Robert Gorman, MD installed as NJAFP President

HIGHLIGHTS FROM THE 2015 SCIENTIFIC ASSEMBLY

CME Inside:
• Treatment of OSA
• Augmentative and Alternative Forms of Communication
• Children’s Executive Function Skills
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How many times have you heard someone say “it’s no big deal, I just have a bit of the flu.” People tend to brush off this illness like it was just a bad cold. But, as I am sure you well know, when the flu hits, there is no mistaking its impact.

During the 2014-2015 flu season, older people were hit the hardest with the H3N2 flu viruses. Among people 65 and older, the flu-associated hospitalization rate was the highest ever recorded since the CDC began tracking that data in 2005. Nearly 60% of flu-associated hospitalizations were among people 65 years and older, with the second-highest hospitalization rate occurring among children 0-4 years.1

When the circulating influenza viruses are closely related to the virus strains in the influenza vaccine, the effectiveness of the vaccine ranges from 50 to 60% for the overall population.2 However the 2014-2015 vaccine was only 23% effective as there was a mismatch in the strain of the A(H3N2) subtype that was included in the vaccine, thereby rendering the vaccine less effective.3

The World Health Organization (WHO) issued their recommendations for the northern hemisphere vaccine for the 2015-2016 flu season this past February.4 The information used to make the recommendations for the vaccine included surveillance data from the Global Influenza Surveillance...
I am greatly honored to be standing before you as your incoming President. Those of you who know me well know that I did not always aspire to become President of the NJAFP. As a matter of fact, when I was a resident I made a pact with my fellow residents, Drs. Joe Schauer and Tom McCarrick. We decided we were going to just focus on practicing good Family Medicine and leave the leadership duties to Uncle Ed Schauer.

Dr. Ed Schauer was a role model. He set the bar high and the responsibility to serve and give back to the medical community was expected. Joe certainly broke our pact a number of years ago, serving as NJAFP President during 1994-1995, but I needed a little encouragement to run for the board.

It was during my year as Secretary that I could see the inner workings of the Academy and the value that we bring to the family doctors and citizens of New Jersey. I was tasked to work on helping to solve some of the hassle factors that plague us and I visited Trenton with our Government Affairs Director, Claudine Leone, Esq., to testify on the Academy’s behalf. It was then that I was convinced that there was much to be done and it was my turn to do it.

Advocacy for our members continues to be a major role for those of us in leadership positions. Many of us complain about the increasing headaches we face today, but I am convinced that without our efforts in Trenton and Washington, the landscape would be much different and not for the better. I have enjoyed working with Claudine and our Government Affairs committee, and as your President I will continue to take a central role in these challenges.

Education for our members is another important role for the Academy and this has payoffs for us in two ways. We clearly benefit from the type of talent and knowledge that we bring together every year for our Scientific Assembly. We catch up in areas where medicine has moved forward scientifically, such as disease treatments and prevention, but we also share our knowledge about how the practice of medicine has changed and how we need to adapt to those changes. We study newer trends of care delivery such as Direct Primary Care (DPC). We look at Chronic Care Management (CCM) to see what aspects are necessary to implement into our practices and how to be reimbursed for our efforts.

The other way in which education helps the Academy is the non-dues revenue stream that it creates for us, adding solvency to our infrastructure. I recently worked with our Deputy EVP, Theresa Barrett, and a team to develop CME activities about advances in diabetes management. These endeavors help us to balance our budget and we look forward to expanding our reach to provide CME for primary care physicians who are not part of the AAFP system.

NJAFP is moving forward with our application to become recognized by the Accreditation Council for Continuing Medical Education (ACME) as a provider of CME. When we receive this additional accreditation, the market for the CME we produce will expand, touching more physicians and patients, and contributing to the financial health of our Academy.

I would like to continue the efforts of my predecessors to advocate for the smaller practices in our state. And the net exporting of our New Jersey trained residents and students have to stay on our radar or the future of healthcare delivery to our patients will be severely compromised.

Much has been written about physician burnout in recent years and surveys published this year have Family Medicine physicians listed as the specialty with the 3rd highest rate, only behind Critical Care Medicine and Emergency Medicine. As many as 50% of family physicians under the age of 35 have reported some period of burnout. We continue to work year after year trying to address and reduce hassle factors and reimbursement undervaluation which are contributors to burnout. I would also like to add some focus on identifying burnout among us and providing resources to help us deal better with it.

Thomas Bodenheimer from California has discussed expanding on “The Triple Aim,” which is focused on enhancing patient experience, improving population health, and reducing costs. Burnout is associated with lower patient satisfaction, reduced health outcomes, and it may increase costs. So burnout imperils the Triple Aim. Bodenheimer recommends that the Triple Aim be expanded to a “Quadruple Aim,” adding the goal of improving the work life of healthcare providers, including clinicians and staff.

I have discussed this with Dr. Chantal Brazeau, the interim Chair of the Department of Family Medicine at Rutgers-New Jersey Medical School. She is our in-state resource on this subject and is excited to collaborate with me in this endeavor. We will coordinate our efforts with Cliff Knight, who is Vice President for Education at the AAFP.

We are blessed and privileged to do the work we do, but we all know it is hard work in today’s environment. We all manage our stress a bit differently. When things are at crisis level in my office, we bring our colleague, Tom McCarrick, into the discussion. He will try to calm us down with the comment, “Look, no one was diagnosed with pancreatic cancer today.” Rich Carello likes to say, “It’s inside work and there is no heavy lifting. It could be worse.” I was honored when I heard him reassuring one of our young doctors by quoting me saying, “When you start feeling sorry for yourself just look at any day’s schedule, see the problems your patients have and realize how lucky you are.”

There is no one else in the State of New Jersey to advocate for you and to try to help you with the practice of medicine more than the NJAFP. As your new President, I pledge to you that I will do my best to continue these efforts in the coming year. These challenges always seem to be difficult, but it is clear to me that we will accomplish more for our patients, the citizens of New Jersey, and for our own health and wellbeing if we work together to overcome them.

Robert Gorman, MD is President of the New Jersey Academy of Family Physicians and a practicing family physician in Verona, NJ.
Welcome to Another Edition of “Oh my, what am I going to write about this quarter” Article. As many of you 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. Sometimes, as in this case, I’m lucky enough to have events guide me.

Recently, I spoke with members of the NJAFP delegation to the AAFP Congress of Delegates as they prepared to represent their colleague family physicians in Denver. By the time you read this, that meeting will have already concluded. In fact, I’m currently writing from somewhere over Cedar Rapids en route to the “Mile High City.” In any event, as the delegation and I have discussed the resolutions that they will debate, many of which will form the policies of the AAFP in the coming years, and the candidates for the various leadership positions whom they will elect, it was impossible to mistake the level of seriousness with which your representatives took their responsibilities. Their dedication to New Jersey family physicians and the patients you serve could only be described as passion; and while I’ve been doing this job long enough to know that time and competing commitments make taking a leadership role in organizations like the NJAFP a difficult choice for some, I also know that passion runs deep in the hearts of most family physicians and guides many of them to “get involved.”

I can almost hear the response from many of you. It’s no secret that many family physicians face overwhelming challenges every day. From ICD-10 to the myriad of payer and governmental requirements that demand your attention, not to mention an increasingly more complex patient population -- most family physicians I know are stretched to the limit. Nowhere is this more the case than here in New Jersey. Even as our work to assist family physicians in getting “off the hamster wheel” of practice in a volume-based system, and advocating for a more cost-effective, and efficient value-based system begins to gain traction, I am certain that many of you must wonder how I can write an article about getting involved in the work the NJAFP is doing while the practice environment is still so difficult for so many. Perhaps some of you consider my equating involvement in these efforts with “passion,” to be just a bit haughty. While I understand, I could not disagree more... passionately.

