

Perspectives

A VIEW OF FAMILY MEDICINE IN NEW JERSEY

Still More Changes Ahead

Navigating Through the Changes in Family Medicine in New Jersey

CME Inside:

Consequences of Under Vaccination

Evidence-Based Questions & Answers



Journal of the New Jersey
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On the Cover

Still more changes are ahead as Family Medicine continues to evolve in this volatile healthcare environment. Get updated on SGR discussions and learn how residents and students are making a difference to keep Family Medicine healthy in New Jersey.

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Science Fiction... What Science Fiction?

Ok, I'll admit it. I am a closet Star Trek fan... not the *Next Generation* Star Trek fan (although I liked that series as well), but the old 1960's, Captain Kirk and Mr. Spock type of Star Trek fan (which, by the way, I watched in reruns, just in case you were wondering).



While not all the technology featured in Star Trek became a reality, some of Gene Rodenberry's vision of the future has actually come to pass. Just about every person today carries their own personal communicator. It's called a cell phone. Thanks to Google, we are getting close to a Universal Translator. Remember Uhura's (Communication's officer) earpiece... Kind of reminds you of a Bluetooth earpiece, doesn't it?

We are getting closer and closer to realities that once only seemed possible in science fiction stories. Last June, Medscape ran a series of small articles entitled *Science or Science Fiction*, highlighting advances in medical technology that could have come right out of a Star Trek movie.¹

The Smartphone Physical: Though not a full-fledged Emergency Medical Hologram Mark I, there are enough different smart phone apps in the marketplace to aid in the creation of one. There are apps that can do an ECG on a patient and transmit the results to their physician. Another smartphone app works with a small glucose device to provide diabetes monitoring that connects the user, caregiver and health-care professional. There are wireless pulse oximeters, blood pressure monitors, and a host of other apps to enhance communication, diagnosis, and care management between physician and patient.

3D Printers: Though not exactly a replicator, 3D printers are allowing scientists to create body parts. Some parts are currently functional, like the jaw made for a woman in the Netherlands or functional ears that receive radio signals.¹ Other 3D parts are still in the experimental phase, such as bones, skin grafts, and blood vessels.²

Hello Computer: IBM's Watson is a cognitive computing system. Cognitive computing uses natural language processing and machine learning to magnify and extend human cognition and expertise, allowing humans to think more creatively. In the healthcare field, Watson is helping physicians and patients make more evidence-based decisions by mining all the available data about the disease, the patient, as well as information in the EHR, clinical studies, journal articles and guidelines to provide the physician with a series of possible diagnoses along with a score that indicates the confidence level for each.³

While we may never see the development of the transporter or warp drive, those explorers who were not afraid to go where no one has gone before, have given us the technology to live better and healthier lives.

Happy Reading,

Theresa J. Barrett, MS
Managing Editor

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The Important Changes We Are Facing

Thomas A. Shaffrey, MD

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

The idea that the presence of a strong primary care foundation is essential to an efficient and cost-effective healthcare system should no longer be in doubt, by anyone. Intuitively, we have all known that from the start of our careers. Allowing primary care physicians to do what we have been trained to do is always an issue with the increasing requirements placed on us. With the advent of the Patient Protection & Affordable Care Act nearly upon us, there are changes coming that will impact each of us.

Contractual Changes. Recently, in advance of the commercial exchanges due to be in effect as of the first of the year, commercial insurers have started to notify some practices of their contract termination. This began in mid-September across the country. Some colleagues on the AAFP Practice Management listserv have

To be as effective as possible this organization needs to hear from you.

shared the text of their notices: "...is amending your Agreement referenced above to discontinue your participation...;" "...due to significant changes and pressures in the healthcare environment...;" to "...streamline physician panels." Others are receiving notices of changes to contract terms – significant reductions of fees. Of course such changes will have dramatic effects on our practices. The NJAFP needs to hear from members with what effect this is having on their patients as well as their practices so that we can effectively advocate for both.

Scope of Practice. There are several bills in the New Jersey State Legislature to increase the autonomy of non-physician healthcare workers. There is the impression that these non-physicians will deliver better primary care at reduced cost. There does not seem to be

a strong comprehension of the actual circumstances in New Jersey where the costs of practicing are among the highest and commercial reimbursements are among the lowest in the country. Rather than spending time and resources on changing the regulations regarding the requirements to practice primary care medicine, the focus needs to be on reestablishing an environment that encourages those with the highest level of training to practice at that level.



Opioid Abuse. This has been an increasing topic in the media. Legislation is being proposed that will increase the responsibility of physicians to be aware of their patients' prescriptions, the use of these medications – by all treating physicians and to further limit a physician's ability to prescribe continued use of these medications.

ICD-10. It is right around the corner. If you have followed the activities of AAFP, you know that Chairman Jeff Cain, MD has sent a letter to the Centers for Medicare & Medicaid Services (CMS) detailing the extra strain the system will add to the already and most over-burdened sector of medical care – primary care physicians.

SGR Reform. Sustainable growth rate (SGR) reform is a formula that CMS is required to use to set Medicare payments. It has caused proposed cuts for the last 10 years (a 24% cut is due on 1/1/14). There is a bipartisan proposal to eliminate the SGR and then freeze Medicare payments at 2013 levels for the next 10 years.

I recognize there is a tremendous range of opinions among members regarding these changes and legislative proposals, as well as individual practice circumstances. Primary care must be made viable for all our members. The NJAFP represents you. I represent you - each and every individual member. To be as effective as possible this organization needs to hear from you on how these issues will affect your ability to continue to keep your practices open, to be able to continue to treat the citizens of New Jersey, our patients. I look forward to hearing your comments regarding these issues and any other issues you wish to discuss. You can reach me at President@njafp.org or contact me through the NJAFP office at 609-394-1711. ▲



Giving Thanks

Ray Saputelli, MBA, CAE

EXECUTIVE
VP'S VIEW

Raymond J. Saputelli, MBA, CAE is the Executive Vice President of the New Jersey Academy of Family Physicians (NJAFP) and the Executive Director of the NJAFP Foundation.

Welcome to my annual “oh my, what am I going to write about” end-of-year article. As most of you who take the time to read this probably know, I treasure the opportunity that this column gives me to communicate with NJAFP members and friends, many of whom I connect with far too infrequently. Still, I often find that I sit staring at the page wondering what new information I can share, what story I can tell, that isn't already told somewhere else within these pages. At this time of year it gets a little easier as I can use the time-honored tradition of sharing “things for which I am thankful” that have occurred within the past year. While there may in fact be crossover with other items, and while the list is certainly not all-inclusive, you may find that you have some reason to be thankful as well.

New Loan Forgiveness Legislation

As this issue goes to press, the state legislature is very close to passing new loan forgiveness legislation for physicians. This legislation, designed to be more accessible than the current program, has been a strategic objective for the NJAFP for several years and is now close to becoming a reality almost exclusively as a result of the efforts of the NJAFP Government Affairs team and provides significant upgrades to the current program. It is focused on primary-care specialties; increases the eligible amount to \$200,000 in tax-exempt repayment over a 4-year period (up to \$50,000 annually); provides incentives to the hiring practice; requires annual review of underserved communities and makes an exception for non-profit clinics in areas not considered underserved; and gives special consideration to New Jersey-trained physicians to address retention issues. While not law yet, we have reason to feel confident and perhaps by the time you are reading this, we all will have even more reasons to be thankful.

SGR Fix

As most are likely aware, there is a bi-partisan, bi-cameral bill that will permanently fix the SGR issue that currently has the AAFP and chapters like the NJAFP in an annual battle to avert up to a 20% reduction in Medicare payment. Organizations like the AAFP, with the support of chapters, have been working with federal legislators to repeal the SGR and replace it with a more reasonable, value-based payment structure since its inception as a part of the 1997 Balance Budget Act.

While the bill is not perfect, is likely to see several adjustments, and is still some months away from becoming law in the best case, there are encouraging signs. Not the least of these signs is a temporary fix through March, 2014, avoiding the down-to-the-wire negotiations that have become a regular year-end issue for physicians in New Jersey and across the country.

NJAFP Student and Resident Leadership

I have the blessing of being able to work closely with medical students interested in family medicine, and with family physicians in training every year, and while each year this interaction provides some of the most energizing work I do, this year has been special. It's probably important to note that student and resident members of the NJAFP board are elected each June, so as I look back over the past year I am able to reflect on the work of more than one class of trustees over the course of a calendar year. It is probably also worthy of mention that the work done by these committed students and residents is the product of a team that is often larger than just the four people who hold the position of Student or

Resident Trustee. With all of that said, and while you will have the opportunity to read about some of the work done by this group in the Student/Resident View of this issue, I am quite awed by the energy with which Trustees Steven, Jerry, Chelsea, Monali, and Deepa and Sara brought to the recent Residents Caucus in Atlantic City last June, and to the Student Forum in Philadelphia (as a part of the Family Medicine Education Consortium) in November. I am reminded of a time around 2001 when I wrote the following words about a group of students and their commitment to Family Medicine. Those words are true today as well about this group, and maybe even more so: “They believe, and they helped me to remember that I believe.” I am convinced that the future is in good hands. It remains up to those of us who toil in the present do our part to ensure that a future is available to these inspiring future family physicians.



