contact Claudine (claudine@njafp.org) or call Sharon Bryant, Program Director, directly at (973) 972-4605 or email njlrp@ca.rutgers.edu to reach the program's staff.

Please consider putting in an application, if not for your practice, then to help NJAFP achieve one of its strategic initiatives: Family Physician retention through Loan Redemption. I would like to keep track of these applications and help you through the process, so please contact me at claudine@njafp.org or at the NJAFP office to let me know if you are submitting or if you have any questions.



Primary Care Practitioner Loan Redemption Program of New Jersey

Administrative Complex, Building I, Room 119
 30 Bergen Street, P.O. Box 1709, Newark, NJ 07107-1709
 Phone: 973-972-4605 * Fax: 973-972-8491

NEW JERSEY MEDICALLY UNDERSERVED INDEX - 1999

These municipalities have been designated as underserved by the State Commissioner of Health and Senior Services based on the New Jersey Medically Underserved Index (NJMUI). The state designated underserved areas are used to place primary care participants in the New Jersey Loan Redemption Program (LRP). The NJMUI ranks municipalities with populations of 5,000 or more according to indicators that are potentially indicative of a lack of access to comprehensive and timely primary health care. Populations of 30,000 or more were evaluated according to four economic indicators; the values for health status indicators were generally too small to provide valid statistics. Geographic areas not designated on the NJMUI can be considered on a case by case basis, if adequate documentation is provided to support the designation.

Municipalities with Populations of 5,000 to 29,999	
Bridgeton city	Fairfield township
Paulsboro borough	Asbury Park city
Salem city	Buena Vista township
Pleasantville city	Lower township
City of Orange township	Phillipsburg township
Egg Harbor city	Keansburg borough
Woodbury city	Mullica township
Middle township	Gloucester city
Maurice River township	Millville city
Glassboro borough	Hammonton town
Fairview borough	Mount Holly township
Long Branch city	Burlington city
Clementon borough	Clayton borough
Harrison town	Egg Harbor township
Garfield city	North Hanover township
Upper Deerfield township	Ocean township
Lodi borough	Riverside township
Pine Hill borough	Union Beach borough
Franklin borough	

Municipalities with Populations of 30,000 or More	
Newark city	Atlantic city
Camden city	East Orange city
Trenton city	Paterson city
Jersey city	Perth Amboy city
Passaic city	Irvington township
New Brunswick city	Elizabeth city
Union city	Lakewood township
Plainfield city	West New York town
Vineland city	

Health Professional Shortage Areas (HPSAs), as designated by the Federal Division of Shortage Designations are eligible placement areas for participants in the NJLRP.

To learn more about the Primary Care Practitioner Loan Redemption Program of New Jersey, we invite you to visit our website at <http://rbhs.rutgers.edu/lrpweb/>

Six Practices Awarded for Innovative Patient-Centered Projects Cari Miller, MSM, PCMH CCE

NJAFP HAS BEEN WORKING with physicians, providers, health systems, federally qualified health centers/community health centers, residency programs, healthcare teams, and other healthcare stakeholders in making the patient-centered approach a foundation for primary care in New Jersey. Since 2009, the Academy has provided education and hands-on assistance to help practices with achieving national recognition as NCQA Patient-Centered Medical Homes and has supported the efforts of primary care practices to institute patient-centered programs.

This year, as part of its Advanced Topics symposium, NJAFP recognized practices that were committed to the patient-centered concept by asking them to submit applications for the first annual Patient-Centered Innovation Award program. Submissions

focused on activities or projects that enhanced quality of patient care, patient satisfaction, cost reduction, staff development, patient engagement, and more. Six practices were recognized for their innovative efforts. Summaries of their efforts are highlighted below. Congratulations to the 2014 recipients!