The NJAFP depends on the passion of members like you to make a difference, but contrary to what many assume, that dependence is not always about attending meetings or serving on committees. People who know me have often heard me say, “Our staff can do many things in the service of our members, but we all forgot to go to medical school.” I’ve been blessed to get to know family physicians well over the past 16 years. In that time, I’ve come to often know how you think, and what is important to you, but I simply don’t have the perspective of a person whose primary responsibility every day is to care for patients who have entrusted me with their health and comfort. As a result, it is critical that I, along with the entire NJAFP team who work on your behalf every day, have the benefit of your input and perspective. Every day there is an opportunity to serve, whether it is answering a survey, participating in a focus group, sharing a thought by email, becoming active in social media, talking to students and residents, writing an article for this publication, testifying on an issue before the legislature, or perhaps deciding to serve at a deeper level in leadership. Each one of these examples and so many that I don’t have the space to mention, are meaningful contributions that make a real difference. Sometimes that is difficult to recognize in the short term as change is often a slow and deliberate process.

Sometimes, however, the value of the work is instantly recognizable. In either case, those who get involved with NJAFP will all acknowledge that it matters, and if you doubt that the opportunity to do work that you are passionate about ask yourself if you are still passionate about being a family doctor. I know that despite the challenges, the vast majority of you would answer “yes.” The work we do is designed to advance what is now being called the quadruple aim, adding higher physician satisfaction to Dr. Don Berwick’s triple aim of lower cost, higher quality, and better health. There is no better way for a family physician in New Jersey who is passionate about their work and their patients to ensure that what they are passionate about is protected -- than to get involved in the only organization whose sole mission is the advancement of the practice of family medicine in New Jersey.

All of that is a long way of saying that the NJAFP needs you. We are at a critical time in health care in our country, and especially here in New Jersey. There is more to do than the small group of dedicated staff and physician leadership can do on their own. I know your time is precious and I am aware that there are many competing requests for the time you are willing to give. I want to offer you the opportunity to put your time in where it matters. Let me know what you are passionate about, where you believe that you can make a difference, and I will find a place for you to put that passion to work in a meaningful way while still respecting the time you are willing to give.

If you are interested in sharing your passion for family medicine; if you are willing to give some time to help us achieve the goals of the quadruple aim, please contact me in the NJAFP office at (609) 394-1711 or by email: ray@njafp.org. Thank you for allowing me the opportunity to ask you to give.

Ray Saputelli, MBA, CAE is the Executive Vice President for the New Jersey Academy of Family Physicians and Executive Director of the New Jersey Academy of Family Physicians Foundation.
ANY PHYSICIAN who successfully completes the examination in 2011 or thereafter will enter the continuous MC-FP process, which requires each physician to successfully complete MC-FP requirements in order to maintain certification. Diplomates certifying in 2011 and beyond will all have a 10-year examination requirement, a simplified financial plan, and flexibility with the module requirements. MC-FP rules now require participation thresholds to be met in 3-year stages. The printed certificate provided to physicians will not have an end date; however, MC-FP requirements must be maintained in order for certification to continue. Certification status will be contingent upon meeting these MC-FP requirements within the 3-year stage deadline.

Each 3-year stage will have the same requirements:

- Minimum of 1 Self-Assessment Module (Part II) (most worth 15 points)
- Minimum of 1 PPM or approved alternative module (Part IV) (most worth 20 points)
- One (1) additional module of your choice (Part II or Part IV)
- At least 50 MC-FP points (acquired by completion of modules) per 3-year stage

In addition, each Diplomate must complete 150 CME credits within each 3-year stage, continuously maintain a currently valid, full, unrestricted license to practice medicine in the United States or Canada, and be in continuous compliance with the ABFM Guidelines for Professionalism, Licensure, and Personal Conduct.

As long as a Diplomate continues to meet these requirements in each 3-year stage, the Diplomate will be listed as board-certified on the ABFM website. If a Diplomate fails to meet these requirements for any 3-year stage, the Diplomate will be listed as “not certified” on the ABFM website. A Diplomate has three years (after becoming “not certified”) to regain certification status by completing the required MC-FP activities. Once the delinquent modules are completed, the Diplomate will again be listed as board-certified, but the break in certification history will be listed permanently on the ABFM website.

If a Diplomate does not meet the current 3-year stage requirements, and does not complete all previously delinquent modules in the next 3-year stage, the Diplomate will be required to complete the MC-FP Re-Entry Process which will include successfully completing the MC-FP Examination.

For more specific information regarding ABFM Diplomate MC-FP requirements, please login to your Physician Portfolio on the ABFM website – www.theabfm.org.

AT A GLANCE
Requirements for Diplomates Certified/Recertified - 2011 and Beyond

FIRST 3-YEAR STAGE* •
- At least 1 Part II module (SAM)
- At least 1 Part IV module (PPM or approved alternative)
- Compliance with ABFM Guidelines for Professionalism, Licensure, and Personal Conduct
  - Includes holding currently valid, full & unrestricted license to practice medicine in US or Canada
- Complete 150 required CME credits

SECOND 3-YEAR STAGE* •
- At least 1 Part II module (SAM)
- At least 1 Part IV module (PPM or approved alternative)
- Compliance with ABFM Guidelines for Professionalism, Licensure, and Personal Conduct
  - Includes holding currently valid, full & unrestricted license to practice medicine in US or Canada
- Complete 150 required CME credits

THIRD 3-YEAR STAGE* •
- At least 1 Part II module (SAM)
- At least 1 Part IV module (PPM or approved alternative)
- Compliance with ABFM Guidelines for Professionalism, Licensure, and Personal Conduct
  - Includes holding currently valid, full & unrestricted license to practice medicine in US or Canada
- Complete 150 required CME credits

If successfully completed stage requirements: Certification/Recertification Examination

If not successfully completed and does not catch up with 3 years: Must re-enter MC-FP Re-entry requirements: 50 MC-FP points (including at least one Part II and one Part IV activity), 150 CME credits, and successful completion of the MC-FP examination.

* If requirements are not met candidate no longer listed as board-certified until requirements are met
+ Refer to ABFM website for certification points
New Guidelines for Adult Pneumococcal Immunization

IN AN EFFORT to lessen the confusion among healthcare providers regarding immunizing adults 65 and older with the pneumococcal vaccine, the CDC’s Advisory Committee on Immunization Practices (ACIP) has proposed new guidelines.1 ACIP is recommending that the two indicated vaccines – 13-valent pneumococcal conjugate vaccine (PCV13 or Prevnar-13) and a 23-valent polysaccharide vaccine (PPSV23 or Pneumovax) – be given at least one year apart, regardless of their order. The full recommendation can be read in the *Mortality and Morbidity Weekly Report* published on September 4, 2015: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6434a4.htm

Reference

More ICD-10 News

The Center for Medicare and Medicaid Services has agreed to make four changes to ease the transition to IDC-10 according to web magazine MD.1 CMS has agreed to not deny improperly coded claims for the first year, as long as the code is from the appropriate IDC-10 code family. In addition, CMS will not penalize physicians for any errors made while trying to meet the various quality standards while treating patients as part of “quality care.” Regarding reimbursement, CMS has agreed to not hold up payment if there is a claims-processing problem with IDC-10. Finally, CMS will create an office of the ICD-10 ombudsman to handle physician problems related to the new codes. Read the full story at the link below.