NJAFP Board

It seems rather self-serving, and perhaps even gratuitous for someone in my position to suggest that they are “thankful” for their leadership. So be it. The group of physicians (and the aforementioned residents and students) that serve on the NJAFP board give of their time and energy, both of which are in short supply for almost every family physician I know, in an effort to promote the specialty and protect the patients you all care for each day. These leaders are not compensated, and in fact are rarely even acknowledged for their service, but they serve a vital purpose in the work of the NJAFP, which has become a significant voice in the healthcare policy discussions in New Jersey. The partnership between these dedicated elected leaders and your professional staff is a model for a successful association, and I am thankful both for the work that we've done in the past year, and the growth we continue to achieve throughout the organization.

Staff

Finally, but certainly not least importantly, I am thankful each day for the team with which I have the pleasure to work. I do not exaggerate when I say that the NJAFP is blessed with a professional team that is among the finest – if not the finest – in the country. From our office team of Candida Taylor, Robbin Comiski, Vicki Fiordilisi, and newest addition Corrina Lucas who form the front-line of our member service efforts, to Cari Miller, who guides our practice management and PCMH consulting division where Cathy Cardea, Tara Zahodnick, and Karen Foster make up the core team, through Claudine Leone who leads our Governmental Advocacy and Public Relations efforts, Bob Meinzer who adds an external face to our CME/CPD activity, and Theresa Barrett who leads our Education, Meetings, and Communications efforts and serves as my deputy staff executive, there is no better, more talented group in the AAFP family.

It has been a good year, and we are poised for even better things in the coming year. As always, I am well aware that the environment could, and in fact should, be better for many of our members. Small, independent practices still find themselves in a fight for survival. The changes that are taking place within the healthcare arena throughout the state and across the country are still unproven and require vigilant attention and advocacy. Still, no other organization in the state is exclusively dedicated to those interests, nor more equipped to lead the fight. I am thankful that I will begin another year leading that charge. Happy New Year and best wishes for a safe, healthy and prosperous 2014. ▲

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Avoiding a DEA Investigation

Opioid use and misuse are very much in the news these days. How do you keep yourself safe from DEA investigations? Here are some tips from a lawyer who has represented physicians caught up in DEA stings.¹

- Follow the guidelines
- Make sure your records meet all the State recommendations*
- Be sure of your patient's identity
- Require that previous diagnostic reports are received directly from other physicians or facility (e.g., MRI center) offices.
- Require a pain management contract for anything other than short-term treatment
- Do not deviate from standard procedure for anyone
- Know what is going on outside of your own office – make sure your staff is trustworthy and trained

The list is much longer than these few tips. One other recommendation is to "Obtain, read and follow the guidance" presented by Scott M. Fishman, MD in the book *Responsible Opioid Prescribing: A Physician's Guide*. In the past, NJAFP has offered CME courses based on the contents of Dr. Fishman's book.

Additional information on pain management regulations can be found on the websites of the New Jersey Office of the Attorney General (<http://www.state.nj.us/oag/>) and the New Jersey Department of Health (<http://www.state.nj.us/health/>).

Reference

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* For information on New Jersey's Prescription Monitoring Program visit <http://www.state.nj.us/ps/calpmp/FAQ.htm>

Are You Choosing Wisely?

Choosing Wisely® is a campaign created as an initiative of the American Board of Internal Medicine (ABIM) Foundation to improve healthcare quality. More than 50 specialty societies, including the AAFP, have identified commonly used tests or procedures within their specialties that are possibly overused.

AAFP has recently published a third list of screening and treatments which should be questioned and discussed with patients. The new list includes:

1. Don't prescribe antibiotics for otitis media in children aged 2-12 years with non-severe symptoms where the observation option is reasonable.
2. Do not perform voiding cystourethrogram (VCUG) routinely in first febrile urinary tract infection (UTI) in children aged 2-24 months.
3. Do not routinely screen for prostate cancer using a prostate-specific antigen (PSA) test or digital rectal exam.
4. Do not screen adolescents for scoliosis.
5. Do not require a pelvic exam or other physical exam to prescribe oral contraceptive medications.

For additional information and to see the complete list of recommendations, visit <http://www.choosingwisely.org/doctor-patient-lists/american-academy-of-family-physicians/>

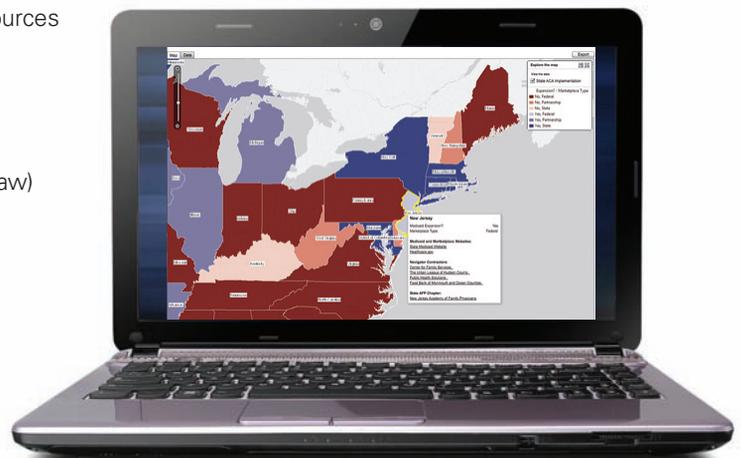
New Affordable Care Act Interactive Map

The AAFP has developed an Affordable Care Act (ACA) interactive map (<http://www.healthlandscape.org/ACAMapper2013/index.html>) with state-specific information on five components of ACA implementation. The map also features links to each chapter website in the 50 states. This map will help you to provide state-specific information to your patients and colleagues on ACA resources in our area.

The five components of the interactive map include:

- Marketplace Type (State, Partnership, Federal)
- Medicaid Expansion Status (signed into law or not yet signed into law)
- State Medicaid Office Website
- State or Federal Marketplace Website
- Navigator Organization Websites for Partnership and Federal Marketplace States

Additional ACA information can be found on the AAFP website at <http://www.aafp.org/advocacy/act/aca.html>



What Have You Done For Me Lately?

Turning Up the Volume

Our members, nearly 2,000 family physicians, residents, and students represent a unique point of view among physicians. To ensure that NJAFP's perspective is heard and understood by a broad audience, NJAFP members and representatives are committed to sharing the message in print and over the airwaves. The lines of communication are open and NJAFP has responded to numerous media requests over the last quarter, thereby bringing clarity and understanding to the wide range of issues that impact the practice of family medicine.

In September, EVP, **Ray Saputelli, MBA, CAE** (*Trenton*) was contacted by Terry Langford of *NJ Public Radio/WNYC* and invited to comment on the decisions family physicians would be forced to confront as a result of the Affordable Care Act.

In September, **NJAFP** provided *Star Ledger* reporter Kathy O'Brien with information for an article she was preparing on the Affordable Care Act.

In October, *Philadelphia Inquirer* reporter Robert Calandra quoted NJAFP President, **Tom Shaffrey, MD** (*Bound Brook*) and AAFP Alternate Delegate, **Mary Campagnolo, MD, MBA** (*Bordentown*) in his piece titled, "Obamacare Worries Small Family Practices."

Also in October, Andrew Kitchenman, a reporter for *NJ Spotlight*, interviewed **Ray Saputelli, MBA, CAE** for his follow-up piece on Advanced Practice Nurses.

In early November, **Tom Shaffrey, MD**, was interviewed on *NJTV* about the impact of the Affordable Care Act.

To join NJAFP's Rapid Response Media Team, contact our public relations specialists, Leza Raffel and Beth Drost at 215-884-6499 or email mediarelations@njafp.org.

New Jersey Medicaid ICD-10 Reminder

The CMS mandate for ICD-10 Diagnosis and Surgical Procedure code implementation is quickly approaching. All providers are required to transition to the new ICD-10 codes and exclusively use only these new codes for date of service beginning October 1, 2014.

"Are you preparing?"

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, 2014 or later. All claims with service dates September 30, 2014 or earlier must use the ICD-9 codes.

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

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Providing Behavioral Health Care in the Wake of Superstorm Sandy

Mary E. O'Dowd, MPH

Mary E. O'Dowd, MPH is the Commissioner of Health for the State of New Jersey.

New Jersey has made tremendous progress recovering after Superstorm Sandy. Many of our Shore communities have rebuilt and are thriving. But more work remains to be done. Families and individuals continue to face challenges in the aftermath of the storm.

The Department of Health's (DOH) recovery plan has focused on increasing awareness and providing resources for social and medical support and mitigating environmental health hazards. We have been working closely with the Departments of Human Services and Children and Families on a comprehensive approach – recognizing that physical and mental health effects of disasters often coexist.

DOH is enhancing recent efforts to address mental health care by funding licensed ambulatory care facilities to provide screening services to identify and refer for treatment individuals with behavioral health problems associated with the displacement and continuing recovery challenges associated with Superstorm Sandy. We have targeted funding to the nine most affected counties in New Jersey – Atlantic, Bergen, Cape May, Essex, Hudson, Middlesex, Monmouth, Ocean and Union.

The stress of a major cleanup and repair coupled with the economic losses incurred as a result of the storm are daunting. The psychological effects can negatively impact an individual's overall health and wellbeing. Residents who are overwhelmed may neglect chronic conditions and as a result exacerbate their illnesses. Stress precipitates behavioral health issues, leads to substance abuse and negatively affects relationships and families. It can also be a contributing factor in episodes of domestic violence and child abuse.

