

Perspectives

A VIEW OF FAMILY MEDICINE IN NEW JERSEY

Improving Adult Immunization in New Jersey

CME Inside:

Immunization and Healthy People 2020 goals



Ebola:

What to tell your patients



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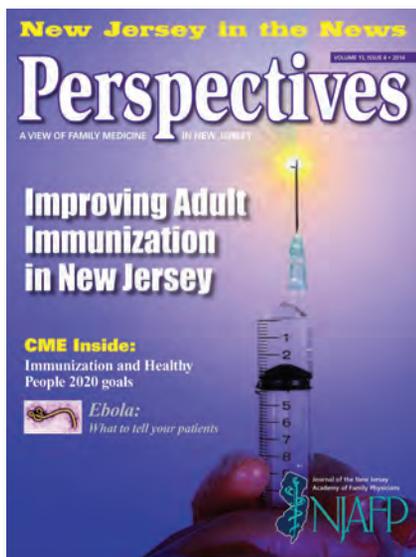
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Crafting Your Message

Words matter. They are one of the most powerful tools we have as humans because we each have the power to take individual words and craft them into powerful messages. When those messages are communicated effectively, they help us to understand each other, build trust and respect, resolve differences, and create environments where creativity and problem-solving can flourish.

History is filled with great speeches, songs and stories, written or sung or spoken by people who know how to combine words into messages to make a point. Winston Churchill said "If you have an important point to make, don't try to be subtle or clever. Use a pile driver. Hit the point once. Then come back and hit it again. Then hit it a third time - a tremendous whack."

Family medicine is poised to deliver "a tremendous whack" with the launch of *Health is Primary*. Hopefully you have heard of the campaign by now. In his President's View column, Dr. Bhaskarabhatla speaks to the importance of spreading the message of primary care through effective communication. He urges all of us not to retreat or withdraw from the complexities of communicating our message, but to "work to improve our ability to listen well, articulate our thoughts and effectively convey clear, understandable messages at the proper time and with the appropriate impact. "

If we want to be effective at communicating, we have to take every opportunity to practice. Some people seem to be born great communicators, but communicating effectively is a skill that can be learned. Here are a few tips to get you started.^{1,2,3}

LEARN HOW TO LISTEN: If you want to be a great communicator, the first thing you need to do is be a great listener. Listening is hard, because it requires you to be fully present to the conversation... a difficult thing to do when your phone keeps vibrating with email, texts and phone calls. To listen fully, put aside those things that may distract you. Also, listen without judgment or jumping to conclusions. Remember, you don't know what is in the other person's mind and you won't know unless you keep an open mind. Other tips to being a good listener are: don't interrupt, ask questions only to ensure understanding, *continued on page 19*



How can we, family physicians be better communicators?

Krishna Bhaskarabhatla, MD

Dr. Bhaskarabhatla is President of the New Jersey Academy of Family Physicians and is in private practice in Woodland Park.

THE HOLIDAY SEASON is here and the new year is waiting in the wings with the reminder of a long list of time-sensitive issues facing primary care - meaningful use, impending Medicaid cuts and the Medicare sustainable growth rate (SGR) formula, just to name a few. Added to this mix are the buzz words: "triple aim," "quadruple aim," "patient engagement" and so on. Everyone wants to be on the primary care bandwagon! Does the public know about and appreciate the value of the continuous, comprehensive, and coordinated primary care that we, family physicians can provide to them? How are we going to define, communicate, and defend what primary care is? The globally accepted meaning of primary care comes from Barbara Starfield, MD, MPH, who defined it as "first contact, continuous, comprehensive, and coordinated care provided to populations undifferentiated by gender, disease, or organ system." How do we help our members come up with an "elevator pitch" which reflects this theme? It all boils down to effective communication.

Have you heard about the new campaign *Health is Primary*? We did recently, and many of us came back from Washington, DC energized with the AAFP's new campaign! In the coming weeks we shall roll out this campaign in our state. We should then spread

Timely and factual communication to our patients, families, and the public is the only way to get our messages conveyed in the proper context.

this message in as many settings as possible. This all begins with us, and then with our patients, their families and our communities. Beyond the word-of-mouth, I would like to hear from you about your ideas for spreading the news via social media such as Twitter, Facebook, and so on.

How can we be better communicators? What is communication? As per the Merriam-Webster dictionary, communication is defined as an "act or process of using words, sounds, signs, or behaviors to express or exchange information or to express your ideas, thoughts, feelings" etc., to someone else. An often-used definition of the term "to communicate" is to express oneself in such a way that one is easily and clearly understood.

Communication is the foundation of our shared human experience. We must strive to first understand ourselves and then to understand our audience so that we can tailor our message to be more effective. I believe that communication means far more than

the ability to express oneself. It means active listening as well as talking and writing. Some people communicate well naturally but, for most, communication is a learned skill. Clearly, people are most effective when they are good communicators. We all can work to improve our ability to listen well, articulate our thoughts and effectively convey clear, understandable messages at the proper time and with the appropriate impact.

As individual physicians, we must communicate effectively with our patients (listening well, talking and writing well). Within our academy, communication occurs at various levels, whether it is a simple exchange of ideas between two members or the complex discussions among multiple members, committees or outside parties. Effective interaction involves an understanding of different and frequently opposing views. Members must listen, analyze information and present their views, focusing on the mutually beneficial (rather than divisive) aspects of an interaction enabling negotiation to occur so that a consensus can emerge that will benefit all involved.

The relationship between our academy and other professional societies paves the way to develop common ground of mutual acceptability. Coalitions and collaboration are the dividends of a commitment to integrate various viewpoints. We also must relate to each other within our academy and beyond with other health professionals. A vital role for our academy is to foster communication pathways in many health policy sectors and media. We should nurture relationships with key players in both private and public payer institutions. The ultimate beneficiaries of such ongoing interchanges on health policy and patient care issues will be our patients. This way we will continue to enjoy the public's trust.

Communicating effectively with media is another important area of concern. We must work to enhance our skills in talking with the media. Many members get opportunities throughout the year to talk with reporters on a number of health-related issues. As family physicians, we are reminded time and again to strengthen our abilities to communicate to diverse audiences. There may be times when it would be easier to retreat or simply not discuss an important point or withdraw from attempting to address the complexities. Being evasive, oversimplifying or poorly transmitting information can only hurt our patients and our profession. Timely and factual communication to our patients, families, and the public is the only way to get our messages conveyed in the proper context. I invite you to get involved in our academy whether in a committee or contributing an article for *Perspectives*, our website content, or blogs. Please send me an email (baskarabhat@gmail.com) with your thoughts. Communication is an activity whose time has come. Let us continue to meet its challenge.

Wishing you all happy holidays and a happy New Year! ▲



LOOKING BACK FORGING AHEAD

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.

“It isn’t easy to change the world; it requires dedication, perseverance, a healthy sense of humor to get you through the rough patches, and unmitigated optimism. There were times when we weren’t sure how our efforts were going to play out. Certainly there were many who thought we were wasting our time, but in the words of Gandhi, “First they ignore you, then they laugh at you, then they fight you, then you win.” We may not yet have secured the victory, but the odds seem suddenly in our favor... I am more convinced than ever that the change we see is not luck, or serendipity, but rather the beginning glimpses of the effects of years of working to change the world.”

I wrote those words in 2012. NJAFP was poised to be a driving force for how health care was going to be delivered in New Jersey. In 2014, we are a force that is changing the face of primary care medicine. We are finally beginning to see the results of our tireless efforts to improve the way care is delivered in this state. We are seeing payers committed to reinvesting in primary care. We now have a solid infrastructure of practices committed to transforming the delivery of health care in a patient-centered, team-based approach.

NJAFP is already on the path to assisting family physicians in reaching the Triple Aim to improve health care. As family physicians, you have always been focused on the individual patient and their families. It is what you do, who you are, and what you will continue to be. Population health management is part of your everyday practice. However, today it is garnering attention from the more mainstream health organizations. As healthcare reimbursement begins to shift to a quality model, family physicians need to be rewarded to meeting quality standards, not only on a per patient basis, but on their whole patient panel. Practices that are delivering patient-centered, quality care realize that value trumps volume.

Containing costs should be a goal all family physicians strive for and cost containment will be the new reality in the practice of medicine. One way to bring cost containment into your office is through the *Choosing Wisely* campaign. While an initiative of the ABIM Foundation, *Choosing Wisely* is supported by many specialty societies, including the AAFP. Using the materials available for the *Choosing Wisely* website (<http://www.choosingwisely.org/>) you can begin to have conversations with your patients based on evidence about the most appropriate care based on each patient’s situation.