Reference

AAFP Resources to Prepare for ICD-10

THE INTERNATIONAL CLASSIFICATION OF DISEASES, 10th revision, Clinical Modification (ICD-10-CM) went into effect on October 1, 2015. The AAFP has created tools, which include a cost calculator, timeline, and other educational materials, to assist practices with the preparation and change to this new system. Information can be found on the AAFP website at: http://www.aafp.org/practice-management/payment/coding.html

New Information on ICD-10

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

CMS Contact information: https://www.cms.gov/Medicare/Coding/ICD10/ICD-10-Provider-Contact-Table.pdf
Every day we are finding new provisions of the Patient Protection and Accountable Care Act ("ACA") that impact physicians and other healthcare providers. Section 1557 of the ACA entitled “Nondiscrimination” has recently gained quite a bit of attention in light of some recent court cases. Section 1557 simply states:

"An individual shall not, on the ground prohibited under title VI of the Civil Rights Act of 1964, title IX of the Education Amendments of 1972, the Age Discrimination Act of 1975, or section 504 of the Rehabilitation Act of 1973, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency or any entity established under this Title (or amendments). The enforcement mechanisms provided for and available under such title VI, title IX, section 504, or such Age Discrimination Act shall apply for purposes of violations of this subsection."

Now in layman’s terms, what does this provision really say? Section 1557 encompasses the current federal civil rights and disability laws designed to prevent discrimination on the basis of race, color, national origin, age and disability. However, because Section 1557 encompasses Title IX, it prohibits discrimination in health care on the basis of sex. It also broadens the federal anti-discrimination laws to include the full range of healthcare entities that receive federal financial assistance. That is, any individual or entity receiving payments under Medicare Part A or Part B, including but not limited to physicians and other healthcare practitioners, physician offices, clinics, hospitals and specialty treatment centers among others.

Section 1557 has also been interpreted to provide a private right of action for “disparate impact claims.” Disparate impact claims focus on policies that appear to be facially neutral but the result of those policies is that they disproportionately affect minorities and other protected classes of people. For example, when the University of Pittsburgh Medical Center decided to close one of its hospitals – the Office of Civil Rights brought a claim against the Medical Center, stating that closing the hospital in question would have had a disparate impact on the poorer African Americans living in that area. What this tells us is that policies and procedures maintained by providers may negatively impact certain segments of the population, although they appear facially neutral. In the past, discrimination on the basis of sex included such issues as the failure of a health benefit plan to cover contraception products for women, but yet cover the cost of sildenafil (Viagra) and discrimination claims based on pregnancy. However, given media’s coverage of issues affecting the gay and lesbian community and media’s coverage surrounding Bruce Jenner’s transformation to Caitlin, be prepared to see an increase in discrimination claims by members of thegay, lesbian and transgender communities. A recent landmark case has set the stage for claims under Section 1557 when a Minnesota judge specifically held that a transgender man had stated a claim for healthcare discrimination on the basis of gender identity under Section 1557. The facts of this case involve a transgender man who presented to a hospital emergency room with a fever and genital pain. His claim alleges that he was misgendered, neglected, and subject to an assaultive physical exam by the physicians when he presented to the emergency room. Although both physicians and the hospital named in the suit moved to dismiss the case for failure to state a claim upon which relief could be granted, the judge did not agree and has allowed the case to move forward through the court system. The judge in reaching her decision, relied upon an opinion letter from the Director of Health and Human Services’ Office of Civil Rights, Leon Rodriguez, who stated that Section 1557 “extends to claims of discrimination based on gender identity or failure to conform to the stereotypical notions of masculinity and femininity.”

What this tells us is that policies and procedures maintained by providers may negatively impact certain segments of the population, although they appear facially neutral.

Susan B. Orr, Esq. is a health law attorney in the law firm of Rhoads & Sinon LLC located in Exton and Harrisburg, PA, and a frequent presenter at the NJAFP Scientific Assembly.

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In the Fall 2014 edition of Keystone Physician, we discussed a 49-year-old-man with GERD, depression, hypertension, and obesity who complained of snoring and excessive daytime sleepiness. Suspicions for obstructive sleep apnea (OSA) was high, and the authors reviewed indicators of and screening for the disorder. This article discusses OSA treatment options.

Case: The patient undergoes a home sleep study which shows an apnea-hypopnea index (AHI) of 26 respiratory events per hour. Before revisiting his sleep specialist, he discusses treatment options with his family physician.

An AHI of 26 events/hr indicates moderate OSA. The decision to treat his sleep disorder depends on many factors, including OSA severity, medical comorbidities, and associated symptoms (e.g. daytime sleepiness). Treatment of severe OSA, with or without symptoms, has been associated with cardiovascular event reduction. Anyone with OSA and daytime sleepiness (OSA syndrome) should be offered treatment. Our patient’s history of depression and hypertension are also indications for definitive treatment, regardless of OSA severity. Weight loss counseling is an essential first step; weight management decreases OSA severity and associated symptoms.

Positive airway pressure (PAP) is first-line therapy for all patients with moderate to severe OSA, those with mild OSA syndrome, and any patients with significant comorbidities (e.g. depression, diabetes, hypertension). PAP works as a pneumatic splint, relieving upper airway obstruction during sleep. A small, quiet device sends pressurized room air through flexible tubing into a facial interface. Available interfaces include “pillows” providing air intranasally, and rarer “oral masks” delivering air only through the mouth.

Mandibular advancement devices (MADs) offer another effective treatment option for patients with mild to moderate OSA who decline or are intolerant to PAP. Generally supplied by dentists, these oral appliances increase upper airway caliber by bringing forward the jaw, tongue, and other soft tissues. While viable treatment alternatives, MADs are not as effective as PAP in normalizing AHI and are not indicated for severe OSA. Dental and medical insurance infrequently cover them.

Various surgical options are available, including uvulopalatopharyngoplasty (UPPP) and maxillomandibular advancement (MMA). These procedures can reduce the AHI, but less effectively than PAP. They carry significant risk of side effects and are reserved for patients intolerant to PAP or MADs, and those with significant craniofacial abnormalities (e.g. mandibular hypoplasia). Tracheostomy remains a viable option for PAP-intolerant patients with severe OSA; the procedure is nearly 100% effective in eliminating obstructive apneic events, but associated social stigma and lifestyle modifications limit patient acceptance.

Obstructive sleep apnea is considered first-line therapy for pediatric OSA but is less effective in adults.

An array of other OSA treatments have emerged. Positional therapy, accomplished by having tennis balls inside the back of a night shirt, sleeping laterally against a full body pillow, or wearing an anti-snoring belt, is available for supine-predominant OSA. It can be effective, but not to the extent of PAP. Patients with mild to moderate OSA can also trial nasal inspiratory positive airway pressure (EPAP) generated by a one-way valve adhered to the base of the nostrils. Although early data shows modest benefit, direct comparisons to PAP in treatment-naïve patients are lacking. Emerging methods of hypoglossal nerve stimulation may also improve airway patency through genioglossus muscle contraction.

Case conclusion: The patient and his physician agree that he should begin PAP therapy. His sleep specialist prescribes autotitrating PAP (APAP) at a range of 5-20 cm H2O. Over the next several months his excessive daytime sleepiness improves, he no longer snores, and he has more energy to use his fitness center.

Although specially-trained primary care clinicians can manage uncomplicated OSA successfully, sleep specialist consultation is typically advised. That specialist’s decision to start APAP versus fixed-setting, continuous PAP (CPAP) is increasingly common. APAP units adjust PAP based on airflow limitation, apneas, and snoring. They are as effective as CPAP and, given reduced need for in-laboratory CPAP titration, can lead to significant cost savings. APAP- or CPAP-intolerant patients and individuals requiring more advanced nocturnal ventilation may use bi-level PAP (BPAP).

Whichever PAP mode is utilized – APAP, BPAP, or CPAP – adherence is essential. A dose-response relationship exists between increasing PAP use and improved sleepiness, blood pressure, and quality of life. Although the Centers for Medicare and Medicaid Services (CMS) and many private insurers require ≥4 hours of use on ≥70% of nights to document adherence, PAP use should be encouraged with all sleep. Family physicians can dovetail their efforts with those of sleep specialists to improve PAP adherence by promoting positive initial experiences with PAP, providing anticipatory support for future troubleshooting, and involving bed partners and other family members in OSA treatment.