Studies have demonstrated that following disasters increases in problems of coping with stress and trauma – such as mental health issues, household discord, substance abuse and domestic violence – are seen. After Hurricane Katrina, New Orleans households were more likely to break up than similar US households sharing the same demographic during the same period.¹ There is also evidence that child abuse may increase following a natural disaster. In the six-month period after Hurricane Floyd hit North Carolina, there was a five-fold increase in the rate of inflicted traumatic brain injury in children under two years old in counties severely affected by the hurricane. Counties that were less affected or not affected at all, didn't experience an increase.²

Often the problems of post-traumatic stress are not seen right away, but they need to be addressed as an integral part of patient care. Many people who do not meet the diagnostic criteria for mental health intervention may, nonetheless, exhibit behavioral problems – putting them at risk for health problems, interpersonal complications with family and friends and difficulties at school or work.

Family physicians, have an opportunity to help identify patients experiencing a range of health effects related to the storm and ensure their needs are addressed. Often, these individuals do not seek help from mental health specialists. However, they do come into regular contact with personal physicians or other medical caregivers making primary care settings a key point of access for screening, assessment, prevention, early intervention, referral and treatment for individuals dealing with Sandy-related issues. Despite this connection, mental health/domestic violence/substance abuse screening and referrals are often not provided in these settings.

It is important for family physicians to look for signs and symptoms of the physical, emotional and psychological stress that patients may exhibit due to the prolonged, continuing stresses posed by the storm.

Families that are facing challenges can visit New Jersey Family Success Centers (FSC) for support and referrals. FSCs are community-based, family-centered neighborhood gathering places where community residents can go for family support, information, referrals and access to services at no cost. FSCs are a 'one-stop' site that provide wrap-around resources and support for families before they find themselves in crisis. New Jersey currently has 51 State-funded FSCs across the state, with at least one in every county. Some of the free services provided by FSCs include: supportive counseling for parents raising children; classes and support groups for families, single parents and teens; parent-child activities; and a variety of workshops on topics such as stress reduction, financial literacy, leadership/empowerment, education, employment, domestic violence, nutritional awareness, healthcare resources, and financial assistance. For more information about Family Success Centers visit <http://www.state.nj.us/dcf/families/support/success/>.

New Jersey also has a program to ensure those affected by stress have help during this difficult time that could be a resource for patients. The Hope and Healing program helps residents cope with the emotional impact of Sandy. This initiative offers confidential mental health information and referrals at 877-294-HELP (4357) (TTY: 877-294-4356). The phones are answered by trained counselors who can assist anyone experiencing anxiety or depression.

Crisis counselors have been canvassing the state since Sandy, meeting with residents in their own neighborhoods, many of whom are dealing with feelings of anxiety, fearfulness, sadness, fatigue and exhaustion. More than 500,000 residents have been provided information or counseling by Hope and Healing staff.

It is up to health care and public health professionals to recognize how people are affected by disasters and to refer them to appropriate resources for help. I'm asking healthcare partners throughout the state to join the Department of Health to increase awareness of health impacts that residents continue to face. Healthcare providers are in a unique position to assess patients and refer those who are

having difficulty to medical and behavioral health resources.

Recovery after one of the most devastating storms to ever strike our state is challenging. By partnering, we can ensure more residents have the resources they need.

For more information on DOH Sandy Recovery Resources visit: http://nj.gov/health/er/hurricane_recovery_resources.shtml.



Evidence-Based Questions & Answers

From Rutgers/Robert Wood Johnson School of Medicine

The Efficacy of SSRIs in Anorexia Nervosa

Lisa Primiani, MD; Rhina Acevedo, MD; Beatrix Roemheld-Hamm, MD, PhD

Rutgers/Robert Wood Johnson School of Medicine
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New Brunswick, NJ

How effective are SSRIs in the treatment of anorexia nervosa?

Evidence-Based Answer:

SSRIs do not seem to demonstrate benefits. There is support that Fluoxetine is not effective. (SOR A, based on RCTs).

Evidence Summary

A 2006 Cochrane systematic review included seven randomized trials (total n=178) of various antidepressants for patients with anorexia nervosa (AN). Four of these trials did not find evidence of efficacy of antidepressants in improving weight gain, the eating disorder itself, its associated symptoms, or any differences in completion rates. Meta-analysis of the data was not possible for most outcomes, and insufficient power to detect differences prevented the authors from drawing definite conclusions. Four trials compared fluoxetine to placebo and found no significant difference in the mean percentage of ideal weight at the end of treatment (SMD = 0.14 95% CI -0.56 to 0.85). One study compared clomipramine to placebo and did not find a significant difference in mean weight gain at the end of the treatment (SMD = 0.64 95% CI -0.37 to 1.65). The other two trials had limited information.¹

A 2006 five-year randomized controlled trial (RCT) study enrolled 93 patients with AN in either intensive inpatient or day-program treatment. Participants who regained body mass index (BMI) of 19.0 or more were eligible to be randomized to receive fluoxetine or placebo for up to one year as outpatients. All patients also received individual cognitive behavioral therapy. Primary outcomes were time-to-relapse and successful completion of treatment for one year. No significant differences were found in the percentage of patients maintaining a BMI of at least 18.5, and completing a full year of treatment (fluoxetine, 26.5%; placebo, 31.5%; P = .57). This study did not show any benefit from fluoxetine in the treatment of patients with AN following weight restoration.²

A 1998 RCT was a seven-week study, examining the effects of fluoxetine 60 mg in 31 women (aged 16 - 45, mean age 26.2) with AN who were receiving inpatient treatment in a clinical research unit. Body weight and measures of eating behavior and psychological state were followed. Average weight was 92 lbs (72.5% of ideal body weight), average BMI was 15.0 kg/m². Four patients in the fluoxetine and placebo group each dropped out of the study.

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Patients in both fluoxetine and placebo groups showed statistically significant improvement on virtually all measures (weight, psychological scales). However, there was no weight improvement between the fluoxetine and placebo groups (fluoxetine group 73.3 lbs. pre- 86.6 lbs, post-treatment, placebo group 71.8 lbs pre- 87.4 lbs post- treatment).³

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Effect of Stress Management on Cardiac Patients

Sneha Kamdar, MD; Anu Kotay, PhD; Beatrix Roemheld-Hamm, MD, PhD

Rutgers/Robert Wood Johnson School of Medicine
Department of Family Medicine and Community Health
New Brunswick, NJ

Does stress management improve outcomes of patients with heart disease?

Evidence-Based Answer:

In patients with cardiac disease, stress management techniques reduce cardiac mortality, risk of non-fatal myocardial infarction (MI), and depression. Stress management interventions have not been shown to improve all-cause mortality. (SOR A, based on a meta-analysis).

Evidence Summary

In 2004, a meta-analysis of 36 RCTs examined numerous non-pharmacologic psychological interventions with a minimum follow up time of six months for adults with congestive heart disease (CHD) (total n = 12,841). Overall, there was a 22% reduction in non-fatal MIs (OR 0.78; 95%CI, 0.67-0.90), but cardiac and all-cause mortality were not reduced (OR 0.86; 95%CI, 0.72-1.03; and OR 0.93; 95%CI, 0.81-1.06; respectively). Significant reduction in depression (using a number of different measures) was also reported (standard mean difference (SMD) -0.3; 95%CI, -0.48 to -0.13).¹

Of the 36 trials in this meta-analysis, 18 tested stress management techniques (utilizing relaxation training, cognitive challenge, and/or specific coping strategies). Among these 18 trials (n = 3,425), there was a 31% reduction in non-fatal MIs (OR=0.69, 95% CI 0.52-0.92).

Total mortality was unaffected (OR 0.88, 95% CI 0.6-1.15) while cardiac mortality was mildly reduced (OR = 0.62, 95% CI 0.38-0.99).¹

A 2005 RCT (n = 154) examined whether an integrative medicine intervention (combination of mindfulness meditation, relaxation training and stress management, as well as education on nutrition, physical activity, and lifestyle) reduced the 10-year risk of CHD among subjects >45 years old with one or more CHD risk factors. There was a 16% relative decline in the intervention group for 10-year CHD risk as determined by Framingham risk scores, versus a 12% relative decline in the usual care group (p = .04). (Risk factors included in the Framingham calculation are age, total cholesterol, HDL cholesterol, systolic blood pressure, treatment for hypertension, and cigarette smoking).²

In 2001, a small pilot RCT (N = 14, 12 male, 2 female), not included in the Cochrane review because of less than six-month follow up time, evaluated progressive muscle relaxation (PMR) for stress reduction in patients undergoing Phase 2 or 3 cardiac rehabilitation. The active group received four 50-minute weekly PMR sessions along with general cardiac rehabilitative care, whereas the control group received only usual cardiac rehabilitation. Analyses of resting heart rate (HR) changes showed a trend toward lower HR after four weeks in the PMR group (71 bpm vs. 65 bpm, p = .052). Analyses of State-Trait Anxiety Inventory scores (scores vary from 20 to 80, with higher scores indicating higher anxiety levels) showed a significant reduction in state anxiety (mean scores 38 vs. 27; p < .05) after four weeks in the PMR group vs. a nonsignificant change in the control group.³