We are seeing the launch of the *Family Medicine for America’s Health: Health is Primary* campaign designed to demonstrate the value of primary care in delivering on the Triple Aim of better health, better care and lower costs. The goal of the project is to transform family medicine to ensure we can meet the healthcare needs of our nation and ultimately improve the health of each American. To achieve that transformation, *Health is Primary* will focus on furthering the evolution of the patient-centered medical home; advancing the use of technology; ensuring a strong primary care workforce; and, shifting to comprehensive primary care payment. We are currently making plans to launch the campaign here in New Jersey, so stayed tuned for more details about how you can get involved.

So while there is certainly still much work to be done and far too many family physicians still struggling to stay afloat, it does seem that years of work are beginning to payoff. The work could not have been done without the help of the whole NJAFP team with whom I am blessed to work. And so, I would like to extend special thanks to the members of the NJAFP physician, residents, and student leaders who give so generously of their time and energy to fight for all family physicians and their patients. These leaders have helped NJAFP become a significant voice in New Jersey health policy discussions. I am proud of the work we have done together.

Our achievements would not be possible without the efforts of the best professional team in the country. I want to thank:

- Candida Taylor, Robbin Comiski, and Pam Joyce
- Cari Miller, Cathy Cardea, Tara Perrone, Karen Foster and Jay Runyon



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Temporary tats may not be so temporary... and may be dangerous too

Temporary tattoos are popular among young adults and teens. To them it is a harmless and temporary way to have some fun or to mark a special occasion. However, research has shown that those temporary tattoos (which normally last from three days to several weeks) may not be so temporary or harmless.

The Food and Drug Administration's (FDA) Office of Cosmetics and Colors has reported that some consumers have severe and long lasting reactions to these temporary tattoos.¹ Reported problems include redness, blisters, raised red weeping lesions, permanent scarring and others. Reactions can happen immediately or up to three weeks later.

Henna, a reddish-brown coloring made from a flowering plant that grows in tropical and subtropical regions of Africa and Asia, has been



used for centuries as a coloring agent and is still used around the world to decorate the skin in cultural festivals and celebrations. Sometimes, however,

"black henna" is often used in place of traditional henna. Black

henna is particularly harmful because the ingredient used to blacken or darken the traditional henna is often a coal-tar hair dye containing p-phenylenediamine (PPD). PPD has been known to cause dangerous skin reactions in some people. The American Contact Dermatitis Society and the American Academy of Dermatology issued a joint health advisory on PPD in 2008. Since then several states have acted to increase awareness of black henna tattoos. Among these states are New Jersey (parental consent for minors prior to receiving a black henna tattoo), Oklahoma (license henna tattoo artists) and Florida (Department of Health will investigate reports of the application of black henna tattoos).² In addition, the Centers for Disease Control and Prevention (CDC) has listed PPD as an allergen.³

You may see "black henna" used in places such as temporary tattoo kiosks at beaches, boardwalks, and other holiday destinations, as well as in some ethnic or specialty shops. While states have jurisdiction over professional practices such as tattooing and cosmetology, that oversight differs from state to state. Some states have laws and regulations for temporary tattooing, while others do not. So, depending on where you are, it's possible no one is checking to make sure the artist is following safe practices or even knows what may be harmful to consumers.

If you have a patient who you believe is having a reaction to a temporary tattoo, contact MedWatch, the FDA Safety Information and Adverse Event Reporting Program at <http://www.fda.gov/Safety/MedWatch/default.htm> or call the FDA at 1-800-FDA-1088.

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Ebola Resources

IN RESPONSE to the Ebola public health emergency, the American Hospital Association (AHA) has provided an Ebola education package. This package contains information that the American Hospital Association believes would be useful to healthcare providers and institutions right now. It includes:

- Informational PowerPoint: Ebola Facts
- FAQ: Safe Management of Patients with Ebola Virus Disease (EVD) in US Hospitals

To access the materials, visit the American Hospital Association website at: <http://www.aha.org/advocacy-issues/emergreadiness/ebola/index.shtml>

Another resource for information on Ebola is the Ebola Response blog written by Steven Keller, PhD, Professor at New Jersey Medical School, Rutgers University and Wendy Epstein, MD, FAAD, Adjunct Assistant Professor, NYU School of Medicine. To access the blog, visit <http://ebolaresponse.blogspot.com/>

CDC Safety Training Course for Healthcare Workers Going to West Africa in Response to the 2014 Ebola Outbreak

As part of a comprehensive and coordinated response to the 2014 Ebola outbreak in West Africa, the CDC has developed an introductory training course for licensed clinicians (e.g., nurses, physicians and other healthcare providers) intending to work in an Ebola Treatment Unit (ETU) in Africa. This course will take place in the United States. The primary purpose of the course is to ensure that clinicians intending to provide medical care to patients with Ebola have sufficient knowledge of the disease and its transmission routes to work safely and efficiently in a well-designed ETU.

For more information and training course dates visit <http://www.cdc.gov/vhf/ebola/hcp/safety-training-course/index.html>

AAFP Member Interest Groups

AAFP is committed to allowing all members to have a voice in the organization. To support their ongoing effort, AAFP has established member interest groups (MIG) who have shared professional interests. These member interest groups focus on Direct Primary Care, Emergency Medicine/Urgent Care, Hospital Medicine, Independent Solo/Small Group Practice, Reproductive Health Care, Oral Health, Single Payer Health Care, Telehealth, and Rural Health.

If you are interested in joining a MIG visit <http://www.aafp.org/about/member-interest-groups/mig.html> and scroll down to the list of MIGs. This page also includes additional information on MIGs.



Meeting Healthy People 2020 Adult Immunization Goals in New Jersey

Theresa J. Barrett, PhD

Theresa Barrett, PhD is the Deputy Executive Vice President for the New Jersey Academy of Family Physicians and a regular contributor to Perspectives.

Dr. Barrett is an employee of the NJAFP. She has no conflicts relevant to this article.

DESPITE OVERWHELMING EVIDENCE that immunization reduces the risk of contracting a serious disease, infectious diseases remain a major cause of morbidity and mortality in the United States.¹ An estimated 30,000 Americans die from vaccine-preventable diseases with over 95% of these being adults.² Most adults are not immunized as recommended, leaving them vulnerable to illness and death.³ Influenza remains one of the leading causes of illness and death in the United States and along with viral hepatitis, and accounts for considerable spending associated with treating the consequences of infection.¹

Every year, the CDC publishes immunization schedules for children, adolescents and adults on their website (<http://www.cdc.gov/vaccines/schedules>). The schedules are designed to guide providers on the appropriate use of vaccines and the population to be targeted.⁴ The vaccine schedules are developed by the Advisory Committee on Immunization Practices (ACIP), which consists of experts in public health, vaccinology, and infectious diseases, along with other related disciplines. The ACIP makes recommendations to the Director of the CDC regarding use of vaccines and related agents for control of vaccine-preventable diseases in the US civilian population. The CDC Director reviews the recommendations made by the ACIP and if the recommendations are adopted they are published as official CDC/HHS recommendations in the *Morbidity and Mortality Weekly Report* (MMWR).

The CDC currently targets 17 vaccine-preventable diseases across the lifespan.¹ For the adult population (aged 19 through > 65 years), recommended immunizations include Influenza, Td/Tdap, HPV, Zoster, MMR, PCV 13 and PPSV23, Meningococcal, Hepatitis A, Hepatitis B and Hib.⁵ Schedules are updated as new information becomes available. According to the CDC website, in addition to the update to pneumococcal vaccines, there are updated recommendations for Hib, HPV, Influenza, and Meningococcal vaccines.⁶

Healthy People 2020 – Adult Goals

The immunization and infectious disease goals set by Healthy People 2020 (HP 2020) are grounded in evidence-based clinical and community activities aimed at disease prevention and treatment and reflect a more mobile society.¹ However, adult immunization rates remain far below HP 2020 goals.¹ It is now recognized that diseases do not stop at a particular country's geographic

border, as evidenced by the latest Ebola outbreak. According to the National Foundation for Infectious Diseases, thousands of adults are impacted by diseases that are preventable (Table 1).⁷ It is important for family physicians to routinely assess their patients' vaccination history and travel history and recommend the appropriate vaccines.⁸ There is strong evidence that a provider recommendation improves vaccine coverage.⁹

**Table 1: Facts About Adult Vaccination⁷
Common Diseases**

Disease	Impact
Influenza	Between 3,000 and over 49,000 people die each year.
Pneumonia	Causes nearly 50,000 cases of bacteremia and several thousand cases of meningitis.
Hepatitis B	An estimated 800,000 to 1.4 million people are chronically infected.
HPV	By age 50 years, 80% of women will be infected with human papillomavirus which causes 70% of all cervical cancers.
Shingles	There are about one million cases of shingles in the US every year.
Hepatitis A	An estimated 100 deaths from hepatitis A occur in the US each year.
Tetanus	Due to high immunization rates, 50 or fewer cases of tetanus occur each year in the US. Tetanus is fatal in about 10% of cases in the US with most deaths occurring in those age 60 years and older and people with diabetes. Almost all reported cases occur in persons who either never completed the primary vaccination series or who have not had a booster vaccination in the past 10 years.
Pertussis	Parents and other adults are the most common source of whooping cough infection in infants, who are at highest risk of death from whooping cough.