SUBMISSION CATEGORIES

- Private Practices with One to Three Physicians
- Private Practices with Four or More Physicians
- Practices part of a Healthcare System or a Healthcare System
- Residency or Faculty Practices
- Federally Qualified or Community Health Centers



(l to r) Dana Lisicki; Mitchell Kaminski, MD; and Christeen Cornell, RN, BSN, CCM accept the NJAFP Patient-Centered Innovation Award for AtlantiCare Physician Group.

Practice: AtlantiCare Physician Group

Egg Harbor Township, NJ

Physicians in Practice: 44

Category: Practice That Is Part of a Healthcare System

Project: Improving Patient Care with Advanced Access

Description: AtlantiCare deemed it critical that patients be able to obtain timely appointments when seeking medical care and set a 65% threshold for maintaining open access in each practice. Metrics are tracked weekly and patient experience scores are monitored regarding patients' ability to obtain appointments.

New appointment cards were created specifically for "Advanced Access." Patients requiring follow-up appointments are provided with a card containing instructions to call back in a specific time period. The team developed a report indicating which patients are due for follow-up appointments. If a patient fails to call, a telephone reminder is automatically generated. Patients receive two system generated calls, followed by office staff calls. Finally, a letter is sent to the patient to schedule an appointment. AtlantiCare



Geralyn Prosswimmer, MD, and David Polizzi, MD share the Highlands Family Health Center's award.

also created signage that explains the benefits of Advanced Access, which is posted in exam rooms and patient registration areas.

Data indicates that the program is exceeding national benchmarks. When patients are surveyed regarding how often they get appointments for urgent care quickly, the benchmark for AtlantiCare was almost 78% versus that of 68% nationally.

Practice: Highlands Family Health Center

Hampton, NJ

Physicians in Practice: 2 physicians and 2 nurse practitioners

Category: Practice That Is Part of a Healthcare System

Project: Pre-visit Planner and Pre-visit Health Review Process

Description: The pre-visit plan is a work list used prior to each visit for patients with a recent care transition and with chronic conditions. The work list includes preventive care, condition management, and transition of care sections. Standing orders permit the pre-visit planner (PVP) to order



Terry Shlimbaum, MD, and Cindy Barter, MD are presented the award for Phillips Barber Family Health Center.

tests, such as colonoscopies and mammograms. Pre-visit planning also includes the pre-visit health review document, which patients receive at registration.

As a result of the introduction of these processes, staff satisfaction has increased because roles are better defined, gaps are closed, and quality metrics are rising. Also, the complete office team is involved. The receptionists provide appointment lists and documents for the PVP and explain the pre-visit health review form to patients at registration. Nurses ensure care gaps are closed when rooming the patient and providing support regarding the PVPs. Physicians provide extensive input for tasks on the work list and use it during huddles. Care is more effective and efficient since gaps are identified prior to appointments and closed by team members during the visits.

Mammography rates have increased 6.5%, colonoscopy rates improved by 11%, diabetic nephropathy screenings are up by 8%, and patients with an A1c less than 8 has increased 13%.



Laura Lenhart, RN, accepted an award on behalf of Sea Girt Medical Associates.

Practice: Phillips Barber Family Health Center

Lambertville, NJ

Physicians in Practice: 9 physicians and 9 residents

Category: Residency or Faculty Practice

Project: Group Visits for Latino Prenatal Patients

Description: Phillips Barber worked with its hospital and public health department to create a plan to provide patient transportation to group visits. To address potential barriers, the visits were scheduled in evenings and provided child care and refreshments. Two interpreters, including one who was a childbirth educator, were present at the sessions.

The group visit format allows the residency program to see 10 patients within a two-hour time frame in contrast to the five hours it typically requires. This provides an extra three hours in which residents could see additional patients, improving access to care. In addition, traditional phone visits using a phone interpreter were averaging approximately \$7000 every six months. Using group visits and onsite interpreters, this cost was decreased to less than \$900 for a six-month period.

Data has demonstrated that Latino patients accessing prenatal care in the first trimester has increased from 53% in 2010 to 85% in 2013. Patient satisfaction regarding education with the new program is overwhelmingly positive.