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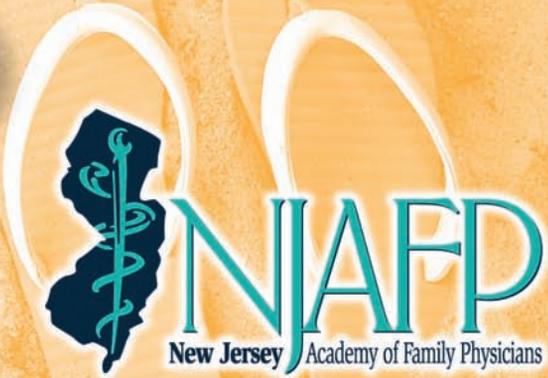
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The Under Vaccination Risk

Theresa J. Barrett, MS

Theresa J. Barrett, MS is the Deputy Executive Vice President of the NJAFP

By the time they enter kindergarten, the majority of children, approximately 90%, receive most of the vaccines advised by the federal immunization schedule.¹ However, there is an increasing trend of under-vaccination in children which places them and their communities at risk for vaccine preventable disease.² The literature offers an unsettling view of the consequences. An unvaccinated Romanian girl infected with measles, returned to the U.S. and created an outbreak of measles in Indiana resulting in 34 cases of confirmed measles,³ an unvaccinated 7-year-old boy infected with measles, returned to San Diego from Switzerland – the resulted was 839 exposed persons, 11 additional cases in unvaccinated children, and the hospitalization of an infant too young to be vaccinated,⁴ an infected Swiss traveler visited a Tucson, Arizona emergency room and set off a cascade of measles infection, mostly among healthcare workers who were either unvaccinated or under vaccinated.⁵ It is not just measles outbreaks that are concerning. In 2010, over 1,000 people in New York and New Jersey were infected with mumps originating with a boy who had just returned from Britain where an outbreak there affected over 4,000 people,⁶ and in 2012, Washington state declared pertussis an epidemic when cases jumped 1,300% from 2011.⁷

Unfortunately, this is not past history. In September of 2013, the Monmouth County Health Department reported that 41 probable cases of mumps were being investigated.⁸ The New Jersey Department of Health in turn sent an alert to all physicians of the potential of New Jersey citizens being exposed to mumps and encouraged physicians to consider the disease in their differential diagnosis.⁹ There were 159 cases of measles reported in the U.S. from January 1, 2013 to August 24, 2013; the second largest number of cases reported since U.S.-originated measles was considered eliminated in 2000.¹⁰ All of the measles cases were the result of importation from other countries.¹⁰

Children who do not receive the full range and appropriate number of vaccinations are at an increased risk for mumps, measles, and pertussis, as well as other vaccine preventable diseases.¹¹ In addition, these children can infect others who were vaccinated but did not have a sufficient immunologic response, cannot be vaccinated for medical reasons, or are too young to be vaccinated.¹¹

In 1961, children were routinely immunized against five common diseases: diphtheria, pertussis, poliomyelitis, smallpox, and tetanus.¹² That number has risen to 16 preventable conditions. Studies that have looked at parents' vaccine choices showed concern over the number of vaccines given to their children as one reason for delaying vaccination or asking the vaccinations be spread out over time.^{13,14}

Another reason offered for the trend of non-vaccination or under vaccination is concern about the safety of vaccines.¹⁵ The Institute of Medicine (IoM) undertook a comprehensive study at the request of the Department of Health and Human Services to address questions about the safety of the current childhood immunization schedule.¹⁶ In the report issued in January of 2013, the IoM stated that:

Upon reviewing stakeholder concerns and scientific literature regarding the entire childhood immunization schedule, the IOM committee finds no evidence that the schedule is unsafe. The committee's review did not reveal an evidence base

suggesting that the U.S. childhood immunization schedule is linked to autoimmune diseases, asthma, hypersensitivity, seizures, child developmental disorders, learning or developmental disorders, or attention deficit or disruptive disorders... rather than exposing children to harm, following the complete childhood immunization schedule is strongly associated with reducing vaccine-preventable diseases. (p.2, 3)¹⁶

Even with the IoM Report, some childhood immunization rates still fall below Healthy People 2020 goals for indicated vaccines (Table 1).¹⁷ Healthy People 2020 has set a 90% immunization rate for all childhood vaccines.

Table 1: Healthy People 2020 Childhood Immunization Goals

Healthy People 2020 Goal: 90%	Actual
≥1 doses of measles, mumps, and rubella vaccine (MMR)	Vaccination coverage remained near or above the national <i>Healthy People 2020</i> target for ≥1 doses of MMR (90.8%)
≥3 doses of hepatitis B vaccine (HepB)	Vaccination coverage remained near or above the national <i>Healthy People 2020</i> target ≥3 doses of HepB (89.7%) Coverage increased from 68.6% in 2011 to 71.6% in 2012 for the birth dose of HepB
≥3 doses of poliovirus vaccine	Vaccination coverage remained near or above the national <i>Healthy People 2020</i> target ≥3 doses of poliovirus vaccine (92.8%)
≥1 doses of varicella vaccine	Vaccination coverage remained near or above the national <i>Healthy People 2020</i> target ≥1 doses of varicella vaccine (90.2%)
≥4 doses of diphtheria, tetanus, and pertussis vaccine (DTaP)	Coverage was below the <i>Healthy People 2020</i> target and either decreased or remained stable relative to 2011 for ≥4 doses of DTaP (82.5%)
≥4 doses of pneumococcal conjugate vaccine (PCV)	Coverage was below the <i>Healthy People 2020</i> target and either decreased or remained stable relative to 2011 ≥4 doses of PCV (81.9%).
the full series of <i>Haemophilus influenzae</i> type b vaccine (Hib)	Coverage was below the <i>Healthy People 2020</i> target and either decreased or remained stable relative to 2011 the full series of Hib (80.9%)

(data set: children born from January 2009 to May 2011, based on results from 2012 NIS)

Other vaccines:

Healthy People 2020 Target	Actual
Hepatitis A Vaccine (HepA) 85%	53.0%
Rotavirus Vaccine 80%	68.6%

The same report showed that families living below the poverty level had lower than average coverage than children living at or above the poverty level (Table 2).¹⁷ It is important to maintain high levels of coverage across all vaccine-preventable diseases in the United States to prevent their resurgence.

Table 2: Immunization Percentages for Families Living Below the Poverty Level¹⁷

Healthy People 2020 Goal: 90%	Actual
≥4 doses of diphtheria, tetanus, and pertussis vaccine (DTaP)	76% coverage vs. 82.5% coverage
≥4 doses of pneumococcal conjugate vaccine (PCV)	73.3% coverage vs. 81.9% coverage
the full series of <i>Haemophilus influenzae</i> type b vaccine (Hib)	73.3% coverage vs. 80.9% coverage
Hepatitis A Vaccine (HepA) 85%	47% coverage vs. 53.0% coverage
Rotavirus Vaccine 80%	59.1% coverage vs. 68.6% coverage

The Family Physician's Role

Because of the success of public health efforts to increase vaccination rates, many parents and physicians have little to no experience with vaccine-preventable illnesses. This, along with concerns over adverse reactions and the number of vaccines given in a child's early years, has resulted in an increase in the number of parents seeking non-medical exemptions from school immunization requirements, leading to outbreaks of vaccine preventable diseases.¹⁸ In addition, a variety of studies have shown that many parents have doubts regarding vaccination, even if they do intend to vaccinate their children.¹⁹⁻²¹

Studies have shown that communication between parents and physicians have a great deal to do with parent perception and whether immunization occurs.^{22,23} Family physicians have the unique opportunity to be able to educate parents and patients on the importance of immunizations, as they are seen as one of the most important sources of information regarding vaccines.^{20,23} By taking the time to educate parents and patients regarding immunizations, physicians have the opportunity to minimize uncertainty, improve satisfaction regarding healthcare decisions, and empower parents to make decisions regarding their child's care.²¹ Education provided by a trusted source like a physician, can go a long way to closing the under vaccination gap. ▲

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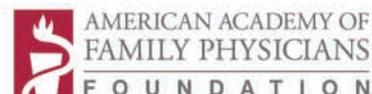
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Perspectives: A View of Family Medicine in New Jersey has been reviewed and is acceptable for up to 4 Prescribed credits by the American Academy of Family Physicians. Term of approval is for one year from beginning distribution date of 1/1/13. This issue (Volume 12, Issue 4, 2013) is approved for 1 Prescribed credit. Credit may be claimed for one year from the date of this issue.

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CME Quiz

1. True or False: Part of the New Jersey Department of Health's recovery plan focuses on increasing awareness and providing resources for social and medical support and mitigating environmental health hazards in the wake of Hurricane Sandy.
2. True or False: Studies have demonstrated that mental health issues increase after coping with stress and trauma.
3. True or False: SSRIs have been shown to be effective in the treatment of anorexia nervosa?
4. True or False: In patients with cardiac disease, stress management techniques have been shown to reduce cardiac mortality.
5. True or False: Applying progressive muscle relaxation at regular intervals in patients undergoing cardiac rehabilitation can significantly lower heart rate and anxiety levels.
6. True or False: In the fall of 2013, Monmouth County reported that 30 probable cases mumps were being investigated.
7. True or False: Because of recent outbreaks of mumps, this disease should not be considered in a differential diagnosis.
8. True or False: The Institute of Medicine has found no evidence that the current vaccine schedule is unsafe.
9. True or False: DTap immunization rates are below the Healthy People 2020 90% goal.
10. True or False: Studies have shown that the communication between physician and parent have a great deal to do with whether a child is immunized.