References
For children with severe expressive communication disorders, augmentative and alternative communication (AAC) can improve their ability to interact with others in everyday settings. AAC promotes wider social interaction by offering different functions from supporting existing speech to providing an alternate for verbal communication. Individuals with autism, cerebral palsy, genetic syndromes, cognitive impairments, hearing impairments, and head injuries use AAC to enhance their communication abilities.1

Depending on a child’s needs, AAC can be applied through the means of unaided and aided forms of communication. Unaided forms of ACC require children to use their bodies to communicate and include sign language, gestures and facial expressions.2 Aided forms of ACC involve the use of equipment/devices to communicate and are categorized by low tech and high tech options.2 AAC was originally the last type of intervention recommended for children with communication disorders.4 Older devices were limited in function because they exclusively helped children with their expressive communication to better convey their wants and needs. Today, there is an increased recognition that AAC devices can also be used to improve children’s receptive communication abilities by helping them receive and understand messages from others.

Examples of AAC features:
- Speech output using text displays that allow two people to exchange information
- Picture board touch screens that use images and symbols
- Spelling and word detection
- Internet to access information
- Multimedia components for videos and photos
- Texting and cell phone features
- Social media to connect with others5

Mobile technology has made AAC more accessible to families with phones and tablets, because these devices are light and portable, less costly and are widely used in society. Although these technologies are easily accessible, it is important for children to receive a referral and formal evaluation for AAC software and devices. A speech and language pathologist will choose a program that uses the best language concepts, organization and layout, selection of target concepts and support for a child’s needs.

Obtaining a referral and arranging funding and training for an aided AAC device can be complicated for any family. Primary care providers can facilitate this process by:
- Identifying communication issues early and making timely referrals – pediatric clinics often offer free developmental screenings6
- Coordinating the AAC assessment with other therapeutic services the child is currently receiving
- Supporting funding of AAC devices and services by providing “medical necessity” letters to funding sources7
- Working with a team of educational and therapy professionals to monitor the effectiveness of the chosen AAC device
- Assisting parents in conversations with school staff and child care staff to ensure that AAC devices are being used effectively in both school and home settings

Children with suspected communication issues should always be referred for an additional evaluation. Early detection and treatment can help children reach their fullest potential.

Children’s Executive Function Skills

BOBBIE VERGO, OTD, OTR/L AND EMMY LUSTIG, BA

The authors have no financial conflicts relevant to this article.

EXECUTIVE FUNCTION is a mental process that allows us to understand our past experiences with present action. As you know, the brain uses this skill to guide behavior toward accomplishing a goal, prioritizing tasks, controlling impulses and focusing our attention.1 Doctors can explain to parents that children are born with the potential to gain these abilities through their experiences with caregivers, family members, teachers and other influential persons impacting their development.

Executive functions are evaluated in children based on their behavior in non-routine situations that require them to use their own degree of judgment.2 Children may show differences in working memory, emotional control, and the ability to think flexibly and engage in self-monitoring.3

If a child has difficulty with executive functions he/she might:

- Be disorganized. For example, may forget to hand in school assignments or prioritize tasks with calendars.3
- Struggle with time management.3
- Have difficulty with open-ended tasks, including assignments with little direction, or cannot switch from the planning phase of a project to its implementation.4
- Have difficulty starting tasks independently. For example, may not know the length of an appropriate break before beginning homework after school.
- Be unable to complete tasks efficiently.3
- Struggle reviewing over school work without direction or guidance.4
- Have rigid routines and dislike change.4
- Become easily frustrated or intolerant of criticism.3
- Forget rules easily. Display difficulty memorizing or retrieving items from memory.3
- Appear impulsive, have uncontrolled impulses, or an inability to manage emotions.4
- When children do not demonstrate appropriate executive function skills, they may show signs of learning differences that require further evaluation. There are many reasons children display discrepancies in executive function abilities. Difficulty with executive functions could be a sign of Autism, OCD, traumatic brain injury, ADHD, or other illness/conditions.
- Doctors can discuss strategies with parents to help children with executive function difficulties stay on task such as:
  - Checklists. This provides kids with manageable steps to complete tasks. Parents can create a list of things that must be completed before the child leaves the house in the morning or a list of steps that are related to completing an assignment in school. Checklists can guide children to independence gradually.5
  - Set time limits. It may be helpful to assign certain tasks time limits to help children understand how long each task should take.
  - Explain the importance of a new process or technique. Children should understand why checklists and guidelines are important and related to their successful changes in behavior. They will feel more committed to meeting expectations.3
  - Stick to Routines. A child should know what is expected of them when they return home from school, such as their break time before beginning homework and eating dinner.3
  - Help children build social connections with adults. Children need a reliable presence that they can trust and healthy relationships with adults will keep them engaged in creative play, and guide them toward gaining better executive function skills.5

Doctors can inquire about children’s executive function abilities during their yearly check-up. Because a child’s difficulty with executive functions may be an indication of other learning differences, it is important for doctors to refer the child for an evaluation as soon as possible. ▲

References

About Pathways.org
Founded in 1985, Pathways.org is a 501(c)(3) organization that empowers parents and health professionals with free tools and resources on children’s motor, sensory, and communication development. For more information about issues related to childhood development, please visit www.pathways.org or email friends@pathways.org.
Instructions: Read the articles designated with the CME icon and answer each of the quiz questions. Mail or fax this form within one year from date of issue to: NJAFP CME Quiz, 224 West State Street, Trenton, NJ 08608 • Fax: 609/394-7712

This medical journal activity, Perspectives: A View of Family Medicine in New Jersey, has been reviewed and is acceptable for up to 8 Prescribed credits by the American Academy of Family Physicians. AAFP certification begins January 1, 2015. 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 Category 1 Credit™, 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

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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.

NAME: _____________________________________________ AAFP MEMBERSHIP NUMBER: ______________________

STREET ADDRESS: ___________________________________________________________________________________________

CITY/STATE/ZIP: _____________________________________________________________________________________________

EMAIL ADDRESS: _____________________________________________________________________________________________

PHONE: _______________ FAX: _______________

1. True or False: An apnea-hypopnea index (AHI) of 26 events/hour indicates moderate OSA.

2. True or False: Treating severe OSA, with or without symptoms, has not been shown to reduce cardiovascular events.

3. True or False: First-line therapy for all patients with moderate to severe OSA is positive airway pressure (PAP)

4. True or False: Mandibular advancement devices (MADs) are not effective treatment options patients with mild to moderate OSA who PAP intolerant.

5. True or False: Uvulopalatopharyngoplasty (UPPP) and maxillomandibular advancement (MMA) can reduce the AHI, but as they carry a significant risk of side effects they are reserved for patients intolerant to PAP or MADs.

6. True or False: There is a dose-response relationship between increasing PAP use and improved sleepiness, blood pressure, and quality of life.

7. True or False: Augmentative and alternative communication (AAC) can be used to improve children’s receptive communication abilities by helping them receive and understand messages from others.

8. True or False: Executive functions are evaluated in children based on their behavior in routine situations.

9. True or False: Checklists and time limits are strategies to help children with executive function difficulties.

10. True or False: Difficulty with executive function is not an indication of other learning disabilities.

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.
A Couple of New Laws in New Jersey to be Aware of…

CLAUDINE M. LEONE, ESQ.

This summer Governor Christie signed into law legislation that will impact your practices and your patients:

APN – Certifying Cause of Death

New Jersey now gives advanced practice nurses the authority to complete death certificates in the same manner as physicians under certain circumstances.