Practice: Sea Girt Medical Associates

Manasquan, NJ

Physicians in Practice: 4 physicians

Category: Primary Practice with Four or More Physicians

Project: Patient Weight Loss Challenge

Description: A peer-to-peer weight loss challenge program emphasized a healthy lifestyle through sensible diet and exercise, coupled with preventive care and self-management. The practice care coordination team developed the 12-week program for staff and patients. Patients were invited to participate via the practice's portal and Facebook page. The practice was able to meet its 50-participant goal. Each participant paid \$20 to join, as well as \$1 for each



(l to r) Robert Gorman, MD; Ashley Renna, MA; Laura Tobin, APN; and Thomas McCarrick, MD receive the award for Vanguard Medical Group.

pound gained and \$2 for each missed weigh-in. Patients were weighed weekly and monitored by the physician and care team. Weekly guest speakers, mini-challenges, trivia games, low-calorie recipes and more, as well as a weekly email providing up-to-date weight loss statistics, were provided. Care coordinators conducted one-on-one sessions for patients who had concerns or wanted questions answered.

In 12 weeks, a total of 481 pounds was lost and the three patients with the most weight loss based on percentage of body fat lost shared the \$900 that was collected.

Practice: Vanguard Medical Group

Verona, NJ

Physicians in Practice: 19

Category: Primary Practice with Four or More Physicians

Project: Primary Care at Home

Description: The primary care at home program allows patients to be treated at home, reducing unnecessary trips to the emergency department and averting chronic disease progress that can result in hospitalizations. Patients are referred to the program through primary care physicians or by transition teams following the patients through a hospital or sub-acute rehab stay.

A medical assistant (MA) is dedicated to support the home care team, coordinates scheduling of visits, and collects records and medical information prior to the initial visit. On follow-ups, the MA calls a day ahead to do medication reconciliation and identify any new medical issues. The MA also works with providers throughout the day to schedule and coordinate lab tests, x-rays, nursing care, hospice care, etc. for the homebound patient. The provider uses a laptop with wireless access to the EHR to document care and access patient records.

To assist homebound patients with community resources, Vanguard Medical Group created a resource guide, which is available on the Internet and lists services, such as podiatrists, dentists, and home health aides.



Teresita Lawson, RPh accepted the award on behalf of Zufall Health Center who won for its patient-centered activity.

Practice: Zufall Health Center

Dover, NJ

Physicians in Practice: 13 physicians and 8 nurse practitioners

Category: Federally Qualified/Community Health Center

Project: Improving Health Outcomes with Clinical Pharmacy Services and Education Program

Description: The center's clinical pharmacy services (CPS) program provides support to chronically ill patients through an innovative patient-centered approach, utilizing a proven process for evidence-based patient self-management and education. During 2013, Zufall focused on providing clinical pharmacy services to patients with diabetes who were also homeless or residents of public housing. As a result, more patients with chronic and uncontrolled health conditions, who were using multiple prescribed medications, have benefited from the CPS program. Significant improvements have been seen in patients who have had their diabetes, hypertension, and high cholesterol controlled. The pharmacist serves as a patient educator for support and health education groups and Zufall partners with a local food market dietician who takes patients through the aisles to emphasize healthy food choices and recipes along with taste tests.

A group of 156 patients was seen in 2013. Patients were referred to the clinical pharmacist by the primary provider based on level of risk. By November of that year, 40% of the patients with diabetes had HbA1c levels less than 8 and more than 65% had levels under 9. In addition, patients with high blood pressure and dyslipidemia were better controlled with 69% of patients having blood pressures of 140/90 or less and 51% achieving an LDL goal. ▲

NOTE: The Patient-Centered Innovation Awards will be offered again in 2015. Be sure to submit your practice's unique programs that have enhanced patient care. The 2015 awards brochure will be available at www.njafp.org.