Influenza and pneumonia are common in the adult population, yet vaccination rates remain low. For the 2013-2014 flu season 42.2% of US adults received a flu shot,¹⁰ and while this is higher than for the 2012-2013 flu season (increase of 0.7%), it is well below the HP 2020 goal of 70%.¹ New Jersey is slightly better than the national average, with 46.1% of adults receiving the influenza vaccine (Table 2).¹¹ The HP 2020 goal for pneumococcal vaccination is 90% for non-institutionalized adults aged 65 years and older.¹ Data indicates that only 60% of adults aged 65 and older have ever

received a pneumococcal vaccine.¹² Again, New Jersey fares slightly better than the national average with 61.9% of adults aged 65 and older immunized against pneumococcal disease (Table 2).¹³

Table 2: New Jersey Immunization Rates

Disease	National	New Jersey	Better/Worse than National Average
Influenza	42.2%	46.1%	Better
Pneumococcal	60%	61.9 %	Better

Barriers

Despite the fact that vaccines are known to prevent morbidity and mortality, barriers to providing them exist. While it is well-known that children need to be immunized, a barrier to adult immunization is that many adults are not aware they need a vaccine, particularly if they are healthy.³ Adults are also often not aware of the need for booster shots to maintain maximum protection or that there are new vaccines available to them.³ In a survey conducted by the National Foundation for Infectious Disease, 58% of respondents admitted that they did not know what vaccines they needed and, with the exception of influenza, 19% thought vaccinations were not recommended for adults.³

Other barriers include inadequate reimbursement, insufficient stocking of some vaccines and inconsistent assessment of vaccination status.² The lack of a provider recommendation for a vaccine has also been shown to be a barrier to patients receiving immunizations.¹² Other identified barriers include patient concern over vaccine safety, urgent concerns dominating visits, and challenges relating to the transfer and documentation of vaccination records across providers.^{2,14}

Overcoming Barriers to Adult Immunization

Primary care physicians see themselves as having a central role in vaccine delivery in the US, indicating that with the right tools they can be instrumental in increasing US immunization rates.² Most of these tools will need to be implemented through systems change, such as instituting standing orders (i.e., pneumococcal vaccines for all adults aged 65 years or older). Other tools to improve immunization rates include tracking systems, chart reminders, patient reminders, and office training of physicians and staff.¹⁴

Information Technology

Becoming familiar with and using information technology tools is one way to overcome some of the barriers to immunizations. There are applications now available to provide information about vaccines which, if incorporated into EHRs, could be a way for practices to systematically assess vaccination status.² Among these applications are the American College of Physicians (ACP) Immunization Advisor App (iPhone only). This app helps physicians apply the latest adult immunization recommendations to practice and helps the physician find the right vaccine by age or underlying medical condition.¹⁵ The CDC also offers an electronic Adult Immunization Scheduler (currently offline as it is being updated with new ACIP recommendations for pneumococcal disease) to help keep physicians up-to-date on adult immunizations.¹⁶

The Community Preventive Services Taskforce recommends the

use of immunization information systems (IIS) to reduce vaccine-preventable disease and improve vaccination rates.⁹ IIS interventions to improve immunizations include client reminder and recall systems, provider assessment and feedback, provider reminders, assessments of vaccination coverage, missed vaccination opportunities, invalid dose administration, and disparities in vaccination coverage.⁹ While IIS was originally implemented for the pediatric populations, it may be more critical for use in the adult population as the adult immunization schedule has become more complex and more adults are likely to receive immunization at multiple locations.² IIS may even help eliminate the communication barriers that exist between primary care physicians and other vaccine providers; however IIS must become much more widespread to be effective.²

New Jersey currently has an IIS – the New Jersey Immunization Information System. However, its use has been limited to children in the state.¹⁷

Resources

AFIX (Assessment, Feedback, Incentive, eXchange)

AFIX is a CDC quality improvement plan used by those who participate to increase immunization coverage levels, reduce missed opportunities to vaccinate and improve practice standards at the provider level. Originally designed by the Georgia Department of Health, AFIX has become a national model program to improve immunization rates.¹⁸

The program assesses (Assessment) the provider's current vaccine coverage levels and immunizations practices; provides feedback (Feedback) of the results along with strategies to improve process, practices, and coverage levels; provides incentives (Incentive) to recognize and reward improved performance; and promotes an exchange (eXchange) of information with providers to follow-up on their progress toward better immunization services and improved immunization coverage levels.¹⁸

Within New Jersey, AFIX is administered by the New Jersey Department of Health's Vaccine Preventable Disease Program. The Vaccine Preventable Disease Program works to reduce and eliminate the incidence of vaccine-preventable diseases affecting children, adolescents, and older adults by raising the immunization coverage rates of New Jersey citizens.¹⁹

What Can You Do?

1. Talk to your patients about the importance of adult immunization
2. Make a strong recommendation for immunization
3. Educate yourself and your patients on the importance of immunizations
4. Institute standing orders
5. Use information technology
6. Immunize at every opportunity

AdultVaccination.org

AdultVaccination.org is a product of the National Foundation for Infectious Diseases. The website serves as an information portal for providers and their patients and is designed to improve immunization rates in adults. The Professional Resources section of the website features a Professional Practice Toolkit. This toolkit contains downloadable resources such as appointment reminder cards, immunization tracking forms, fact sheets, and many more resources to help improve immunization rates in adult patients.²⁰

Centers for Disease Control and Prevention (CDC)

The CDC has a vaccine and immunizations section. Here you can download recommended immunization schedules for adults and children, data on vaccines in the US, vaccine side effects and safety information, and a host of other information related to immunizations.²¹

Conclusion

While there are many high-level infrastructure changes focused on improving immunizations, individual family physicians can take steps to improve immunization rates in their practice and their community. Taking advantage of EHR capabilities, using an immunization information system, and leveraging emerging technology and apps are a few immediate actions that can be taken. Other interventions, as recommended by the National Vaccine Advisory Committee, include educating yourself and your patients about the importance of adult immunizations, teaming with other providers in your community who provide vaccines to create a wide provider network for adult vaccines, and developing an on-going, comprehensive outreach campaign to your adult patients on why they should be immunized.¹² And according to the evidence, the most important step you can take is to simply make a strong recommendation to your patients to get immunized. Research has shown that a physician recommendation for immunization is a sure way to improve vaccine coverage.⁹ Helping to ensure your adult patients are immunized is one of the best ways you can keep them healthy.

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NJAFP offers CME online

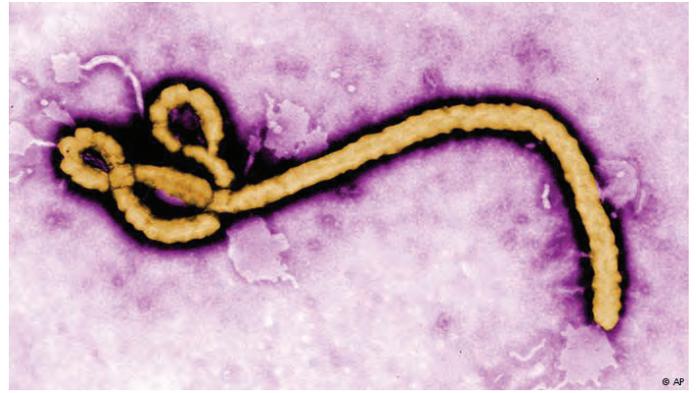
NJAFP in conjunction with ArcheMedX has launched a 10 part e-learning program designed to address educational and practice gaps in the treatment of Major Depressive Disorder (MDD), a leading cause of disability throughout the world which afflicts 7% of the U.S. population every year. To access the course go to <https://mddlesson.archemedx.com/initiatives/managing-major-depressive-disorder/register/new>





EBOLA

What you can tell your patients



While news of Ebola has all but faded from the mainstream media in the US, the virus has not been eradicated and remains a threat to natives of West Africa and the aid workers who travel there to lend assistance. Fear of the Ebola virus still remains. Here are 10 things you can tell your patients about Ebola.