Previously, advanced practice nurses were able to pronounce death and provide the medical information required for the death certificate. However, a physician’s signature certifying the cause of death was still required to execute the death certificate.

The new law gives advanced practice nurses the authority to determine and certify cause of death and sign a patient's death certificate ONLY when (1) the collaborating physician is not available AND (2) the advanced practice nurse is the patient’s primary care provider.

Full authority to determine and certify cause of death was not granted to the advanced practice nurses under this law. NJAFP and other medical professional societies vigorously opposed this legislation without the limitations ultimately approved. The State was specifically responding to reported delays in the execution of death certificates, particularly where the patient died in hospice or at the patient’s home and the collaborating physician was not immediately available.

Nothing in this new law alters NJSA 26:6A-4, which only authorizes licensed physicians to make a declaration of death based upon neurological criteria.

New Jersey Prescription Monitoring Program (PMP)

Changes have been recently made to the existing PMP. The New Jersey Prescription Monitoring Program is an electronic system operated by the State to monitor controlled dangerous substances dispensed in outpatient settings. It is available to all licensed healthcare practitioners authorized by the State to prescribe or dispense controlled dangerous substances (CDS) medications. The relevant changes:

- You no longer have to proactively register for the PMP. Although we had great success in New Jersey with 85% of physicians already registered with the PMP, the new law will automatically register physicians upon renewal of their CDS Registration.
- Another significant hassle with the PMP that impacted workflow was the inability for a physician to delegate checking the PMP. The original law only authorized the registered physician, APN or PA to log in to the PMP directly. The new law now allows medical assistants working in the practice to access the PMP on behalf of the physician, APN or physician assistant.

The State, however, did not just want healthcare professionals simply registered with the PMP, but rather incorporating the PMP into their daily practice.

- The new law now requires physicians, APNs, and PAs to consult the PMP the first time they prescribe a Scheduled II CDS to a patient for acute and chronic pain, and at least quarterly for patients that continue to receive prescriptions under a treatment plan for pain. This requirement to check the PMP at initial prescription does not apply to Schedule II CDS not prescribed for...
pain, including medications for ADHD. (NJAFP and the medical community successfully fought the
original draft of this proposal, which would have
required physicians to check the PMP at every pre-
scription for all CDS Schedules regardless of its pur-
pose every time).

• Pharmacists also now have to check the data-
base before dispensing a Schedule II CDS if
there is a reasonable belief the patient may be
seeking the prescription for any reason other
than the treatment of a medical condition. The
law also requires pharmacy permit holders to
submit prescription information to the division
every seven days, rather than the current re-
requirement of every 30 days - making the PMP
more current.

There are also continued efforts by the State to
access CME for improving access to PMP data across state lines. New
Jersey’s PMP currently shares its PMP data with
29 other states through PMP Interconnect. How-
ever, our neighbors, New York and Pennsylvania,
still remain offline with data sharing with other
states. See map. ▲

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

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 through-
out 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

It’s just the flu... continued

and Response System (GISRS) network, which in-
cludes National Influenza Centers (NICs), WHO
Collaborating Centres (CCs) WHO Essential
Regulatory Laboratories (ERLs) and WHO H5
Reference Laboratories, genetic characterization
of viruses, antigenic characterization of viruses,
antiviral resistance, vaccine effectiveness and avail-
ability of potential vaccine candidates.4 The rec-
ommendation for the 2015-2016 vaccine is for the
vaccine to contain an A/California/7/2009 (H1N1)
pdm09-like virus; an A/Switzerland/9715293/2013
(H3N2)-like virus; and a B/Phuket/3073/2013-like
virus. It is further recommended that the quadri-
valent vaccines containing two influenza B virus-
es contain the above three viruses and a B/Bris-
tane/60/2008-like virus.4

Because there is no way of knowing who will get
the flu and who will not, the CDC recommends “everyone six months of age and older should get a
flu vaccine every season.”3 This recommenda-
tion has been in place since February 24, 2010
when the CDC’s Advisory Committee on Immuni-
zation Practices (ACIP) voted for “universal” flu
vaccination in the United States to expand protec-
tion against the flu to more people.1

When making treatment decisions for patients
with flu, the CDC recommends the use of clinical
determination based on time since symptom onset,
underlying conditions, and disease severity.3 An-
tiviral treatment with a neuraminidase inhibitor is
recommended for all patients with confirmed or
suspected influenza who are at a higher risk for
complications from influenza due to age or under-
lying conditions.4

While no one is certain what the 2015-2016 flu
season holds for you or your patients, the CDC
advises you and your staff to get a flu shot and
recommend that your patients do the same.5-7 Re-
sources for you and your patients regarding the flu
can be found on the CDC website at http://www.
cdc.gov/flu/index.htm.

Happy Reading. ▲

References
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nation/Virus.htm.)
4. Recommended composition of influenza virus vaccines for use
in the 2015-2016 northern hemisphere influenza season. 2015.
www.cdc.gov/flu/protect/keyfacts.htm.)
6. Use of Antivirals: Background and Guidance on the Use of Influ-
flu/professionals/antivirals/antiviral-use-influenza.html/#Box.)
7. Influenza Vaccination Information for Health Care Workers. 2015.
NJAFP on Capitol Hill

This past May, several members of the NJAFP represented the Academy on Capitol Hill at the Family Medicine Congressional Conference. Sponsored by AAFP and the Council of Academic Family Medicine (CAFM), the Family Medicine Congressional Conference educates participants on family medicine’s legislative priority issues, trains attendees on how to lobby on Capitol Hill, and allows participants to put these skills to use with federal legislators and their staff. Advocacy is a high priority of AAFP and the CAFM organizations; every family physician and educator can learn how to be effective in Washington and at home.

Are You Looking For A Family Physician?
Check Out the NJAFP Job Board at:
http://www.njafp.org/practice-opportunities/positions-available

Do you have a position available in your practice? The NJAFP Practice Opportunities page is the ideal place to post ads for positions available in your office and… it’s also a great way to let your colleagues know if you are looking for a job!

Members of NJAFP can post their own ads by simply logging in to www.njafp.org and following the path to “Post a New Position” – under the “Practice Opportunities” tab. There is an easy to use template with no size restrictions on content - so you can be as descriptive as you need to be in order to find the perfect family physician for your open position.

Ads run for 30 days and the site will send you a reminder notice for renewal (if needed) 5 days prior to the end date. You may renew your own ad or just send us an email to office@njafp.org and we will renew the ad for you for an additional 30 days.

Non-members and job placement agencies may have their ads posted for a just $100 a month!* We offer free renewal to the advertisers if their ad lacks sufficient response to fill the position to their satisfaction. To post ads as an agency or non-member - send the content of your ad in the body of an email to office@njafp.org. We will post the ad for you and send you a link for approval.

Check out the NJAFP job site and perhaps we can post an ad for you today. Visit www.njafp.org/practice-opportunities/positions-available and see if we can help you find the perfect job right here in New Jersey.

*Upon request, NJAFP will also provide our posting service to members at no additional cost.

In the News

Joe Schauer, MD (Farmingdale) has joined Osler Health IPA, a physician owned and physician managed IPA, as President and Chief Operating Officer.

With Sympathy

The Academy extends its deepest sympathies to Dr. Maria Ciminelli on the passing of her mother this past May, and to Dr. Robert Gorman on the passing of his mother in August.
The following Resolutions were adopted:

**NJAFP 2015 Resolution #4**

**PCMH, CPCI, and Other Bad Acronyms**
K. Saradarian, MD

**RESOLVED:** That the NJAFP ask the AAFP to help create a less burdensome Practice Transformation model which will require less redesign and documentation than the current NCQA and CPCI models. And be it further

**RESOLVED:** That the NJAFP ask the AAFP to strongly and actively advocate for their new transformation model and assist members and their practices to become involved in this prospective new model.