ANSWERS ON PAGE 22

NEW JERSEY VIEW

Congratulations to...

Al Tallia, MD (*New Brunswick*), Chair of the Department of Family Medicine and Community Health at Rutgers, has been named the executive director of Robert Wood Johnson Partners, an ACO formed by collaboration between Robert Wood Johnson University Hospital and Rutgers University.

Jeff Brenner, MD (*Camden*) Medical Director of the Urban Health Institute, has been named one of the 2013 MacArthur Fellows by the John D. and Catherine T. MacArthur Foundation for his work in developing new healthcare delivery models to meet the medical and social service needs of Camden residents.

David Zalut, MD (*Voorhees*) has been recognized by the New Jersey Primary Care Research Network for outstanding contributions to the future of practice-based research.

Around the State...

Robert Wood Johnson University Hospital and **Rutgers University** are working together to create a unique Medicare accountable care organization (ACO) that will involve academic researchers working with physicians. The ACO – Robert Wood Johnson Partners - will launch in January of 2014. This ACO will be a unique addition to the other ACOs in New Jersey as it does not revolve around a hospital system. To read the entire story, visit <http://www.njbiz.com/article/20131008/NJBIZ01/131009817/Robert-Wood-Johnson-Rutgers-to-create-unique-ACO>.

In the News...

NJAFP Government Affairs Director, **Claudine Leone, Esq.**, was quoted in a *NJSpotlight* article regarding the trend to greater doctor shortages. To read the full article go to: <http://www.njspotlight.com/stories/13/09/25/trends-toward-greater-doctor-shortage-worry-state-legislators/>

Peter Carrazzone, MD (*North Haledon*) and **Claudine Leone, Esq.** were quoted in a *Star Ledger* article on Medicare patients. The full article is available at http://www.nj.com/politics/index.ssf/2013/08/nj_doctors_least_likely_to_accept_new_medicaid_patients_survey_says.html

Robert Eidus, MD, MBA (*Cranford*) and **Claudine Leone, Esq.** were quoted in a *NJSpotlight* article regarding New Jersey's ranking in accepting Medicare patients. The full article is available at <http://www.njspotlight.com/stories/13/08/07/new-jersey-doctors-rank-last-in-the-nation-in-rate-of-accepting-new-medicaid-patients/>

Save the Date

2014 will see the NJAFP's return to the Sheraton Atlantic City for the annual Summer Celebration and Scientific Assembly. The Education Committee is working on a stimulating program, filled with new topics in clinical care and family medicine that you are not going to want to miss. Mark your calendar now to attend this exciting event.



All events will take place at the Sheraton Atlantic City Convention Center Hotel

Practice Management Preconference: Thursday, June 12, 2014
Town Hall: Thursday, June 12, 2014

House of Delegates: Friday, June 13, 2014

Scientific Assembly: Friday, June 13, 2014 to Sunday, June 15, 2014

President's Gala: Saturday, June 14, 2014

SAM Study Hall: Sunday, June 15, 2014



Information on the conference will be posted on the NJAFP website as it becomes available. Visit <http://www.njafp.org/SCSA>.

Important Deadlines to Remember



Deadline for resolutions to be considered for the House of Delegates: **April 30, 2014**

Deadline for nominations for board positions: **April 30, 2014**

Deadline for nominations for Family Physician of the Year: **April 15, 2014**

Call for 2014 New Jersey Family Physician of the Year

It is not too early to start thinking about nominating a colleague as the 2014 New Jersey Family Physician of the Year. The New Jersey Family Physician of the Year embodies the principles of excellence, combined with comprehensive and compassionate care, for which family physicians are known.

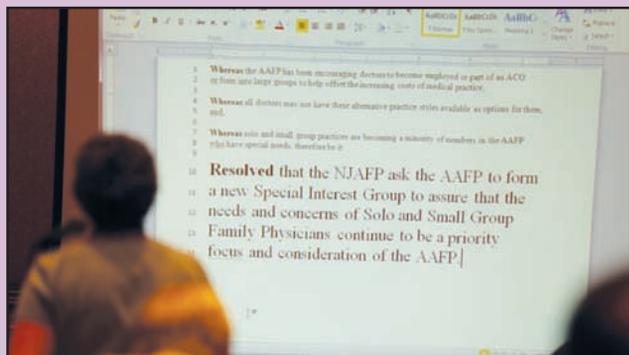
The full details on how to nominate a colleague for this award are available on the NJAFP website at <http://www.njafp.org/SCSA>. Click on "2014 Call for Family Physician of the Year" on the left menu bar.



Nominations are due in the NJAFP office by April 15, 2014.
Contact Candida Taylor at candida@njafp.org for more information.

There is Work to be Done

There is no doubt that the world of health care is changing, and will continue to change as the Affordable Care Act continues its evolution. This is not a time to sit back and watch what is going to happen in New Jersey, or across the nation. If you have an idea to make the practice of family medicine better, an idea that will fill an unmet Academy need, or an idea that will keep students in New Jersey, then vow to write a resolution and submit it for consideration at the NJAFP House of Delegates, which will take place on Friday, June 13, 2014 at the Sheraton Atlantic City Convention Center Hotel.



Writing a resolution is a formal, but not difficult, process. Visit <http://www.njafp.org/SCSA>. Click on the Call for Resolutions and Nominations link on the left menu bar and follow the instruction for submission.

Resolutions are due in the NJAFP office by April 30, 2014. Questions? Contact Executive Vice President, Ray Saputelli, MBA, CAE at ray@njafp.org.

Wanted: Leaders in Family Medicine

"Innovation distinguishes between a leader and a follower." – Steve Jobs

Are you considered a leader by your colleagues or your community? NJAFP is seeking member family physicians who will lead and shape Academy policy over the coming years. Interested members are asked to review the nomination criteria at <http://www.njafp.org/SCSA>. Click on the Call for Resolutions and Nominations link on the left menu bar and scroll down to nominations.

Nominations are sought for the following positions:

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Nominations are due in the NJAFP office by April 30, 2014. Questions? Contact Executive Vice President, Ray Saputelli, MBA, CAE at ray@njafp.org.

With Sympathy...

The New Jersey Academy of Family Physicians sends its sincere condolences to the family of members who have recently passed away.

Charles L. S. Brennan, MD, Jr. of Palmero, NJ passed away in November 2013.

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Claudine M. Leone, Esq.

Claudine M. Leone, Esq. is the Government Affairs Director for the NJAFP.

The Physician Payments Sunshine Act (Sunshine Act) was enacted by Congress as part of the Patient Protection and Affordable Care Act (ACA) to ensure transparency regarding so-called transfers of value between physicians and those who produce or market medical products (biopharmaceutical and medical technology companies). The 2013 value benchmark is \$10 or more, but that figure will be adjusted annually for inflation.

According to the Centers for Medicare and Medicaid Services (CMS), which is administering the program, the goal of this increased transparency is to raise awareness about financial relationships between biopharmaceutical companies, device manufacturers, and healthcare providers.

The final rule implementing the Sunshine Act (<http://www.gpo.gov/fdsys/pkg/FR-2013-02-08/pdf/2013-02572.pdf>) was published in the Feb. 8, 2013 Federal Register. Although implementation is lengthy and still has some areas of uncertainty, the new rules and pending database will impact all physicians, regardless of specialty.

So, what does the Sunshine Act require companies to report?

- Meals provided both in and out of the physician's office if the physician eats any of the food or beverages (buffet meals, snacks, soft drinks, coffee, or other refreshments available to everyone at a CME accredited activity are exempt);
- Travel expenses including destination;
- Physician educational items that do not directly benefit the patient, including textbooks and scientific journal reprints;
- Consulting fees, including payments for serving on an advisory board;
- Payments for speaking engagements, unless the event is an accredited CME program;
- Payments related to various other activities and services provided by physicians, such as consulting on product development; and
- Certain grants or other indirect payments to third parties, if the manufacturer learns within a specified period of time that the organization used any portion of the grant to pay a physician for any reason.

What types of payments are exempt from reporting requirements?

- Grants to an accredited CME provider if they comply with the requirements imposed by specified accrediting agencies;
- Product samples, coupons and vouchers intended for patient use;
- Materials intended to educate patients, such as brochures, posters, and anatomical models;

- Gifts from family members and personal friends who work for a manufacturer; and
- Payments to physicians providing healthcare services to manufacturers' employees or family members, as well as payments for certain services that are not directly medical, such as serving as an expert witness in litigation.



Sunshine Act's Key Dates

August 1, 2013:

Biopharmaceutical and medical technology companies began collecting data on payments and transfers of value paid or given to physicians and teaching hospitals.

What this means for you: It is recommended that you begin tracking payments, transfers received and current relationships to ensure accurate reporting in the future.

March 31, 2014:

Biopharmaceutical and medtech companies/group purchasing organizations will report all data (August through December 2013) to CMS.

What this means for you: CMS will compile data on a public site.