This information is adapted from the CDC publication [Top 10 Things you REALLY need to know about Ebola](http://www.cdc.gov/vhf/ebola/pdf/top-10-things.pdf), available from the CDC website in poster form: <http://www.cdc.gov/vhf/ebola/pdf/top-10-things.pdf>

10. Your dog or cat is not spreading Ebola.

There have been no reports of dogs or cats becoming sick with Ebola or of being able to spread Ebola to people or other animals. Because the risk of an Ebola outbreak spreading rapidly in the United States is very low, the risk to pets is also very low.

9. Food and drinks imported into the United States from West Africa are safe to eat and drink.

To date, no one has been infected with Ebola from foods that are imported into the United States. You can't get Ebola from food grown or legally purchased in the United States.

8. Mosquitoes are the deadliest insects in the world, but they don't carry Ebola.

There have been no reports of mosquitoes or other insects transmitting Ebola virus. Only mammals (for example, humans, bats, monkeys, and apes) have become infected with Ebola virus and spread it. Mosquitoes do carry other organisms, like malaria and West Nile virus that can make people very sick, and sometimes even cause death.

7. Your family members, coworkers, and neighbors returning from countries with Ebola outbreaks don't pose a danger to you and your family.

Ebola is spread through direct contact with blood or body fluids (including but not limited to urine, saliva, sweat, feces, vomit, breast milk, and semen) from a person sick with Ebola. Not everyone coming from countries with Ebola outbreaks has been in contact with someone who has Ebola. Travelers coming from countries with a large Ebola outbreak will be given a CARE (Check and Report Ebola) kit at the airport to help monitor themselves for Ebola symptoms. In addition, they will be actively monitored, meaning they are checked on at least once a day by public health officials. It's safe for you and your family to be around people being monitored as long as they do not have signs or symptoms of Ebola.

6. Household bleach and other disinfectants kill Ebola.

Household bleach or an EPA-registered hospital disinfectant will kill Ebola.

5. If you're feeling sick, think flu not Ebola.

Although flu and Ebola have some similar symptoms, Ebola is a rare disease, particularly in the United States. Flu is very common. To date, four cases of Ebola have been detected in the United States, and two of those were imported from West Africa. Every year in the United States, millions of people are infected with flu, hundreds of thousands are hospitalized, and tens of thousands die from flu. Unless you have had direct contact with someone who is sick with Ebola, your symptoms are most likely caused by flu and you do not have Ebola.

4. Ebola is not airborne.

Ebola is not a respiratory disease and is not spread through the airborne route. There is no evidence that Ebola is spread by coughing or sneezing. Ebola might be spread through large droplets (splashes or sprays), but only when a person is very sick. That's why hospital workers must wear personal protective equipment to stay safe around people with Ebola.

3. The Ebola outbreak is not affecting the safety of airline travel.

Airline travelers in the United States are extremely unlikely to become infected with Ebola. All travelers coming from Liberia, Sierra Leone, Guinea, or Mali, arrive at one of five airports in the United States where entry screening by Customs and Border Protection and CDC is taking place.

2. Ebola is only spread from one person to another once symptoms begin.

Symptoms of Ebola appear anywhere from 2 to 21 days (average 8 to 10 days) after being exposed. A person infected with Ebola cannot spread it to others until symptoms begin.

1. You can't get Ebola from a handshake or a hug.

Ebola is spread through direct contact with body fluids from a person sick with Ebola. Direct contact means that blood or body fluids (including but not limited to urine, saliva, sweat, feces, vomit, breast milk, and semen) from an infected person (alive or dead) have touched another person's eyes, nose, or mouth, or an open cut or wound.

More information for your patients about Ebola is available on the CDC website at <http://www.cdc.gov/vhf/ebola/resources/infographics.html>

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.

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

Members – To obtain credit:

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

Nonmembers – To obtain credit:

1. Complete and return this quiz to the NJAFP with a check for \$15 made payable to the NJAFP and a self-addressed, stamped envelope to NJAFP CME, 224 West State 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:* 95% of the 30,000 Americans who die from vaccine preventable diseases are adults.
2. *True or False:* Influenza is one of the leading causes of illness and death in the United States.
3. *True or False:* ACIP Recommendations for Pneumococcal Vaccines for All Adults 65 Years or Older have not changed since 2010.
4. *True or False:* The CDC currently targets 17 vaccine-preventable diseases across the lifespan.
5. *True or False:* Adult immunization rates are meeting Healthy People 2020 goals.
6. *True or False:* New Jersey is below the national average, with 46.1% of adults receiving the influenza vaccine.
7. *True or False:* Many adults are not aware they need a vaccine, particularly if they are healthy.
8. *True or False:* There is no role for information technology to overcome barriers to immunizations.
9. *True or False:* Ebola is not a respiratory disease and is not spread through the airborne route.
10. *True or False:* Ebola is spread through casual contact with body fluids from a person sick with Ebola.

ANSWERS ON PAGE 19

2015 Tar Wars in New Jersey

The NJAFP has received an AAFP mini-grant for our 2015 Tar Wars program.

The grant has been awarded based on the following proposal:

While New Jersey's state average for high school smoking is lower than the national average by 2.8%, there is still much to be accomplished here. The current administration has failed again to budget for NJ's Comprehensive Tobacco Control Program - sending the message that smoking is not a problem in NJ. However, NJ's report card issued by the American Lung Association's State of Tobacco Control Program¹ revealed a "thumbs down" for not addressing a health problem that costs the state almost \$5.6 billion annually. NJ scored well on smoke-free air (A) and the cigarette tax of \$2.70/pack (B), but NJ is still lacking in providing for tobacco control and spending (F), and cessation programs (F). As State funding continues to dwindle it becomes ever more important for NJAFP to provide students with the resources and education to choose to be tobacco-free and remain vigilant in the fight against tobacco use.



New Jersey has identified 54 "Medically Underserved Communities" as not having adequate access to health care, resulting in chronic conditions that go unchecked and untreated. The prevalence of smoking and tobacco use and associated conditions, such as asthma and COPD are most common in these areas. These communities are in great need of information and resources to help them improve their lack of access to health care. We propose a 3-pronged approach to provide tobacco education/cessation resources in communities where smoking and tobacco use is significantly above the state average.

We have proposed three distinct actions to help us achieve a better rating in New Jersey. These are:

- 1.** Use Family Medicine residency programs to provide Tar Wars programs in medically underserved school districts. A portion of the grant will be used to purchase art supplies (paper, markers, etc.) for students to participate in a statewide poster contest.
- 2.** Collaborate with local health departments to provide a bilingual patient education piece to be distributed in local clinics, drug stores, retailers and physician offices. This piece may be a large postcard, double-

sided in English and in Spanish. It will provide facts about the risks of smoking, how to identify symptoms that may point to more significant respiratory problems, State quit lines, available therapies and other resources.

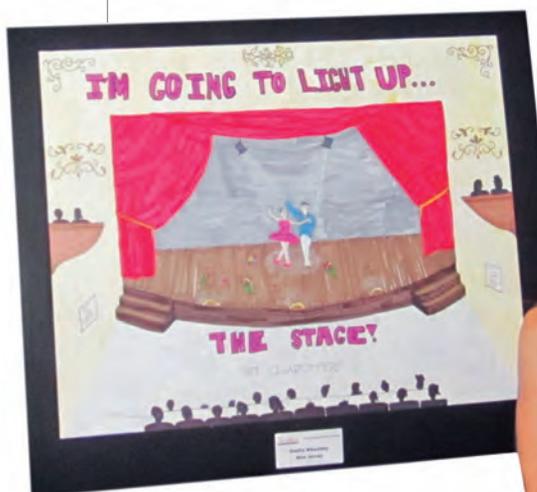
- 3.** Establish a statewide Tar Wars poster contest that mirrors the national program's goals and event on a state level. NJAFP is located in our state's capital and we are in close proximity to the NJ Capitol Building. New Jersey's rich colonial history dating back to the Revolutionary War makes Trenton an ideal destination to teach students about advocacy and our legislative process. Teaching students how to have a voice in their future may encourage them to broaden their expectations of what they can achieve.