Report on National Conference for Residents and Students

Rodrick Stewart

Rodrick Stewart is a 4th year medical student at Rowan University School of Osteopathic Medicine and serves as a Student Trustee for the NJAFP.

As I sit in my Chicago hotel room on the morning before my first away rotation, I can't help but positively reflect on one of the most overwhelmingly positive weekends I have ever experienced. My first journey to the AAFP National Conference of Residents and Students has left me energized, excited, and wanting to go back. Although I could not experience everything this conference had to offer (I would need several clones to pull off that feat), I did manage to squeeze in a tremendous amount work and fun. I attended several workshops on various topics such as how to engage your patients about unnecessary interventions, minority interests in family medicine, and residency interview do's and don'ts. On top of all of that, I participated in the student congress, co-authored a resolution, and successfully ran for a national position.

I would be remiss if I completed this article without first acknowledging Candida Taylor from the NJAFP office staff. As the conference approached, I had just completed my first rotation as a fourth year and (hopefully) conquered my COMLEX Level 2 PE exam. In the midst of all of this I realized I had not yet booked a hotel room for the conference. Thanks to Candida's herculean effort my lodging was secured, and I was guaranteed not to be homeless for the duration of the conference. I would now like to publicly thank her for all that she has done.

Thursday morning kicked off my whirlwind weekend with an orientation for first time conference attendees. There was a lot of great information given out about workshops, the residency fair, the conference app (fancy), and special events. To my Student Trustee counterpart, Cheryl Monteiro, I highly recommend you attend this session next year when it is your turn to represent New Jersey at the conference. Following this session I ventured over to a workshop on preventing unnecessary interventions. There was a huge emphasis on the website www.choosingwisely.org, which is a collection of consensus statements from the AAFP and various professional physician societies such as the American College of Physicians (ACP), and the American College of Obstetricians and Gynecologists (ACOG) on the necessity of various tests and procedures. I highly recommend this site to everyone, including students, so we can help curb the use of unnecessary tests and procedures.

Next on my agenda was the minority interest roundtable. I will admit that I was pleasantly surprised by the fact that it was so well attended. We had a standing room-only turnout where students and residents expressed their concerns on issues from minority student enrollment to finding mentors, navigating the match as an

IMG (International Medical Grad), and encouraging other minorities to pursue family medicine. The hour and a half we spent discussing these issues was entirely too short, but very inspiring.

The afternoon saw the opening session of the Student and Resident Congress of Delegates. Many future Family Medicine leaders were eager to get involved and run for various positions.

It was a refreshing sight to see so many people ready to serve the organization for the advancement of the field. After much careful consideration, I would later announce my candidacy for the position of student delegate to the AAFP Congress of Delegates. To wrap up the session we were given instruction on resolution writing and encouraged to caucus with our state members, or others to formally take part in the process. Before the evening's festivities began I co-authored a resolution with two fellow student members that would later be reviewed by a reference committee and, ultimately, voted on by the student congress.

The first day of this year's conference culminated with the opening of the residency fair and expo hall. I was previously unaware that so many family medicine residencies existed before I witnessed this event. At the time of this writing, there are still several program representatives I would have loved to have had the opportunity to talk to, but couldn't because of time and the sheer size of the fair. Luckily, I was able to spend time at the booths of all of my top residency choices, so I consider it a huge success. There were also many valuable resources given to the students such as the residency guide, "Strolling Through the Match."

For the remainder of the conference, I balanced the business of representing New Jersey in the Student Congress of Delegates with attendance at informational sessions such as the Do's and Don'ts of Residency Interviewing, where we were given valuable information on how to handle difficult questions and ensure our best effort when on the interview trail.

On Saturday the moment of truth arrived. I would find out if I could win an AAFP election, and whether or not my fellow students supported my resolution. Although I suffered from a bad case of the nerves, I delivered my speech as intended and reached enough of my constituents to vote me in as one of the two new alternate student delegates to the AAFP Congress of Delegates. My resolution was also favorably voted upon which made the day that much better.