August 2014:

You will be able to access the consolidated reports via CMS' online web portal, the NPPES (National Plan and Provider Enumeration System) registry, and, if needed, you will have 45 days to contact the manufacturer/GPO to seek correction(s) or modification(s).

What this means for you: Get on these sites in August 2014 and check the data reported for your National Provider Identifier (NPI) is correct – and if not, have it corrected before the site goes public.

September 30, 2014:

CMS will release most of the data on a public website.

Have you checked your NPI lately? If not, it's time.

For reporting purposes under the Sunshine Act, physicians will be identified based on their distinct NPIs. If your NPI has not been updated to correspond with your current specialty, there is the potential that a reported professional interaction could be perceived as unethical or in violation of the regulations. In order to avoid this confusion, you can help to ensure accurate reporting by:

continued on next page

Preparing for CMS Audits

Denise Anderson, PhD

Denise Anderson, PhD is the NJ-HITEC Director of Strategic Initiatives.

Stage 1 Meaningful Users - Be Prepared for a CMS Audit

Primary care providers who have successfully attested in 2011 or 2012 for Stage 1 Meaningful Use (MU) and received federal incentives and are now preparing for Stage 2, may be subject to a Centers for Medicare & Medicaid Services (CMS) audit. The fact is that approximately one in 20 participants in the federally funded Electronic Health Record (EHR) incentive payment program can expect to be audited for compliance with Meaningful Use and other program criteria according to an April 2013 article by Joseph Conn in ModernHealthcare.com.

CMS contracted with Figliozzi & Company, CPAs P.C. in July 2012 to conduct *Medicare Meaningful Use Audits* of certified EHR technology as required by Section 13411 of the Health Information Technology for Economic and Clinical Health (HITECH) Act. The HITECH Act provides the Secretary, or any person or organization designated by the Secretary, the right to audit and inspect any books and records of any organization receiving an incentive payment.

Here is a list of what physicians should know:

- All providers attesting to receive an electronic health record (EHR) incentive payment for either the Medicare or Medicaid EHR Incentive Programs should retain **ALL** relevant supporting documentation (in either paper or electronic format) used in the completion of the Attestation Module responses;
- Documentation to support the attestation should be retained for **six years** post-attestation. Documentation to support payment calculations (such as cost report data) should continue to follow the current documentation retention processes;

- CMS, and its contractors, will perform audits on Medicare and dually eligible (Medicare and Medicaid) providers. States, and their contractors, will perform audits on Medicaid providers;
- CMS and states will also manage the appeals processes –



How a physician should prepare for a CMS Audit:

- To ensure you are prepared for a potential audit, save the supporting electronic or paper documentation that supports your attestation. This includes documentation related to:
 - Owning an ONC certified EHR system;
 - A copy of your MU report with numerators and denominators associated with Core and Menu requirements;
 - Screenshots for all the “Yes” or “No” requirements that you attested for MU; and
 - A copy of the Clinical Quality Measures (CQMs) report with all numerators and denominators.
- Upon audit, the documentation will be used to validate the provider accurately attested and submitted measures, as well as to verify the accuracy of the incentive payment.

NJ-HITEC Meaningful Use Director, Bala Thirumalainambi explains what is next, “Once you receive the CMS audit letter, you may be asked to either upload your supporting documents, or securely email them, or send them using regular mail to the auditor by a specific deadline. Providers can review the CMS Audit Supporting Documentation and the Audit Overview Tip Sheet to obtain an understanding of the audit process.” ▲

Sunshine Act *continued from previous page*

- Updating your NPI information or obtaining an NPI through the NPPES website: <https://nppes.cms.hhs.gov/NPPES/Welcome.do> ;
- Working with the relevant biopharmaceutical companies if you do receive reportable value to ensure they have your correct NPI, state licensure information, business address, and specialty;
- Tracking your own reportable data from biopharmaceutical companies and clarifying reportable data with each company.

With all that said, on October 28, 2013 AAFP, working with dozens of other specialty societies, requested CMS reverse some of the interpretations in the final regulations – specifically interpretations related to the reporting of physician education

items, including textbooks, reprints of peer-reviewed scientific clinical journal articles – and even abstracts of such information-rich articles. CMS took the position that these are not written for patients, intended for patient consumption or directly beneficial to patients and, therefore, would be subject to the law’s reporting requirements – and therefore reportable. These medical societies are seeking to reverse this interpretation.

For more information on AAFP’s recent advocacy efforts on this issue: <http://www.aafp.org/news-now/government-medicine/20131101sunshineltr.html>.

For more information on the Sunshine Act and its impact on physicians: <http://www.healthdialogues.org/wp-content/uploads/2012/12/Physician-Payments-Sunshine-Act-Fact-Sheet.pdf>. ▲

Co-Management Agreements for Patient Care

Susan B. Orr, Esq.

Susan B. Orr, Esq. is a health law attorney in the law firm of Rhoads & Sinon, LLP, located in Exton and Harrisburg, PA. Rhoads & Sinon recently merged with Tsoules, Sweeney, Martin, & Orr, LLC.

A Co-management Agreement is entered into between primary care providers (PCPs) and specialists to define the respective responsibilities of the PCP and the specialist to ensure the coordination of shared patient care. It is essentially a care coordination plan developed by the providers that coordinates the roles and work of the providers, as well as the communication between the providers themselves and between the providers and the patient.

Co-management Agreements are customized to meet a patient's unique medical situation. They are generally used for high-risk patients with chronic problems or for patients who receive frequent care from both a PCP and a specialist.

Types of Co-Management Agreements

There are three types of Co-management Agreements: (a) Shared Management for the Disease, (b) Principal Care for the Disease, and (c) Principal Care of the Patient for a Consuming Illness for a Limited Period.

(a) In a "Shared Management for the Disease" Co-Management Agreement, the specialist and the PCP share long-term management for a patient's referred condition. The agreement specifically describes how the specialist will provide expert advice, guidance, and periodic follow-up and how the PCP will manage the patient's condition day to day.

EXAMPLE: A patient with chronic lymphocytic leukemia is referred to an oncologist. The oncologist determines that the patient is stable and no intervention is needed, but the patient will need periodic labs and exams. The patient has diabetes and requires frequent visits to the PCP. The physicians agree that the PCP will periodically assess the leukemia, but the oncologist will follow up with the patient annually.

(b) In a "Principal Care for the Disease" Co-management Agreement, a specialist is responsible for the long-term, comprehensive management of the patient's referred condition. The PCP receives consultation reports from the specialist and provides input on secondary referrals and on quality of life/treatment decision issues. In addition, the PCP maintains control over all other aspects of the patient's care, including new or other unrelated health problems, and remains the first contact for the patient.

EXAMPLE: A patient has thyroid cancer with nodal mets at the time of presentation. An endocrinologist arranges post-operative care, follows thyroid hormone suppressive therapy, and monitors disease status. The endocrinologist orders neck US, TG panel and TSH; and orders, refills and adjusts the LT4 doses. The patient sees the PCP for

other issues. If another provider orders TSH, the patient knows that only the endocrinologist should make adjustments in the LT4 dose.

(c) And finally, in a "Principal Care of the Patient for a Consuming Illness for a Limited Period" Co-management Agreement, a specialist is temporarily the patient's first contact due to the significant nature and impact of the patient's disorder. The PCP receives ongoing treatment information and provides input on secondary referrals made by the specialist.

EXAMPLE: A transplant hepatologist primarily manages the multi-system complications of a post-liver transplant patient in the first post-transplant year. The transplant hepatologist takes care of secondary referrals. Gradual transition back to primary management by the PCP will be initiated after stabilization of acute issues by the hepatologist.



What to Include in a Co-Management Agreement

Co-management Agreements should include the following terms, at a minimum:

- Patient name and medical condition for which co-management applies;
- Who is accountable for which processes and outcomes of care;
- Consultative information requirements;
- Frequency and timeliness of information flow between providers and patient;
- Term of agreement (short term, long term, indefinite); and
- How secondary referrals will be handled.

When you lay out who is accountable for which processes and outcomes of care, be sure to specifically include the following: ordering of labs/diagnostic tests/studies; communication of results to patient/other physician; medication management/notice of changes; and notification of changes in patient status (e.g., hospitalizations, emergency care, etc.).

Conclusion

The key to an effective Co-management Agreement is advanced planning. Your Co-management Agreements should set forth detailed plans for roles and responsibilities as well as communication. The end result is enhanced communication among providers and patients, specifically about the patient's care and care planning.

Susan Orr, Esq. is a health law attorney with the firm of Rhoads-Sinon, LLP. Any questions concerning co-management agreements should be directed to Susan Orr at 610-423-4200 or sorr@rhoads-sinon.com.

EHRs Can Help Save Lives with Health Guidance Recommendations and Other Clinical Decision Support Tools

Shankar Santhanam, MD

Shankar Santhanam, MD is a family physician in Lawrenceville, NJ. He can be reached at drsanthanam@gmail.com.

The managed healthcare system imposed by insurers and other payers limits the amount of time we can spend with our patients. In our haste to get patients in and out of exam rooms, it can be challenging to remember everything at the point of care. An electronic health record (EHR) system can remind us of evidence-based best practices and ensures that we are vigilant in following the latest life-saving health maintenance guidelines.