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**NJAFP 2015 Resolution #5**

**Release of Transitions of Care Information from Hospitals**
T. McCarrick, MD and R. Gorman, MD

**RESOLVED:** That the NJAFP be asked to investigate a method in which the rules governing the release of information from New Jersey hospitals to the primary care physician be clarified and enforced so that necessary records are made available in time for the transition of care visit with primary care providers in NJ, and therefore be it further

**RESOLVED:** That the AAFP be asked to investigate a method in which the rules governing the release of information from hospitals to the primary care physicians be clarified and enforced so that necessary records are made available in time for the transition of care visit with primary care providers throughout the country, and be it further

**RESOLVED:** That NJAFP should work with all appropriate stakeholders to ensure that the IMPACT act is implemented in NJ.

---

**The following resolution was referred to the Board of Trustees:**

**NJAFP 2015 Resolution #3**

**Universal Vaccines**
K. Saradarian, MD

**RESOLVED:** That the NJAFP Board of Trustees be tasked with advocating, promoting and requesting legislative changes required to make possible Universal Vaccinations for Children and Adult and be it further

**RESOLVED:** That the rules and regulations for vaccine storage be based on hard science not recommendations of the ideal storage solution (minimum recommendations not maximum) and documentation be easy.

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**The following Resolution was not adopted:**

**NJAFP 2015 Resolution #1**

**CMS Chronic Care Management Codes**
R. Thompson, MD

**RESOLVED:** That NJAFP go on record that the current CMS Chronic Care Management fee plan is ill conceived and due to underfunding it will not properly promote the desired goals of enhanced proactive primary care and that NJAFP advocates a review of this program and its goals as well as consideration of prospective CCM payments to primary care doctors, and be it further

**RESOLVED:** That NJAFP promote a resolution to the 2015 AAFP Congress of Delegates in Denver requesting AAFP Advocacy with CMS to review the CCM program and its goals as well as provide consideration of prospective CCM payments to primary care doctors.
New Jersey Research Poster Contest Winners Recognized

The top two research posters in the Physician category, and the top two research posters in the Resident category were recognized by EVP Ray Saputelli at this year’s President’s Gala. NJAFP congratulates the winners and thanks all those physicians and residents who participated.

This year’s winning posters were:

**Poster Category – Physician**

*Research: Internet search patterns during disease outbreaks*

Primary Author: Bennett Shenker, MD
Secondary Author: Evan Wright, DO
Additional Authors: Zeeshan Khan, MD; Robert Kruse, MD; Shumaila Alam, MD; Alexandria Reilly, MD; and Matthew McGuire, MD

This study reports on the Internet searching patterns of populations in response to outbreaks of disease. Internet search patterns after an identified outbreak may reflect the speed with which populations become aware of epidemics and pandemics. These results may suggest strategies for improving awareness during disease outbreaks.

**Clinical Inquiry: A curious case of acute headache in primary care office**

Primary Author: Palanipriya Kaylan, MD
Secondary Author: Avril Anthony-Wilson, MD

This inquiry is intended to guide the primary care physicians in prompt recognition of acute glaucoma and to facilitate immediate intervention. It should be entertained as part of the differential diagnosis when evaluating patients with headache. Visual acuity and eye exam must be part of the initial evaluation in these patients.

**Poster Category – Resident**

*Research: Family physicians contribute significantly to emergency care of Medicare patients in urban and suburban areas*

Primary Author: Gerald Banks, MD

Rural populations rely on primary care trained physicians to provide emergency services. Less is known about primary care’s contribution to emergency services in urban settings. This analysis shows that one out of five emergency Medicare claims in urban settings are generated by primary care trained physicians, demonstrating a significant contribution by primary care to the emergency workforce in the most populated areas.

*Community Project: Peer teaching sex education with at-risk adolescents: A COPC intervention at Edison Job Corps*

Primary Author: Sarah Abdelsayed, MD
Secondary Author: Rhina Acevedo, MD
Additional Authors: Betty Hammond, MD

This is a review of a community-oriented health intervention for at-risk adolescents at Edison Job Corps. The focus was health promotion by having students act as peer educators. Outcomes showed peer educators were effective at promoting increased knowledge of sexual health. This reinforces the value of empowering youth to change their communities.

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Robert Gorman installed as President of NJAFP

Robert Gorman, MD (Verona) was installed as President of the New Jersey Academy of Family Physicians at the Presidents Gala celebration in Atlantic City on June 13 at Caesars Atlantic City. The event was featured on MyCentralJersey.com (http://mycj.co/1iJmseq) and MyVeronaNJ.com (http://bit.ly/1VXIZm2).

Dr. Martha Lansing named NJAFP Family Physician of the Year

Martha Lansing, MD (Hopewell), associate professor and vice chair of family medicine and community health at Rutgers Robert Wood Johnson Medical School was named the NJAFP Family Physician of the Year for her commitment to improving the quality of life for patients and for members of the community. Read the full account at http://mycj.co/1QcMKQH.

Resident of the Year

Joan N. Medina, MD (Freehold) was the 2015 Resident of the Year for her “demonstration of the outstanding attributes of a Family Physician.” Dr. Medina is the third resident from CentraState’s residency program in the past eight years to earn this award among the 13 family medicine residency programs in the state. Read the full story at http://bit.ly/1ibh432.

President’s Award

Government Affairs Director, Claudine Leone, Esq. (Trenton) was the recipient of the 2015 NJAFP President’s Award for her outstanding service to the Academy. Read the full story at http://bit.ly/1QcMSPk

Scientific Meeting Highlights
INCE 2009, NJAFP has worked with physicians, providers, health systems, community health centers, healthcare teams, and others to develop innovative approaches to patient-centered care. To highlight practice achievements, NJAFP recognizes practices through the Patient-Centered Innovation Award program.

This unique award program is an opportunity for practice teams to showcase innovations they have designed and implemented that positively impact approaches to patient-centered care. The Patient-Centered Innovation Award (PCIA) recognizes practices and care teams, innovative programs and projects, and a commitment to excellence in patient care.

This year’s PCIA recipients were recognized at the 2015 Advanced Topics in Healthcare Symposium on June 11, 2015 at Caesars Resort Hotel in Atlantic City, NJ:

CAPE REGIONAL PHYSICIANS ASSOCIATES created a new full-time position for a Patient Care Coordinator (PCC). As a result of this new PCC’s involvement, patients in transition-of-care now receive dedicated and personalized care, including follow-up within one day of discharge, medication reconciliation and proper-use instructions. PCCs also ensure that outpatient services start as scheduled with a follow-up appointment in the patient’s medical home two weeks from discharge. These changes have led to significant improvements in hospital discharge compliance by 60%!

COLUMBUS FAMILY PHYSICIANS revamped an 8’x8’ storage room into a relaxing, soothing, and warm Care Management Room, allowing patients to open up about their conditions and engage on a deeper level with the care manager. As a result, Columbus has been able to create detailed care plans for over 85% of their high-risk patients.

DIGESTIVE HEALTHCARE CENTER has partnered with Horizon Healthcare Innovations to provide value-based colonoscopy services, which resulted in lowered costs, and increased patient care and satisfaction scores. In addition,
a national program developed after this model is being rolled out. “The Bundled Colonoscopy Program” offers cost-controlled services and enhances quality of care by introducing nationally recognized parameters by which patients can judge the completeness and accuracy of the procedure, and the technical expertise of the provider. Since the program’s launch in 2013, Horizon Healthcare Innovations has publically reported a 6% increase in screening colonoscopies within their network, and the practice’s patient satisfaction scores have increased to over 98%.