I can say that my first AAFP conference was an overwhelming success, and I cannot wait to go back next year. I will use my new position to represent New Jersey and all medical students to the best of my ability. I would like to thank my chapter and the physicians of this great state for providing this opportunity for me. ▲



A Tar Wars Essay

Deborah F. Miller, MD, FAAFP

Dr. Miller is a family physician in practice in New York State and has been a Tar Wars presenter for 12 years. She is also a member of the AAFP Tar Wars Program Advisors.

I have enjoyed being involved with the students throughout the years. It is always interesting to hear their responses to how many adults they think smoke or use tobacco products -- as a very high percentage. They are usually very intuitive to the short and long term effects of using tobacco products. They know that it smells bad, causes yellow teeth, holes in clothing and breathing difficulty. They marvel and think about wonderful items that they would like to own if they saved their money by not using tobacco products. Some students get very winded or light headed from the straw exercise.

I like to have them place their name tags on their desks so I can call

with the evolving products and e-cigarettes and the way the advertisers are choosing to send out their messages. Those new products are discussed also because they are usually brought up somewhere in our discussions. Other topics that are frequently discussed are the effects of secondhand smoke and what has happened in someone's life to a loved one who had bad effects from tobacco products. The children are usually very engaged in the one hour that it takes for me to present the presentation/interaction. At the end I tell them about the poster/video contest and encourage them all to enter. The art teacher and I have worked together to review the posters and choose the best one to send off to the state level of competition. In the years that I have presented this program I have had three New York State (NYS) poster contest winners and one NYS National video contest winner. I am very proud of all the students' attention and effort in the Tar Wars program. At the school's end-of-year

I still ask them WHY in the WORLD anyone would want to use tobacco products

on the students by name to answer the questions I pose for them. I still ask them WHY in the WORLD anyone would want to use tobacco products if the tobacco products cause terrible short and long term effects, cost so much, make it hard to breathe and the majority of the population does not use them. As we discover, peer pressure, nicotine addiction, image, looking grown-up, losing weight and of course advertising are reasons people decide to use those products.

The Tar Wars program guide has been evolving as it should

award ceremony, I present the top poster winners with gift cards and other prizes that are sponsored by the school PTA.

The child that got me started in presenting this program is now a senior in high school, and my youngest is a big 5th grader. I will no longer have any children in that school next year but my intent is to continue presenting Tar Wars to the school's students. It has been a lot of fun and a program that I believe can and has made a difference in our school children who have attended the presentation. ▲

4 Free CO*RE Webinars Coming This Fall!

The State Academies of Family Medicine are pleased to invite you to attend a FREE webinar on Extended-Release/Long-Acting Opioids: Achieving Safe Use While Improving Patient Care. We have scheduled 4 webinars during the next several months -- one of them should be perfect for your busy schedule.

The 90-minute webinars meet the FDA requirements for ER/LA opioid risk management and mitigation strategies (REMS), and include cases, tools use and more. A post-activity assessment will help you gauge your increase in knowledge and competency. Upon completion of the assessment and evaluation you will receive 1.5 AAFP Prescribed credits and we'll send you both the faculty slides and additional resources you can use to improve your care of patients.

November 11 – Tuesday November 13 – Thursday

REGISTER TODAY!

If you have any questions, feel free to contact Shelly Rodrigues at srodrigues@familydocs.org



Collaborative for
REMS Education

2014 Tar Wars National Poster Contest, Washington, DC, July 22-23

IT WAS WITH GREAT PLEASURE this July that we accompanied our 2014 NJ State Tar Wars Poster Contest winner, **Emilia Wheatley** and her family to Washington, DC. Emilia's winning entry proudly announced that she would rather light up the stage than light up a cigarette. Emilia was joined by her dad, Matt Wheatley, mom, Maria Suarez and younger sister Anabel (older sister Sara, who won the NJ contest in 2012 was away at camp, but sent her congratulations for a job well done).