In order to realize these goals and meet our objective of improving New Jersey's smoking report card, we will be contacting New Jersey Family Medicine residency programs located in medically underserved areas of the state to participate in the program. Stay tuned for further information or send an email to candida@njafp.org if you have questions - or call us directly at 609/394-1711 if you would like to participate.

For a list of medically underserved areas in New Jersey, please visit: <http://www.nj.gov/health/hs/professional/documents/njmmu99.pdf>

Reference

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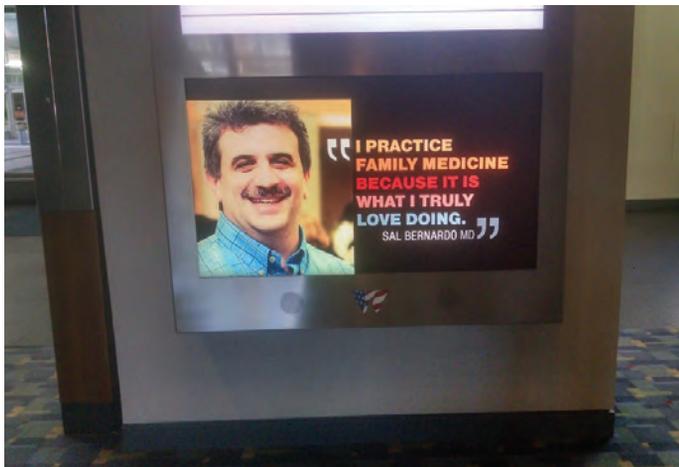
2014 NJ State Tar Wars
Poster Contest winner -
Emilia Wheatley

In the News...

The **New Jersey Academy of Family Physicians (NJAFP)** and **ArcheMedX** announced the launch of a new 10 part e-learning program designed to address educational and practice gaps in the treatment of Major Depressive Disorder (MDD), which remains a leading cause of disability throughout the world and currently afflicts 7% of the US population every year. Given the continued difficulty in effectively treating patients who suffer from MDD, NJAFP and ArcheMedX have developed a more interactive and impactful online learning program that will assist physicians across the US in more accurately diagnosing and effectively treating MDD. To register for the program go to <https://mddlesson.archemedx.com/initiatives/managing-major-depressive-disorder/register/new>.

Representatives of the NJAFP attended New Jersey's Pain Management Council which is charged with developing best practices for managing pain while maintaining controls against Rx drug diversion and abuse. To read the article, go to <http://www.workerscompensation.com>.

Mary Campagnolo, MD, (Bordentown) NJ Delegate to the AAFP Congress of Delegates, was featured in a Medscape article regarding the AAFP resolutions aimed at easing practice impediments. Read the article at <http://www.medscape.com/viewarticle/833683?src=emailthis>.



Sal Bernardo, MD (Freehold) was featured on the AAFP Scientific Assembly kiosks at the Washington, DC Convention Center this past October

Gerald Banks, MD (Trenton) was voted Secretary of the AAFP Medical Interest Group (MIG) on Emergency Medicine/Urgent Care today. Dr. Banks is the first resident physician to serve as an officer on this group.

Congratulations to New NJ Top Docs

Michael P. Basista, MD (*Bloomfield*)
Dean P. Boorujy, DO (*Livingston*)
Veena Desai, MD (*Emerson*)
Robert T. Gorman, MD (*Verona*)
Irving H. Kaufman, MD (*Somerset*)
Dena L. Lacara, DO (*Verona*)
Michele Nitti, DO (*Glen Ridge*)
Anthony Pastena, DO (*Nutley*)
John F. Tabachnick, MD (*Westfield*)
Dyanne P. Westerberg, DO (*Camden*)

Jeff Brenner, MD (Camden), founder of the Camden Coalition of Healthcare Providers (CCHP) was elected to the Institute of Medicine, one of the highest honors in health and medicine. According to the CCHP:

"This honor reflects the growing importance of population health in our modern medical landscape, as well as the Coalition's success innovating within the field of population health. While our work with complex patients is centered in Camden, New Jersey, our learning about how to work with complex patients to address complex medical, behavioral and social factors is critical to our nation's health and well-being."

The **New Jersey Academy of Family Physicians (NJAFP)** recently celebrated five years of providing practice transformation and patient-centered medical home consultation services to help align primary care practices to best serve patient needs. Since 2009, NJAFP has worked with physicians, practice teams, hospitals and health systems, federally qualified and community health centers, residency programs, health plans and key healthcare stakeholders for practice transformation services and patient-centered medical home (PCMH) recognition. In those five years, NJAFP has assisted more than 1,500 physicians in approximately 1,000 practices across the country, including clients in New Jersey, Florida, Georgia, Pennsylvania and Texas. For more information see page 21.

Thomas Ortiz, MD (Newark) appeared on the TV show *Tiempo* to discuss diabetes in the Latino community. To watch the program visit <http://7online.com/uncategorized/tiempo-watch-this-weeks-show/31525/>

Krishna Bhaskarabhatla, MD (Paterson) was featured in an article on NJ.com regarding whether temperature swings can make you sick. The article can be found on http://www.nj.com/healthfit/index.ssf/2014/11/can_temperature_swings_make_you_sick_docs_weigh_in_on_old_wives_tale.html

Claudine Leone, Esq. (Trenton) NJAFP Government Affairs Director was quoted in an article in *NJBiz*, "Website aims to help health insurance shoppers - see who's in-network and who isn't." To see the article go to <http://www.njbiz.com/article/20141216/NJBIZ01/141219828/Website-aims-to-help-health-insurance-shoppers-see-who-s-in-network-and-who-isn-t>

Audits and Investigations of Medicaid Managed Care Companies

Susan B. Orr, Esq.

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

THE MISSION of the New Jersey Medicaid Fraud Control Unit (MFCU) is to protect Medicaid beneficiaries and the Medicaid program from fraud, waste and abuse. Specifically, the MFCU has the authority to investigate and prosecute fraudulent activities by healthcare providers against the Medicaid program.

However, you probably already know this.

What you may not know is that any time a managed care organization (MCO) such as Horizon NJ Health enters into an agreement with the State to have their network providers deliver services to Medicaid beneficiaries, the MCO must inform the MFCU of any provider audit or investigation the MCO plans to undertake.

Prior to the MCO conducting an audit or investigation of a provider, the MCO must give notice to the Medicaid Fraud Division (MFD). Notice must contain the following information: the name and address of the group or individual provider, tax ID number, NPI number, the names of individual providers (if in a group), the provider's earnings, a description of the allegations including CPT codes and whether or not modifiers were involved. The MCO may only proceed with its investigation or audit if the MFD has no objections. However, depending upon the allegations, the MFD may request a joint investigation.

The allegations must be of suspected fraud, waste or abuse. Be alert that the MCO is not just investigating providers where there appears to be blatant fraud activity, but they also investigate providers whose billing patterns may be slightly different than their peers. For example, they will look at:

- The number of the detailed or comprehensive visits billed
- The number of E&M visits also containing a 25-modifier indicating that a separately identifiable E&M service was performed on the day of a procedure
- The number of tests performed to determine if they are reasonable and necessary
- Billing services provided by ancillary providers "incident to"

New Jersey law limits recoupment of an overpayment by an MCO to claims paid no later than 18 months from the date of payment. However, any time there is suspected fraud by a healthcare provider where there is a pattern of inappropriate billing, the time frame and Medicare and Medicaid claims can be extended up to ten years. Therefore, any audit or investigation will most certainly include claims paid longer than 18 months from the date of the audit/investigation.

In the event the MCO discovers an overpayment as a result of its

audit/investigation, notice is sent to the MFD detailing the amount to be recovered, the method of repayment and any corrective action plan by the provider. Notice must be provided regardless of the amount recovered.

Any time an audit/investigation results in an overpayment, it is highly recommended that a settlement agreement with the MCO be entered into to prevent the MCO from taking further action against the provider related to the audit. Such release should be as broad as possible to prevent any further investigation and should encompass specific past and future time frames. Unfortunately, any settlement agreement with the MCO will not apply to the MFD who still could conduct its own investigation.

If not currently in place, it is highly recommended that a medical group develop a working compliance plan. A compliance plan that simply sits on the shelf is of no value, rather it needs to serve as a reference with guidelines as to how to ensure compliance with all applicable federal and state statutes, as well as third party payer guidelines. A compliance plan is not only required as a condition of enrollment in the Medicare program, but will help to mitigate any overpayment determination.