FAMILY PRACTICE OF MIDDLETOWN created a new position for a Geriatric Patient Care Coordinator, hiring a nurse already skilled in caring for the aging population. This position now provides personalized assistance to the predominantly elderly patient. This service has resulted in stronger relationships with patients and their families, which has significantly improved communication, care coordination and care transitions – as well as satisfaction levels for the patients, their families, and members of the office staff. Family Practice of Middletown has successfully increased their nursing home census by 20% and their home care census by 75% since they hired the new coordinator.

KENNEDY HEALTH ALLIANCE took on a full-scale overhaul of their patient access services center, with the goals of improving overall quality of care and decreasing unnecessary utilization of health services. As a result of earning the NCQA Level III PCMH recognition this January, their focus on patient satisfaction and access to care outside of office visits has become more significant. Through the team-based, system-wide patient access center, Kennedy patients have 24/7 access to their health information, as well as clinical advice via the patient portal. The team approach that Kennedy encourages results in around-the-clock access to healthcare needs, including the ability to schedule same-day and after-hours appointments seven days a week from 8am until 11pm. The health system also extended office hours to include nights and weekends for both routine and urgent care needs. Results of these efforts include patient satisfaction scores reaching 4.74 on a five-point scale, as well as several qualitative improvements.

MARC FEINGOLD, MD, LLC reached out to Weight Watchers in 2013 to start a weight loss program in their practice. The practice pulled all of the patients with a BMI over 30, and put out a call for interested participants. A local affiliate hospital provided additional support by offering free trial memberships to their gym for Dr. Feingold’s patients. Patients were encouraged to track their progress on their mobile devices, using the Weight Watchers app. As of this year, Weight Watchers is also providing the patients with free wrist monitors to track steps taken, and exercise and sleep patterns. The 27 patients participating have lost a total of 561.5 pounds, with many able to decrease or discontinue hypertension medications.

Congratulations to our 2015 Recipients!

Jessica “Jay” Runyon is a project facilitator for the New Jersey Academy of Family Physicians.
More Awareness & Support Needed for End-of-Life Planning

Proposed Legislation Would Increase Access, Reimbursement

STEPHEN GOLDFINE, MD

As our population ages, more people will need end-of-life services and support. However, many Americans are reluctant to plan ahead for such care, often leaving relatives to make difficult decisions during a crisis. Family physicians can help prevent suffering and stress by counseling patients and families in advance care planning, but they face a variety of obstacles -- from lack of training to inadequate reimbursement.

A number of experts nationwide have begun advocating for advance care planning, and proposed legislation promises greater access and reimbursement for end-of-life counseling and care.

In New Jersey, Samaritan Healthcare & Hospice, which provides palliative care for people with serious and/or terminal illness, recently launched a major initiative to address this critical issue. As South Jersey’s first and largest hospice, we see firsthand the physical and emotional toll on both patients and families resulting from the widespread lack of advance care planning.

Indeed, 38% of New Jersey residents surveyed last year had never discussed end-of-life wishes with their families, and 54% had no written documents for their end-of-life wishes, according to a poll by the New Jersey Health Care Quality Institute and Monmouth University Polling Institute.

This issue, of course, isn’t limited to senior citizens and their loved ones; a serious disease or injury can strike at any age. Therefore, it is extremely important for everyone to think about these matters and make their wishes known, in case they lose the ability to communicate.

Starting the Conversation

Samaritan’s highly visible “Conversations Campaign” aims to educate the public about end-of-life planning and care, and to encourage people to discuss these important matters with their loved ones. The campaign appears on billboards, online, and on local trains and station platform signage. A sample message: “Let’s talk about what no one wants to talk about… Pain. Illness. Mortality. Don’t endure it alone… Start the conversation at SamaritanNJ.org.”

At the Samaritan website (www.samaritannj.org) under the heading “Conversations” visitors will find information, documents, and online tools to help them develop their advance care wishes, discuss those wishes with their family and/or doctor, and formalize their wishes in writing.

The site poses such questions as:

– Who do you want to make healthcare decisions for you when you can’t make them?
– What kind of medical treatment do you want or not want?
– What do you want your loved ones to know?

These conversations need to take place as early as possible, when people have time to think and talk things over, not when the person is in the ICU. A visit to one’s primary care provider can serve as a good trigger for these discussions. The website lists other potential prompts, including major life events or worsening health.

As part of the communication campaign, Samaritan also offers free workshops to physicians, other healthcare providers, and community groups to educate both professionals and the general public about end-of-life issues.

Local institutions are getting involved, too. For example, two South Jersey health systems – Virtua and Lourdes – are partnering with Samaritan to provide high-quality palliative care to their patients. In addition, Rowan University School of Osteopathic Medicine collaborates with Samaritan on New Jersey’s first hospice/palliative fellowship, to help train future healthcare professionals in this important area.

The New Jersey Health Care Quality Institute, through its Mayors Wellness Campaign, is also addressing this timely topic. The Institute’s “Conversation of a Lifetime” initiative seeks to engage local communities in advance care planning. It recently launched in three pilot communities -- Gloucester Township, Princeton, and Tenafly – with a variety of events and activities.

Pending Legislation

Federal and state legislators have also begun to recognize the need for better end-of-life planning and access to palliative care. As a result, the following bills are pending (as of press time):

• The Care Planning Act of 2015 (S1549), before the U.S. Senate, would fund advance care planning discussions with doctors, nurses, and other healthcare professionals. It would also create a pilot program offering home-based support of patients with multiple and complex chronic conditions. Currently before the Senate Finance Committee, the bill is sponsored by Senators Mark Warner (D-Va.) and Johnny Isakson (R-Ga.).

• The Palliative Care and Hospice Education and Training Act (H.R. 3119), before the U.S. House of Representatives, would establish multiple supports for palliative and hospice training, including education centers, grants for
physician and nurse training, and career development incentives. Lead sponsors of the bill are Congressmen Eliot Engel (D-N.Y.) and Tom Reed (R-N.Y.). Congressman Emanuel Cleaver (D-Mo.) is an original co-sponsor.

- **NJ Legislation A3911 / S2931** would require healthcare facilities to provide information and facilitate access to palliative care services. The bill was approved 74-1 by the Assembly and is now before the Senate Health, Human Services and Senior Citizens Committee. The legislation originated in the Assembly, where it is sponsored by Assemblywoman Nancy Pinkin and others.

- **NJ Legislation S2435 / A4233** would increase access to advance care planning for Medicaid beneficiaries. The bill is now before the Senate Budget and Appropriations Committee and the Assembly Appropriations Committee. The bill originated in the Senate, where it is sponsored by Senator Richard Codey and others.

  We encourage everyone to voice their support for these bills by contacting their state and federal representatives.

### Palliative Care vs. Hospice

In many cases, family members put off decisions regarding a relative’s declining health, especially when they’re unsure what their loved one would want. Families may be in denial, lack information about available resources, or fear that acknowledging the possibility of death means they’re abandoning hope.

Yet, if a person becomes unable to communicate, relatives and medical personnel are forced to make key choices about his or her care and day-to-day life. Another unwanted consequence is that families delay seeking end-of-life services until very late in the process, often resulting in weeks or months of needless pain, anxiety, and emotional turmoil for patients and loved ones. Samaritan encounters such situations frequently.

Many people simply don’t understand what palliative and hospice care are so they are afraid to request these services at the appropriate time. Samaritan defines palliative care as providing symptom relief and physical, emotional and spiritual support, starting any time after diagnosis of a serious illness or injury. Hospice is palliative care given in the last six months of life.

Advance conversations enable families to discover these and other valuable community resources, talk about them, and incorporate them into an action plan for whenever a health crisis hits.

As many families have told us, advance care planning is the ultimate gift people can give to their loved ones. ▲

For more information, visit [www.SamaritanNJ.org](http://www.SamaritanNJ.org).