Thanks to the extraordinary teaching talents

of Emilia's school nurse, Robin Ince, RN from the Franklin Elementary School in Westfield — Emilia's poster also received Tenth Place Honorable Mention in the National Contest! We were very proud of her indeed.

Of course, no Tar Wars National program is complete without a visit to our nation's capital and an appointment with NJ senators, **Cory Booker** and **Robert Menendez**. Emilia learned through the Tar Wars program how to relay the important message to our legislators to continue to protect our environment from second-hand smoke by sponsoring bills that advocate for cleaner air and consider the future health of all Americans. There was also a quick visit

with Emilia's congressman, **Leonard Lance** (R-7th), who took a special break from his budget finance committee meeting to congratulate Emilia and talk to her about her poster.

Update: August 20, 2014 – AAFP has updated the Tar Wars program changing the focus of the budget for 2015. While the National Conference will no longer take place, more resources and tools will be made available to family physician practices to educate patients and help them quit. For the full story, go to http://www.aafp.org/news/health-of-the-public/20140820reimagine tobacco.html?cmpid=em_22054645_L9



Senator Booker with (l to r) Mom, Maria and daughters Anabel and Emilia.



A winning poster with a beautiful message.



Emilia explained her smoke-free concept to Congressman Lance.

Support Your Foundation

FOUNDATION
VIEW

“No act of kindness, no matter how small, is ever wasted.”

– Aesop

The New Jersey Academy of Family Physicians Foundation (NJAFP/F), a 501(c)(3) philanthropic organization, is a source of substantial and unique support for the advancement of Family Medicine in the areas of research, education, student interest, and academic achievement.

Specifically the New Jersey Academy of Family Physicians and our Foundation work to:

- Increase interest in family medicine among medical students and college students through its scholarship and grant programs.
- Assist men and women in entering the practice of family medicine through preceptor programs and resident repayment programs.
- Enhance the specialty through encouragement and support of research by medical students and family physicians.

Please consider joining your fellow family physicians in supporting the work of the Foundation to help us better serve those who wish to stay and practice Family Medicine in New Jersey.

Consider providing a monthly gift – donating over time provides continual support to these important programs and enables us to better plan the future of the Foundation and expand its outreach.



YES! I would like to support the NJAFP Foundation!

Enclosed is my check in support of the *Resident and Student Trustee initiative* for \$ _____.

Please charge my credit card to support the *Resident and Student Trustee initiative* for \$ _____.

I would like to make regular monthly donations to the NJAFP Foundation.

Please charge my credit card \$ _____ per month.

 Card # _____ Exp. Date: _____

Name: _____

Telephone: (_____) _____

Billing/Mailing Address: _____

City: _____ State: _____ Zip: _____

Mail to NJAFP Foundation (Resident/Student Initiative); 224 West State Street, Trenton NJ 08608 or Fax to 609-394-7712

New Jersey Academy of Family Physicians Foundation is a non-profit 501(c)(3) corporation and the philanthropic arm of the New Jersey Academy of Family Physicians. Donations are completely tax-deductible. However, you should always consult your tax advisor. All donations will be acknowledged. Upon receipt of your donation, the NJAFP/F will send you a card acknowledging your gift for your records. Contributions are accepted via regular mail to: NJAFP Foundation, 224 West State St., Trenton, NJ 08608-1002. Donations may be made online by visiting www.njafp.org and clicking on "NJAFP Foundation/Make a Donation" under the tab "About NJAFP." Donations may be made in memory of someone special. Please contact Candida Taylor at candida@njafp.org or call 609/394-1711.

Lessons from Room 6

Sara Leonard, MD

Dr. Leonard is a family physician from Freehold, NJ, the Medical Editor for Perspectives and a member of the NJAFP Board of Trustees.