Clinical decision support tools are vitally important because practice often lags several years behind knowledge in most medical specialties. Chances are the latest evidence-based recommendations have changed since we learned about them. Clinical decision support can make us smarter clinicians by bringing global medical knowledge to the local point of delivery for better patient outcomes.

Clinical decision support has many different definitions, but I explain it as evidence- and rules-based recommendations delivered to the clinician in the exam room when we are seeing the patient. Broad examples include contraindication alerts to notify a clinician if a medication or treatment is not recommended for a particular patient given their medical history; suggestions to help a clinician come up with ideas of how to manage or treat a patient's condition; or even automated data interpretation can help a clinician determine whether a fluctuation in readings is within or outside of a typical patient.

I believe my patient's life was saved by the point-of-care guidance of the EHR system.

I was personally involved in a patient case that fully demonstrated the power of an EHR system to not only improve care, but even save a patient's life. First, some background: I am a partner in a pediatrics and family medicine practice with two offices located outside of Trenton. The combined offices have an active case load of approximately 9,000 patients, and we handle about 12,000 visits per year at both locations.

My practice adopted an EHR system in 2009. The EHR system includes health maintenance guidelines from the US Preventive Services Task Force (USPSTF), the Centers for Disease Control (CDC), and others. These tools remind me of current and up-to-date preventive care recommendations at the point of care. At the same time, the EHR system allows me to rapidly document notes in a natural and intuitive manner without losing my subjective observations or the narrative of the visit.

Improved Patient Outcomes

This automatic health maintenance guidance played a key role when I performed a standard physical examination on a 65-year-old male smoker not too long ago. I believe my patient's life was saved by the point-of-care guidance of the EHR system.

The patient had hypertension and was an active smoker. An abdominal aortic aneurysm (AAA) occurs in about 10% of men over 65 who have risk factors for vascular disease (e.g., heredity, obesity, and smoking). Aware of the patient's risk for an abdominal aortic aneurysm, I performed a standard abdominal exam, but did not detect anything that would raise my suspicion.

Based on the patient's risk factors, however, the EHR system recommended the patient be additionally screened to rule-out an abdominal aneurysm. Specifically, the EHR system's on-screen reminder notified me that screening for an abdominal aneurysm is currently recommended for this population.

Although I could not palpate a mass or note any unusual bruits on the exam, the risk-factor reminder tilted my decision making, and I ordered an abdominal ultrasound and told him to get it done immediately. The subsequent ultrasound revealed a large aortic abdominal aneurysm and bilateral iliac aneurysms in his legs.

It was a very serious situation, and his life was on the line. Rupture of an abdominal aortic aneurysm causes up to 30,000 deaths per year in the U.S., with an 80 percent mortality rate; it is the third leading cause of death in men over 60.¹ Without immediate surgery, the patient had a high risk of the rupture and sudden death.

The patient underwent a series of multiple operations to have the damaged tissue repaired. Further testing during these procedures also found a thoracic aneurysm and multi-vessel heart disease. The patient ended up undergoing iliac artery coil embolizations, abdominal and thoracic aortic aneurysm repairs, CABG x3, and a pacemaker placement for Type II Mobitz Heart block. The surgeries were successful and the patient is currently recovering under my care.

Thanks to the latest health maintenance guidelines incorporated into my EHR system, I was reminded at the point of care to recommend testing that ultimately proved critical for this patient. My patient knows that the EHR system played a key role in saving his life. When I showed him the evidence-based health maintenance recommendations in the program, he was incredibly grateful that I was using an EHR system. ▲

Reference

1. Reardon RF, Cook T, Plummer D, (2008) Abdominal aortic aneurysm. In Ma OJ, Mateer JR, Blaivas M, (Eds.), *Emergency Ultrasound*. 2nd ed. (pp. 149-168). New York, NY: McGraw-Hill.



The Tide is Turning: FMEC NJ Student Reception in Philadelphia

Monali Desai and Chelsea Brower

Monali Desai and Chelsea Brower are both fourth-year medical students at Rutgers New Jersey Medical School in Newark and the Student Trustees for the NJAFP.

Anyone who has ever planned an event knows that along with the secret thrill at the thought of success is the equally terrifying thought of failure – failure being an empty room. On a bright, cold autumn morning in Philadelphia, the NJAFP student and resident trustees collaborated with Primary Care Progress, to host a New Jersey Student Reception at the Family Medicine Education Consortium (FMEC). The goal of the reception was to facilitate an open discussion with New Jersey medical students about factors that may impact their choice to pursue family medicine. The Governor's Suite was booked, guest speakers were arranged, food was ordered...and then we waited...waited to see if New Jersey students would come, and perhaps wondered, deep down, whether the tide in family medicine was turning in New Jersey.

To our surprise, student after student trickled in. Soon the suite was packed with residents, medical students, faculty, family doctors, and even high school and college students. The room was filled beyond capacity. Debra Briggs, President and CEO of the New Jersey Council of Teaching Hospitals, and Andrew Morris-

Hearing some of the negative perceptions about family medicine was definitely startling since we clearly have seen so many of the positives. But that is why honest discussion is so important.

Singer, President and Principle Founder of Primary Care Progress, helped start off the event by briefly speaking about the importance of primary care.

The students and residents then split up into three discussion groups based on which topic they wanted to talk about. One group discussed their reasons for and against practicing primary care in New Jersey. We felt it was important to find out what specifically influenced people's decision to leave the Garden State or not. Many of the reasons to stay were expected and understandable: family; familiar training ground; established connections/

networking through their medical school experiences. Reasons to leave ranged from returning to family or following a 'significant-other;' perception that New Jersey family doctors were referring patients to specialists too often; and a lack of comprehensive integrative medicine tracks.

Another group discussed what their ideal family practice would consist of if they were given a blank check. There was an overwhelming desire for multidisciplinary teams consisting of, but not limited to, a pharmacist, nutritionist, social worker, diabetic educator, psychologist, etc. One student voiced a desire for a community wellness garden and a gym located on site, providing a practical, tangible way to achieve a healthy lifestyle. The last group sat cross-legged on the floor and spoke about the obstacles in medical school – internal and external – that they faced when considering family medicine. Some spoke about the perceived monotony (i.e. only seeing sore throats, back pain, and chronic diseases) and lack of procedures, especially obstetrics. Others cited a lack of student and resident role models. Some noted poor preceptor experiences during the first three years. Other students mentioned financial concerns, – lower salary, but staggering debt.

As we looked around us, we heard the steady babble of conversation accentuated with bursts of laughter. At other times, groups grew very quiet listening to a member speak intensely about their experiences or concerns about the future. As student trustees well into our fourth year, we are at the peak of our excitement and passion for our field. Hearing some of the negative perceptions about family medicine was definitely startling since we clearly have seen so many of the positives. But that is why honest discussion is so important. Without it, we do not know what students really care about, what experiences they have had, and thus, in what way we can show them the real depth and breadth of family medicine. At the end of the day, changing a student's mind is, perhaps, too far-reaching, but opening their mind to the real possibilities of our field is our responsibility.

We hope that this event is the beginning of many more exciting NJAFP events helping students to explore the possibilities and realities of family medicine. ▲



NJAFP Student Trustees, Monali Desai (l) and Chelsea Brower (r).

Addressing the Primary Care Workforce Shortage in New Jersey: Fanning the Flames of Excitement for Family Medicine

Deepa Sannidhi, MD

Deepa Sannidhi, MD is a PGY-2 at the Hunterdon Family Medicine Residency program in Flemington, NJ.

Every New Jersey medical student who decides to go into family medicine has a similar story to tell about their career choice – senior residents from other specialties telling them they were making a mistake for choosing family medicine; attendings and advisors who tell them they are too smart to go into primary care; or attendings who serve a backhanded compliment saying they are making a “brave, noble decision.” With so many misconceptions and misguided advice inhibiting medical students from choosing a career in family medicine, it is astounding that any students go into primary care in New Jersey at all. In the midst of a shortage in primary care providers that has reached near crisis levels, especially with the passage of the Affordable Care Act, New Jersey institutions of medical education continue to produce

With so many misconceptions and misguided advice that barrier medical students from choosing a career in family medicine, it is astounding that any students go into primary care in New Jersey at all.

an overwhelming majority of graduates that will provide specialty care. While the alarms are sounded every year in newspapers, magazines and scientific journals, few strategic efforts are put towards specifically addressing this problem. That is why NJAFP resident trustees, Steven Nguyen, MD and Jerry Banks, MD, NJAFP student trustees, Chelsea Brower and Monali Desai, and I took it upon ourselves to try to empower those ‘brave and noble’ students that are choosing family medicine, to spread positive influence about primary care at their schools.

At this year’s Family Medicine Education Consortium (FMEC) Northeast Regional Meeting for family medicine residencies and medical students, we organized a student reception for New Jersey students. Medical students in New Jersey usually have family medicine clerkships with family physicians in the community, but they do not always have full exposure to what family medicine is,

or can be. And sometimes it takes exposure to only one model family physician to inspire them to pursue family medicine. At the NJAFP “Changing Culture” Medical Student Reception at the FMEC, we wanted to bring these role models to the students. Speakers who helped amplify the palpable excitement about primary care and family medicine included Mary Campagnolo MD, AAFP Alternate Delegate for the NJAFP Board of Trustees, and Andrew Morris-Singer MD, of the New Jersey Council of Teaching Hospitals. To engage the students, we had residents and students brainstorm on the barriers that may prevent someone from choosing primary care specialties such as family medicine, and to consider potential solutions to those problems. Engaging students at FMEC is a small, but necessary step for New Jersey trainees interested in furthering the cause of the primary care workforce shortage. To keep the momentum moving forward, the students from our reception, along with representatives from NJAFP will visit every medical school in New Jersey to speak to medical students about family medicine and primary care, with the dual goal of engaging students interested in primary care and exposing those who are still ambivalent about their career choice to the broad scope and opportunities available in family medicine.