Stephen Goldfine, MD, DABFP, CAQGM, DABHPM is the chief medical officer for Samaritan Healthcare & Hospice and a renowned palliative care physician with more than 25 years of experience. He also sees patients and families at Samaritan’s medical practice, Palliative Medical Partners, and with Primary Care of Moorestown. Dr. Goldfine is certified by the American Board of Hospice and Palliative Medicine and the American Board of Family Medicine.

### References

FOR THE FIRST TIME in its 26 year history, AAFP’s Tar Wars has become an exclusively a state chapter-run program. While the AAFP will continue to provide a website of resources and best practices for successful Tar Wars presentations, the tobacco awareness program will be run by the state chapters. The change in the scope of the program was proposed by the AAFP last year when it was decided to focus more on the doctor/patient relationship to encourage greater awareness of quit lines and tobacco cessation resources. The chapters are still encouraged to deliver the Tar Wars program in local schools, but the poster contest and other related activities will be the states’ responsibility to encourage and bring to completion.

We are delighted to report that this year NJAFP had an exciting Tar Wars program, conservatively estimated at reaching over 900 students – more than two-thirds of whom reside in medically underserved communities. In large part, our success was due to our Family Medicine residency programs that went to local schools to deliver the program to fourth and fifth graders. However, we also need to thank the AAFP for providing NJAFP with a mini grant that allowed us to produce support materials and reach out in a more personal manner. The NJAFP had bi-lingual post cards printed in English and Spanish (courtesy of Trentypo, Inc.) to distribute in family health centers in urban and medically underserved areas, as well as specially developed flyers to market the program in targeted school districts.

The main focus of the program is to teach about the great possibilities we can pursue when we make healthy choices in life. This message is at the heart of the program. As you know, Tar Wars is a tobacco education program that teaches children about the harmful effects of tobacco use, manipulative marketing, and advocacy efforts. But the main focus of the program is to teach about the great possibilities we can pursue when we make healthy choices in life. This message is at the heart of the program and moving forward, is the central idea for the poster contest. In the poster contest Tar Wars students are challenged to creatively depict what they have learned from the program and share their goals for the future, focusing on achievement and good health. Not everyone fully understands this concept as it becomes challenging to step away from the “death and dying” messages so closely related to smoking. However, we do get entries from some students who are able to follow this directive in a beautiful and uplifting manner.

The 2015 NJ Tar Wars Poster Contest winners all hailed once again from school nurse, Robin Ince’s 4th grade class at Franklin Elementary School in Westfield. We are proud to announce that First Place was awarded to Lauren McDonough, Second Place to Henry Hipschman and Third Place to Abigayle Mitrow. On June 4th, another successful year for Tar Wars in New Jersey. 

CANDIDA TAYLOR
all three winners arrived with their parents at the NJ Statehouse in Trenton and were treated to a private tour of the historical building by an extremely talented tour guide. Our guide explained how an idea can become a bill that then becomes a law. He stressed how important it is for young people (such as our winners) to think about legislation that can improve the quality of life and present those ideas to legislators – or they might like to become legislators themselves one day!

Our tour ended in the Goldfinch Square of the Statehouse where the winning posters had been on display for the past week. Thank you to Senator Tom Kean from Westfield who met with us and congratulated our winners on their fine accomplishment. And thanks in part to the AAFP grant, a monetary award was provided to each winner – ($125, $75 and $50) which they happily accepted and promised not to “spend it all on one place.”

In closing we would like to thank all those individuals (family physicians, school nurses, educators and volunteers) who step out into their communities to deliver this important and valuable program. Without your commitment to this program, we would not be able to reach so many young people who are on the threshold of making choices that could have long-term effects. We want those long-term effects to include smart, healthy achievements. These young students of today will soon be writing America’s future success stories – and hopefully we can say we that served a small part in their dreams.

To learn more about Tar Wars, visit www.tarwars.org or call Candida Taylor at 609-394-1711, email: candida@njafp.org

12 Years of MedFest and still going strong!

That’s Right... this is our 12th year of MedFest, our collaborative program with Special Olympics New Jersey (SONJ) – conceived to provide pre-participation exams to people with special needs to qualify them to participate in Special Olympic sports and other activities. The primary objective of these events is to establish inclusion for athletes, not exclusion. Under the direction of our healthy athletes’ coordinator, Dr. Jeff Zlotnick (who holds a CAQ in Sports Medicine), the New Jersey MedFest program has qualified nearly 1000 students since its inception, and has served as the model program for other states that have implemented a version of MedFest for their Special Olympic state chapters.

We are happy to report that another successful MedFest program took place at Bancroft House in Haddonfield, NJ on August 26, 2015. Bancroft House is a non-profit, leading provider of programs and resources offering support to...
Bancroft's services include special education, vocational training and supported employment, structured day programs, campus and community living programs, short-term behavioral stabilization services for children, in-home and outpatient services. (Visit www.bancoft.org for more information and contacts).

For some time SONJ and NJAFP have been exploring opportunities to take the MedFest program to students' facilities rather than having schools bus their students to us. Transporting student athletes to the SONJ headquarters in Lawrenceville has frequently presented a challenge to schools financially and logistically, often resulting in last minute cancellations that couldn’t be helped. So we were eager to tour the Bancroft School when we were invited to organize a MedFest program at their facility.

Cooley Hall on the Bancroft campus proved to be a perfect location for a MedFest. Thanks to our New Jersey Family Medicine Residency programs and the volunteers from SONJ and Bancroft - a very successful event was held. With over 40 volunteers, we qualified approximately 80 adult Bancroft students to participate in Special Olympic activities. Once again, the day was filled with smiles, hugs and making new friends.

We would like to thank the following residency programs for their participation and donation of valuable professional time:

- Hackensack UMC at Mountainside
- Hunterdon
- NYMC Hoboken
- Overlook
- Rutgers RWJ at CentraState
- Rutgers RWJ New Brunswick
- Rutgers RWJ at Somerset
- St. Joseph’s
- Virtua

Thanks go to Gina Dain, ATC and Tim Lengle, ATC from the Athletic Trainers Society of New Jersey for ‘manning’ the musculo-skeletal station at MedFest.

We especially would like to thank Special Olympics New Jersey’s Andrea Picariello for her extraordinary help in coordinating the event and making sure that all the MedFest supplies, signs and details were exactly where they should be – and of course, also for providing all of our volunteers with a delicious breakfast and lunch to sustain us through the day.

Thank you to Jeanne Bozicek of Bancroft House, who coordinated with the Bancroft staff for the use of their facility and grounds. My personal thanks to the staff members who were so very accommodating and sprang into action when we had to readjust station exams, or move from one place to another to avoid sudden back-ups.

All worked together for a very successful event and it would not have been so well organized without the dedicated cooperation of so many wonderful people. Thank you to everyone! 

Ms. Taylor is the New Jersey State Tar Wars Coordinator for the NJAFP
Philanthropy
(from Greek φιλανθρωπία) etymologically means “love of humanity” in the sense of caring, nourishing, developing and enhancing “what it is to be human” on both the benefactors’ (by identifying and exercising their values in giving and volunteering) and beneficiaries’ (by benefiting) parts.

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.

YES! I would like to support the NJAFP Foundation!

☐ Enclosed is my check in support of the NJAFP Foundation for $ ____________________.

☐ Please charge my credit card to support the NJAFP Foundation for $ ____________________.

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

   Please charge my credit card $___________ per month.

☐ I would like to designate my gift for:  ☐ Resident & Student Trustee Initiative  ☐ Tar Wars in New Jersey

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Mail to NJAFP Foundation, 224 West State Street, Trenton NJ 08608 or Fax to 609-394-7712

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Let’s talk about what no one wants to talk about.


Start the conversation at SamaritanNJ.org