Any questions about this article or how to develop a compliance plan, please contact Susan B. Orr, Esq. at Rhoads & Sinon, LLP, 610-423-4200 or sorr@rhoads-sinon.com. ▲



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Crafting Your Message *continued*

and pay attention to what isn't being said.

BE AWARE OF BODY LANGUAGE: How we hold ourselves in the course of a conversation can communicate volumes without a word even being spoken. Be aware of the other person's non-verbal cues as well. Face-to-face you can read the person's expression or posture; over the phone you can detect tone and cadence. Don't ignore these important cues to what is really being said.

GET RID OF UM'S AND AH'S: Tune into your own speech and keep track of how often you use these unnecessary conversation fillers. They detract from your message.

LEARN HOW TO TELL A STORY: Know why you have to tell this story; come up with the ending first before you figure out the middle, endings are hard; put your story on paper, in your head it will never get told.

As we start to spread the message that *Health is Primary*, perfecting our communication skills to spread that message effectively is going to be important. The best way to practice communication skills is to communicate. Let us know what you think about the campaign or why it is important to the story of primary care. We will publish your thoughts in "Letters to the Editor" (with your permission, of course). Send me an email to editor@njafp.org.

Happy Reading,



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

References

1. Schilling, D. Ten steps to effective listening. <http://www.forbes.com>
2. Pinola, M. Top 10 ways to improve your communication skills. <http://lifehacker.com>
3. Pixar. 22 Rules to phenomenal storytelling. <http://www.slideshare.net>

FORGING AHEAD *continued from page 7*

- Claudine Leone who leads our Governmental Advocacy and Public Relations efforts,
- Bob Meinzer and Jack Douglass who add an external face to our CME/CPD activity,
- 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. 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 2015. ▲



CME Quiz Answers:

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



The graphic features the NJAFP logo (New Jersey Academy of Family Physicians) and the text "SCIENTIFIC ASSEMBLY" in large blue letters. A golden scroll in the foreground reads "Save the Date June 12-14". The background shows the Caesars Atlantic City building with the word "CAESARS" in large yellow letters and "ATLANTIC CITY 2015" in large blue letters at the bottom.

The Year in Review

Claudine M. Leone, Esq.

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

FOR THIS GOVERNMENT AFFAIRS VIEW, I have compiled a hot-topic list of articles that have previously appeared (and have been updated) in NJAFP communications, whether in the e-newsletter, *Perspectives* or on the website.

Prescription Drug Monitoring Program Update— Physicians are registered and using it

Approximately 20,000 New Jersey physicians and 5,000 other licensed healthcare practitioners this year gained direct access to the New Jersey Prescription Monitoring Program (NJMPMP), a significant milestone in the fight against the deadly epidemic of opiate abuse.

As of today, 85% of New Jersey's physicians – or 25,501 of the State's eligible physicians – are able to access the NJMPMP. This represents a 467% increase since December 2013, when approximately 4,500 physicians had NJMPMP access.

Additionally, 56% of all healthcare practitioners in New Jersey – or 35,500 of the state's eligible prescribers and pharmacists of all kinds – have direct access to the prescription-tracking database. This represents a 256% increase since December 2013, when 9,965 healthcare practitioners had access to the NJMPMP.

You no longer have to worry about registering for the PMP. The State will be automatically registering you upon renewal of your CDS registration. This decision eliminated the burdensome registration process of the program that was preventing physicians from registering.

Also in 2014, the Division of Consumer Affairs expanded the NJMPMP to include direct data-sharing with the PMPs maintained by Connecticut and Delaware, and began efforts to build a similar data-sharing partnership with New York State. During the first five months of the partnerships with these two states, the interstate hub has enabled 11,904 prescriber data requests between New Jersey and Delaware, and 10,408 prescriber data requests between New Jersey and Connecticut.

Legislation is pending that would mandate "use" of the PMP when writing CDS prescriptions to patients. This would be for the initial CDS prescription and quarterly thereafter if there is long term use. NJAFP is actively opposing the mandate. Whether a mandated check of the PMP will become law ultimately falls in the hands of Governor Christie when the bill is approved by the Legislature.

End-of-Life Care CME must be completed before April 30, 2015 for license renewal

The New Jersey Board of Medical Examiners requires 100 continuing medical education credits, of which at least 40 of such credits shall be in Category I. Commencing with this biennial

renewal period which started on July 1, 2013, two of the 40 credits in Category I courses shall, pursuant to P.L. 2011, c. 145 (C.45:9-7.7), be in programs or topics related to end-of-life care. The Board did not direct the content, but only is requiring that the program be related to end-of-life care. It is completely possible that many of you have already complied with this requirement with Category I CME taken over the last license renewal period.

We anticipate that NJAFP will have CME on this topic for the next 2015-2017 license renewal period.

While it isn't likely for family medicine: if a licensee believes that this mandate has little applicability to his/her practice area, waivers or extensions can be requested. The licensee, within 60 days of the expiration of the biennial renewal period, (i.e., by April 30, 2015) needs to send to the Board office, by certified mail, return receipt requested, or other proof of delivery, a letter explaining why such waiver/exemption is applicable. If granted, the extension or waiver is effective for the biennial licensure period in which the extension and/or waiver is granted. If the reason(s) which necessitated the extension and/or waiver continues into the next biennial period, the licensee shall apply to the Board for the renewal of such extension and/or waiver for the new biennial period.

Student Athlete Physicals and Cardiac Screening Module — Still not available

I know we have said this before... The State is supposedly really in the final stages of completing the Student Athlete Cardiac Screening Module that is now required to be completed by physicians and other providers performing and signing off on student athlete physicals. They fully expect the module to be available for the 2015-2016 academic year.

This law came about after the Legislature was challenged to respond to the sudden cardiac deaths of student athletes in New Jersey. Dr. Steven Rice, a pediatrician with Jersey Shore Medical Center, took control of this issue and chaired the Task Force in charge with implementation. Dr. Jeffrey Rosenberg, NJAFP member and family physician with The Summit Medical Group, was actively involved in the task force to ensure that this requirement was implemented in a way that did not overburden family physicians. Many of you are anxiously awaiting this module and NJAFP is fielding many calls and emails on this topic. First and foremost, please be advised that the NJ Department of Education and individual school districts are well aware that this module has yet to



be finalized and not yet available to physicians. School districts will not require the “box” attesting that you completed the module to be checked until it is made available and you have the opportunity to complete it. Once it is made available, we anticipate that there will be a grace period to comply. The module itself is not a “CME requirement.” The module will need to be completed only once to allow providers to sign off on student athlete physical forms. We will advise you as soon as it is made available and a link to the module will be posted to the NJAFP website.

A Resource for Family Physicians: Discussing Breast Density

In 2014, New Jersey joined 14 other states in passage and implementation of a law requiring radiologists to raise the issue of breast density in their patients’ reports. All women who have mammograms will get a follow-up letter telling them they may have dense breasts and to raise the topic with their doctors.

In order to provide clear direction regarding a radiologist or ordering physician’s obligation to inform patients about their breast composition, the Advisory Counsel of the New Jersey Section of Obstetricians and Gynecologists (NJ-ACOG) has developed a toolkit to assist in the management of patients and dense breasts.

NJ-ACOG has made this toolkit available to family physicians in New Jersey in the hope that the guide will assist you as you talk

with your patients about breast density and other risk factors for breast cancer. Please feel free to copy and distribute the FAQ sheets and Breast Density brochures to your patients. The toolkit “Discussing Breast Density” can be accessed at <https://www.acog.org/~media/Sections/NJ/DiscussingBreastDensity.pdf>

Physicians can now prescribe naloxone to patients and/or their families

Under NJ Law (P.L. 2013, c. 46, known as the Overdose Prevention Act), physicians can prescribe naloxone to anyone in a position to assist others during an overdose (e.g., bystanders) - this is called third party prescribing, as the drug is not necessarily intended to be used for the person receiving the prescription. There is immunity from liability for physicians in the law and the BME relaxed prescribing rule: there is no need for an examination before or follow-up after the issuance of the naloxone prescription.

The physician or pharmacy dispensing an opioid antidote to a patient shall ensure the person receiving the prescription receives “patient overdose information.” This information shall include, but is not limited to (1) opioid overdose prevention and recognition, (2) how to perform rescue breathing and resuscitation; (3) opioid antidote dosage and administration; (4) the importance of calling 911 for assistance with an opioid overdose; and (5) care for an overdose victim after administration of the opioid antidote. ▲

NJAFP speaking for you in 2014

Liz Thomas

Liz Thomas is President of Thomas/Boyd Communications, a public relations firm located in Moorestown, NJ.