My own path to family medicine residency began when I became involved in the national leadership of the American Medical Students Association, where I met students from all over the country who served as wonderful role-models for me. These advocates proudly stated their goal of going into primary care or family medicine. Motivated to echo these efforts, NJAFP representatives will be organizing a lobby day to expose students to the process of primary care advocacy. Student leaders engaged in this advocacy process will serve as role-models that New Jersey medical students can identify with. In order to change the culture of our medical schools, the fire that keeps students excited about primary care needs to be continually nurtured. To ensure success, this effort will require the support from many different areas of their medical school experience. Our goal is to continue fanning the flames.

Representatives of the NJAFP would like to extend a special thank you to Larry Bauer, MSW, MEd from FMEC, Ray Saputelli, MBA, CAE from NJAFP, and the staff at Primary Care Progress for their help coordinating this successful event. ▲



Tar Wars in 2013-2014 School Year

Candida Taylor

Candida Taylor is the NJ State Tar Wars Coordinator for the NJAFP.

It seems like only yesterday

that the days were filled with warm sunshine that lingered into evening as we wondered on the commute home what to grill for dinner – yet suddenly we find ourselves staring down into the gizzard of Thanksgiving as entire generations of turkeys blithely wait to be sacrificed so we may recount our life's blessings in deep gratitude. (Of course by the time you read this, the turkeys who thought they had fortuitously escaped the inevitable, are now being led to the final 2013 slaughter event.) I digress – my apologies...



The point I am trying to make is that time is flying by rather rapidly (unlike turkeys which can't fly) and we are already deep into the current school year. There are 4th and 5th grade children eager to learn of the harmful effects of tobacco versus the great possibilities that present themselves if students choose another path in life (again unlike the turkeys – that have no choice).

This past July we celebrated the **25 Year Anniversary of Tar Wars** in Washington, DC. It was quite a milestone, but the take away message was that it is our volunteer

family physicians, healthcare providers and educators who determine the future success of Tar Wars – and the future health of our children. Without your efforts to thwart tobacco use, tobacco companies will continue to market to young, unsuspecting future smokers in their desperate quest to replace the smokers they have used up – the ones they have led to “slaughter.” While the language may feel uncomfortable to some – this is precisely what tobacco companies must do to survive – they must continue to recruit smokers/users because they actually kill their own customers.

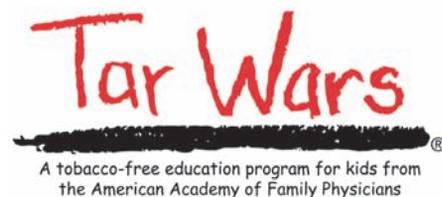
Please consider what a powerful effect you as a family physician can have on a child weighing the option of taking that first puff. Here's what we know:

- More than 3,800 kids under the age of 18 smoke their first cigarette every day¹
 - Good news: one out of every three will quit smoking¹
 - Bad news: one out of every three will die from smoking or complications related to smoking^{1,2}
- According to the Surgeon General,² teenagers who smoke are:
 - Three times more likely to use alcohol.
 - Eight times more likely to smoke marijuana.
 - And 22 times more likely to use cocaine.

To learn more about Tar Wars, please visit www.aafp.org/tarwars. To sign up to be a presenter and get all the materials necessary to present in a school in your community, please visit <http://www.aafp.org/patient-care/public-health/tobacco-cessation/tar-wars/presenters.html> or contact me at 609-394-1711 or candida@njafp.org.

Please encourage your Tar Wars pupils to participate in the 2014 Tar Wars Poster Contest. The poster contest is a wonderful

way for students to creatively express what they learned from Tar Wars and to reinforce the positive message that all things are possible when we make healthy choices in life. The New Jersey State Tar Wars Poster Contest deadline will be May 9, 2014 so we can comply with the National AAFP Tar Wars Poster Contest deadline of May 15.



Please make sure your participants' posters are received in our office with the appropriate accompanying paperwork also available at <http://www.aafp.org/patient-care/public-health/tobacco-cessation/tar-wars/poster.html>

For more resources to help your smoking patients quit, please go to <http://www.aafp.org/patient-care/public-health/tobacco-cessation/ask-act.html>

Remember – the turkeys don't have a choice (that's why they're turkeys), but we always have a choice to do the right thing and to help others. That's why (one of many reasons, I am sure) you became a family physician.

For assistance setting up a presentation, contacting a school or finding additional resources, please call Candida Taylor at the NJAFP office at 609-394-1711 or email me at candida@njafp.org.

References

1. Centers for Disease Control and Prevention. Surgeon General's Report on Preventing Tobacco Use Among Youth and Young Adults. <http://www.surgeongeneral.gov/library/reports/preventing-youth-tobacco-use/full-report.pdf>.
2. Tobacco Free Kids. <http://www.tobaccofreekids.org/research/factsheets/pdf/0001.pdf>.

If they can't get to the mountain... Bring the mountain to them! And that's what we've started doing.

Jeffrey A. Zlotnick, MD, CAQ, FFAFP – Medical Consultant to SONJ

Back in 2003, the NJAFP in conjunction with Special Olympics New Jersey (SONJ) started a program called "MedFest." This program was part of the "Healthy Athletes Initiative" from SONJ (Special Olympics New Jersey) which targeted an estimated 300+ students with developmental disabilities in some of the poorer school districts whose ability to participate in Special Olympics was limited due to lack of a pre-participation exam (PPE). If we did not get the PPE's done for these athletes, they would have never had the opportunity to participate.

Students from these schools were bussed down to the SONJ headquarters in Lawrenceville, NJ where Family Medicine Interest Group Students, Family Medicine Residents, and members of the Athletic Trainers Society of New Jersey did pre-participation screening exams in a station exam format. This was the first time family physicians had been involved in this level of screening, employing station exams to evaluate large numbers of students in a single event. The program also had national implications as MedFests have been done in multiple states and is a recognized program by Special Olympics International.

However, despite the success of the program, there were still numbers of students who could not be brought down the SONJ headquarters for various reasons. So, starting this year, we will be bringing MedFest to them through a mobile screening center.

November 14, 2013 was the second event where the SONJ Mobile



Health Unit was brought to the Eden Autism Services Center in Princeton, NJ. Starting next year SONJ will be bringing this specially equipped "van" to other schools across New Jersey that have not been able to transport their students to Lawrenceville. These will be done in conjunction with the usual annual MedFest program.

One special reminder! Don't forget, the Special Olympics National Games are coming to New Jersey in June 2014! We're going to need lots of volunteers to help with a second MedFest prior to the games and for medical support at the games.

We'll keep you posted.

Special Olympics NJ Mobile Health Unit

Now that SONJ has 'wheels,' they have embarked on a road show program bringing the benefits of their facility to special needs students in regions of the state where budget and mobility constraints prevent students from visiting SONJ's Lawrenceville headquarters. The following dates have been announced as special events to provide screenings to students. The selected dates and regions are (actual locations to be determined):

Floor Hockey Tournament

January 11, 2014
Stockton College
10:30am – 3:00pm

Winter Games

January 27, 2014
Mountain Creek
12:00pm – 4:00pm



Special Olympics

Area 8 Bowling

February 7-8, 2014
Egg Harbor Township
Feb. 7 – 10:00am – 2:00pm; Feb. 8 – 10:00am – 3:00pm

Spring Sports Festival

March 29, 2014
Wildwood
10 am – 4 pm

MedFest

April 9, 2014
Jersey City (This event will replace the Spring MedFest usually held in Lawrenceville)
10:00am – 2:00pm

Each event will require approximately 1 to 3 attending/resident physicians

If you are interested in volunteering at any of these events, please contact Andrea R. Picariello (Healthy Communities Manager, Special Olympics New Jersey Sports Complex) at 609-896-8000, ext. 266 or email her at ap@sonj.org if you are interested in participating in any of the events listed above.

A Cause Worth Supporting

This fall the NJAFP Resident and Student Trustees undertook the task of discovering how medical school students feel about New Jersey...why they stay, why they don't, what do they look for in a residency program, and many other issues important to students. What our Trustees found is that a lot of myths exist about practicing family medicine in New Jersey.

Our Trustees have vowed to work to dispel the myths and to continue to work to keep more residents and students in New Jersey. To do that they need your help. You can be a part of opening a student's mind to the possibilities of practicing family medicine in New Jersey by a simple donation to the NJAFP Foundation. Just fill out the form below and mail or fax to the NJAFP office, or go on line to <http://www.njafp.org/about-njafp/njafp-foundation/make-donation> (choose grants and scholarships).

Make sure to read the article in Resident and Student View to get the entire story on the Resident and Student Trustees initiative.

"To our surprise, student after student trickled in. Soon the suite was packed with residents, medical students, faculty, family doctors, and even high school and college students. The room was filled beyond capacity..."



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