"HI DOC! I LOST TEN POUNDS," Molly declared exuberantly as I entered the room. "I joined a gym and I've been doing real good," she added proudly when I closed the door and turned to praise her accomplishment. Her eyes beamed and I was instantly reminded of the peculiar child-like quality that makes this seventy-six year old woman stand out in my memory despite the fact that I had only seen her a few times. "Yeah," she giggled, "I knew you'd be happy," still basking in the glow of her achievement.

As I scanned the computer screen for Molly's last A1C, she added "I could tell you were mad at me last time I was here." Confused, I responded, "I wasn't mad at you. What would make you think that?" I couldn't imagine ever being mad at Molly. "I could see it on your face," she said. "You were not very happy with me." I didn't need to wonder what it was she saw on my face; I knew right away. It wasn't anger, it wasn't directed at her, and I certainly had no idea she'd noticed it.

I saw Molly in room 6 during the visit in question. The very fact that we were using room 6 already indicates that things were not running smoothly in the office that day. But what I remembered most was not the room or the bad day. What immediately came to mind was one very specific moment in time. I remember looking at Molly's medication list and feeling completely and utterly defeated. Prior to that day, I had seen Molly one or two other times for very minor issues. Although she identified a primary provider within the group, I realized in room 6 that she had actually been caught in a revolving door of physicians and had not had good continuity with any single provider for quite a while. She was there for follow up on her chronic conditions. According to Molly, her chronic conditions were asthma and diabetes. According to the numerous cardiac and other medications listed in her chart, she had forgotten to mention a few other significant ones. I asked about a cardiologist and she said she didn't have one anymore. I asked about an echocardiogram, CHF, thyroid problems, and atrial fibrillation. She told me it's all in her chart. It wasn't.

From across the room I saw her two puffy feet and non-existent ankles overflowing from her shoes like the amorphous overstuffed limbs of my first Cabbage Patch doll. She mentioned feeling dizzy. At that moment, I was dizzy too. I was dizzy with the frustration of working within the constraints of 15 minute office visits that, according to the clock, are often over before they begin. I was questioning my ability to provide good care for my complicated patients

in a time when the healthcare model seems to be evolving further and further from my ideals. The guilty feeling that I am part of a system that had come up short in caring for Molly, and others like her, really began to gnaw at me. It may have looked like anger, but what Molly saw on the face of this new physician, not yet one full year out of residency, was pure disillusionment.

William Osler is said to have advised, during bedside rounds, to not see an illness but rather the patient who has the illness. I often paraphrase this when speaking to medical students about how family doctors are different. That day in room 6, I failed to practice what I preach. I saw a poorly run office, multiple complicated medical issues, a long list of medications, data lost during EHR transition, prior authorization forms, unmet core measures, poor quality indicators, etc. I entertained philosophical thoughts about the current state of health care, my place in it, and my decision

to become an employed physician. With all of that clouding the air, I didn't get a clear view of Molly.

As soon as Molly told me about her weight loss, I was instantly humbled. I knew immediately that I had looked at this patient on several occasions, but had never really seen her. This seventy-six year old woman, who doesn't drive, took it upon herself to join a gym because she noticed that her finger-stick glucose readings were increasing and she wanted to be able to continue

managing her diabetes without medication, since she already takes so many. Despite her overall limited understanding of, and perhaps limited ability to understand, her health issues, Molly understood that. And she went out and did something about it. Most of my patients don't. A ten pound weight loss in six weeks is significant. It's significant enough to make me stop and take a better look – at Molly, and at myself.

Driving home that evening, I couldn't believe how I had allowed all of those negative forces into the exam room that day. The doctor-patient relationship is sacred. It's the thing I value most highly in all of medicine. It's why I became a family doctor. How dare I violate it! It would have been easy for me to blame the system or the factors du jour over which I have no control, but I accepted full responsibility for sweet Molly spending six weeks believing I was angry with her. I thought about it a lot over the weeks that followed, and I promised myself that every time I enter an exam room and close the door, I will remember what I am closing it against. ▲



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