- **April 17, 2014** – NJ101.5 - Sal Bernardo, MD (Freehold), NJAFP Board Chair, was interviewed by 101.5 about the new strain of influenza B. <http://nj1015.com/new-flu-shows-up-in-nj-audio/>
- **April 28, 2014** – *NJSpotlight.com* – Ray Saputelli, MBA, CAE (Trenton), spoke to *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/>
- **June 26, 2014** – *Hunterdon County Democrat* – 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
- **July 9, 2014** – *NJBiz.com* and *NewsIndiaTimes.com* – Krishna Bhaskarabhatla, MD (Paterson), was featured on *NJBiz.com* and *NewsIndiaTimes.com* as being named President of the Board of Directors of NJAFP.

http://www.njbiz.com/article/20140709/NJBIZ01/140709796/Krishna-Bhaskarabhatla?utm_source=Listrak&utm_medium=Email&utm_term=http%3a%2f%2fwww.njbiz.com%2farticle%2f20140709%2fNJBIZ01%2f140709796%2fKrishna-Bhaskarabhatla&utm_campaign=Health+Care+Weekly%3a+Private+exchanges+gaining+popularity+in+health+plan+world

<http://newsindiatimes.com/bhaskarabhatlaelected-president-of-physicians-academy/>

- **July 22, 2014** – *NJSpotlight.com* – Claudine Leone, Esq. (Trenton), Government Affairs Director, spoke to *NJSpotlight* regarding awareness of naloxone. <http://www.njspotlight.com/stories/14/07/21/survivors-of-overdose-victims-call-on-doctors-to-prescribe-opioid-antidote/>

- **August 4, 2014** – *The Star-Ledger* – Robert Gorman, MD (Verona) NJAFP President-Elect, was interviewed 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*.

- **August 8, 2014** – *The Star-Ledger* - Donna Marie Kaminski, DO (Somerset), was featured in *The Star-Ledger* as recipient of the 2014 New Jersey Family Medicine Resident of the Year. http://www.nj.com/essex/index.ssf/2014/08/cedar_grove_medical_resident_honored.html

- **September 18, 2014** – *Inside Jersey Magazine* - Robert Gorman, MD (Verona), was interviewed about the Affordable Care Act and its impact on physician practices and patients. http://www.nj.com/inside-jersey/index.ssf/2014/09/the_affordable_care_act_turns_1_how_njs_medical_landscape_is_changing.html

- **November 24, 2014** - NJ Advance Media for *NJ.com* – Krishna Bhaskarabhatla, MD (Paterson), was interviewed about whether or not temperature swings can really make you sick.

http://www.nj.com/healthfit/index.ssf/2014/11/can_temperature_swings_make_you_sick_docs_weigh_in_on_old_wives_tale.html

- **December 16, 2014** – *NJBiz* – Claudine Leone, Esq. (Trenton), provided a statement on *PlanCompass.com*, a recently-launched website with the goal of helping health insurance shoppers see who is in-network and who isn't.

<http://www.njbiz.com/article/20141216/NJBIZ01/141219828/Website-aims-to-help-health-insurance-shoppers-see-who-s-in-network-and-who-isn-t>

Avoiding the Rabbit Hole, or How to Not Get Lost in Your EHR

Jessica Runyon

Jessica Runyon is a project facilitator for the New Jersey Academy of Family Physicians.

WE HAVE ALL HEARD by now that the electronic health record (EHR) system by Texas Health Resources

(THR) was not at fault when Texas Health Presbyterian Hospital in Dallas sent Thomas Eric Duncan home after he admitted to visiting Liberia, complained of symptoms that could be caused by the Ebola virus, and admitted to having been in contact with infected individuals. Mr. Duncan died from the virus ten days after his first visit to the Dallas emergency department.

After the hospital initially issued a statement saying that “a flaw in the interaction between the physician and nursing portion of the EHR caused the patient’s travel history to not appear in the physician’s standard workflow,” THR issued a correction two days later stating that the EHR was not to blame, but hasn’t elaborated any further.

Despite the lack of EHR culpability in this unfortunate situation, the controversy reopens a necessary dialogue about the importance of setting up an EHR system carefully, and the necessity of regular reviews and maintenance. This turn of events highlights a very important piece of the documentation process – and one that NJAFP stresses to the practices that we work with: the need to establish, in advance, a set of standard operating procedures (SOPs) for EHR documentation that are easily accessible as a resource for all staff, and are included in all EHR-related training.

NJAFP stresses that the bottom line is, team members should document patient information in the same location within the EHR, ensuring that all care team members know exactly where to find the information needed, thus avoiding the necessity to search multiple areas and decreasing the likelihood of missing important information.

EHR systems can provide significant flexibility for a practice, and while this allows practices to model these systems according to their needs, it also creates a conundrum – sometimes, too many options can lead to chaos. An example can be made with immunization documentation: a patient’s immunization history can be documented in a health maintenance tab, an immunization log, in a patient’s history or in a doctor’s or nurse’s notes. If the practice, as a whole, doesn’t have a uniform plan in place for the one place staff should be documenting this information, then the team members who may need to review or retrieve this information, or those responsible for generating reports from the EHR system, may not be querying the right location - or even worse, the location of documentation may not be retrievable at all. NJAFP Project Facilitator Tara Perrone, MHA, states that “Often-times, practices document in locations of

author¹ said, “People are mostly working to meet the federal requirements and not paying as much attention to the patient safety issues.” In a related article, Singh and colleagues recognize that “EHR-related errors are complex, and the roots of these errors are often multifaceted. Risks for EHR-related errors and breakdowns may be related to features of the technology itself, user behaviors, and organizational influences on how the EHR is routinely used, maintained, and monitored.”²

In response to these concerns, Singh and colleagues have developed The Safety Assurance Factors for EHR Resilience (SAFER) Guides, which are “designed to help health-care organizations conduct self-assessments to optimize the safety and safe use of ... EHRs”³ in a variety of areas. The Guides include a checklist of “recommended practices,” downloadable reference materials, practice worksheets, assessment resources

“Oftentimes, practices document in locations of the system that are not part of a ‘structured data field’ and the data cannot be extracted at all.”

the system that are not part of a ‘structured data field’ and the data cannot be extracted at all.” So unfortunately, even with the best of intentions and resources, it is possible to set up a personalized and working EHR structure, and not notice the potential for loopholes and cracks.

Hardeep Singh, a researcher at the Michael E. DeBakey VA Medical Center’s Center for Innovations in Quality, Effectiveness and Safety, and recent EHR study co-

and follow-up tools. According to the website, the “SAFER Guides are designed in part to help deal with safety concerns created by the continuously changing landscape that healthcare organizations face.” The site states that, while following their guidelines does not guarantee legal compliance, performing periodic self-assessments using their Guides can be useful in identifying those areas where changes need to be made for the safe use of EHRs. The site encourages

that “EHR safety and effectiveness can be improved by establishing proper configuration procedures, policies, and practices.”

One of the areas covered by the SAFER Guides is Clinician Communication.⁴ The Guide stresses the importance of this communication and the possible ramifications of a communication breakdown. Tying this back into the recent controversy in Texas, SAFER notes that “Several attributes of EHR-based communication can result in a disconnect between the sender and the receiver of clinical information...” The Clinician Communication Guide stresses the importance of establishing SOPs, and following protocols, but also allows for an evolving system. Ideally, with the right collaboration, SAFER states that using their Guides “should lead to a consensus about the organization’s future path to optimize EHR-related safety and quality: setting priorities among the recommended practices not yet addressed, ensuring a plan is in place to maintain recommended practices already in place, dedicating the required resources to make necessary improvements, and working together to mitigate the highest priority communication-related safety risks introduced by the EHR.”

When working with practices and clients, NJAFP has always strongly recommended the development and adoption of guidelines and SOPs to ensure regular monitoring of EHR documentation by care team members. This monitoring should be performed monthly, quarterly, annually or at some other regularly-defined interval by one assigned individual in the practice. That individual should then be held accountable for ensuring the monitoring is completed and the results are reported back to leadership and to each individual using the EHR system.

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NJAFP Celebrates Five Years of Providing Successful Practice Transformation and PCMH Consultation Services

September 29, 2014 – Since 2009, the New Jersey Academy of Family Physicians (NJAFP) has worked with physicians, practice teams, hospitals/health systems, federally qualified and community health centers, residency programs, health plans, and key healthcare stakeholders for practice transformation services and patient-centered medical home (PCMH) recognition. The Academy has assisted more than 1,500 physicians in approximately 1,000 practices across the country, including clients in New Jersey, Florida, Georgia, Pennsylvania, and Texas.

Highlights of NJAFP’s services include:

- Assistance with practice change efforts and guidance in efficient office operations
- Hands-on education for National Committee for Quality Assurance (NCQA) PCMH recognition
- Leadership training and gap analysis
- Training to boost practice teams’ communications and understanding of patient-centered concepts
- Quality improvement program development to enhance operations, quality, and satisfaction
- Creation of office operations manuals, processes, and protocols
- Assisting Accountable Care Organizations (ACOs) meet operational and cost-savings goals
- Assessment and selection of technology systems

NJAFP’s multi-disciplinary team works with our clients to provide valuable, personalized, and innovative services. Our team has more than 75 years of combined experience working with physician practices, hospitals, FQHCs, and other healthcare providers and stakeholders. Our diverse skill set also includes information technology, data mining, identification and implementation of shared decision tools, population health management, organizing and conducting patient and family advisory councils, and staff training. Our team members’ accomplishments include:

- Serving on the NCQA PCMH Certified Content Expert Panel Advisory Board
- PCMH Content Expert Certification from NCQA
- Serving as Learning Faculty for the Centers for Medicare & Medicaid Services’ Comprehensive Primary Care Initiative
- Development and implementation of first large-scale health plan PCMH project in New Jersey
- Selection as grant receipt to implement innovative quality improvement and continuing medical education programs to increase immunization rates and enhance chronic pain management care
- Serving as speakers at national, regional, and local meetings

NJAFP has the proven experience, knowledge, and multi-disciplinary team ready to provide clients with individualized services to meet practice needs, budgets, and time frames.

For more information about NJAFP’s consulting services and experience in practice transformation, PCMH and other services, please contact Cari Miller, MSM, PCMH CCE, Director Program Operations, via phone (609-394-1711) or email (cari@njafp.org).

Health is Primary

Family Medicine for America's Health

At the 2014 AAFP Assembly in Washington, DC eight leading physician groups launched the *Health is Primary* campaign to demonstrate the value of primary care in delivering on the Triple Aim of better health, better care and lower costs. The campaign will use national advertising, workplace programs and stakeholder outreach to raise awareness of the role of primary care in the healthcare system. The groups will also drive a five-year strategic initiative to transform family medicine to meet the changing needs of the healthcare system.

Health is Primary is a three-year communications campaign to advocate for the values of family medicine, demonstrate the benefits of primary care, and engage patients in our healthcare system. The aim of the campaign is to build a primary care system that reflects the values of family medicine, puts patients at the center of their care, and improves the health of all Americans.

Family Medicine for America's Health, the organization behind *Health is Primary*, is a new collaboration between the nation's eight leading family medicine organizations to drive continued improvement of the US healthcare system and demonstrate the value of true primary care. Family Medicine for America's Health represents:

- American Academy of Family Physicians
- American Academy of Family Physicians Foundation
- American Board of Family Medicine
- American College of Osteopathic Family Physicians
- Association of Departments of Family Medicine
- Association of Family Medicine Residency Directors
- North American Primary Care Research Group
- Society of Teachers of Family Medicine

Family Medicine for America's Health is focused on transforming perceptions and behavior around health and health care and fostering awareness and action to support the essential role of primary care. At the same time, they want to transform the specialty of family medicine to ensure that it can meet the nation's healthcare needs and ultimately, improve the health of every American. Specifically, this means:

- Furthering the evolution of the patient-centered medical home;
- Advancing the use of technology;
- Ensuring a strong primary care workforce; and,
- Shifting to comprehensive primary care payment.

The *Health is Primary* campaign will educate and activate patients to increase collaboration between physicians and patients, providing them with actionable information about how to improve their health through exercise, nutrition, prevention, and chronic disease management. The Campaign will be running quarterly mini-campaigns about a range of health issues throughout the course of the campaign. The goal is to arm patients with information that will help them understand what primary care is and how to get the most from their medical home.

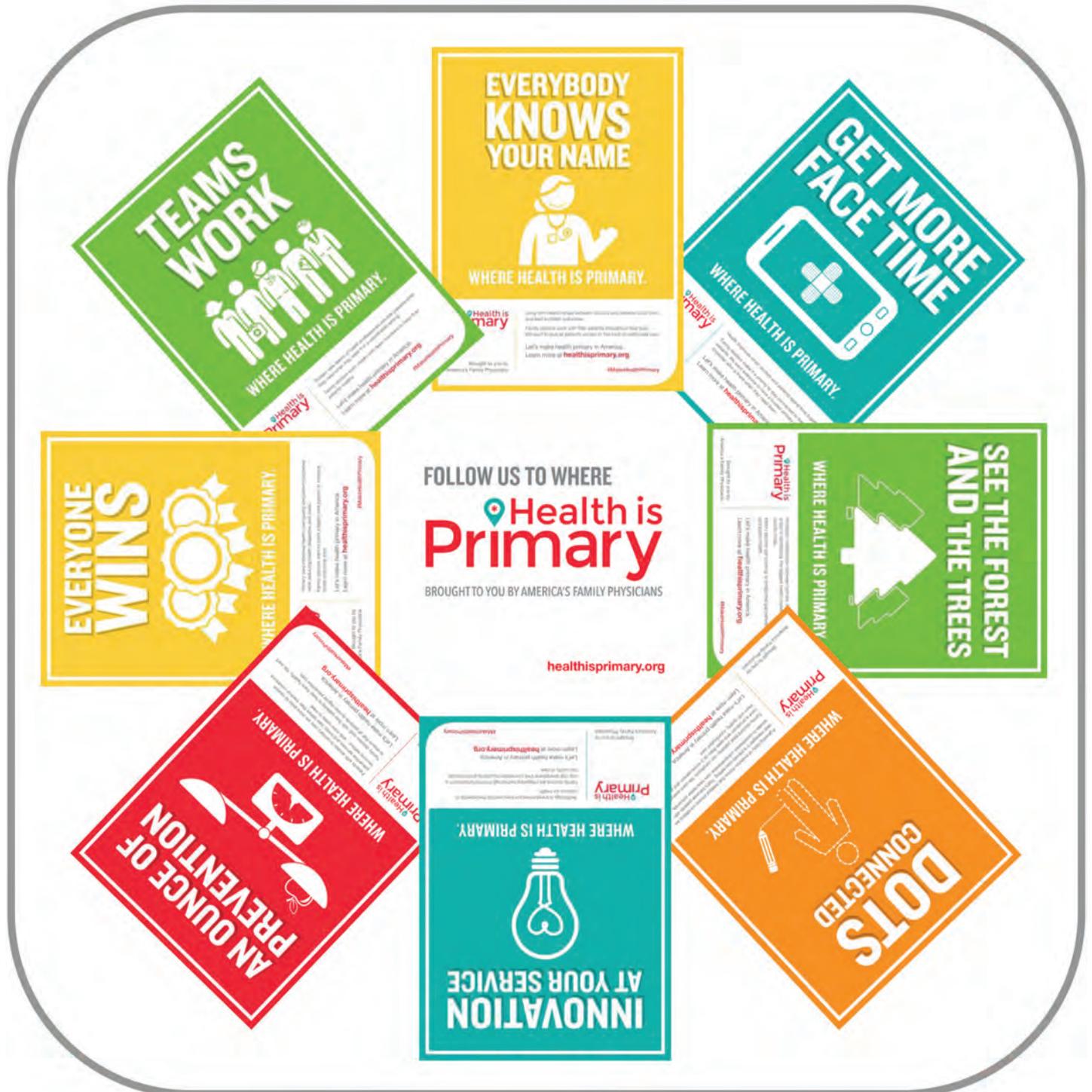
The Campaign will travel around the country to showcase examples of how true primary care works. The goal is to use these stops to bring together local stakeholders—patients, employers, and policymakers—to look at community-level interventions that are working to enhance and expand primary care and improve health. There are many places where health is primary in America. The Campaign wants to learn from them and bring them to scale. The tour will kick off early in 2015. *Health is Primary* will also be focused on technology and advancing the use of apps and other tools to improve patient/physician communication. ▲

Stay tuned for how NJAFP will be joining the Health is Primary campaign. Details coming early in 2015.



Look for these ads to follow the **Health is Primary** campaign.

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"We are responsible for the world in which we find ourselves, if only because we are the only sentient force which can change it."

– James Baldwin, American novelist, essayist, playwright, poet, and social critic

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

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.



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