A VIEW OF FAMILY MEDICINE IN NEW JERSEY

Perspectives

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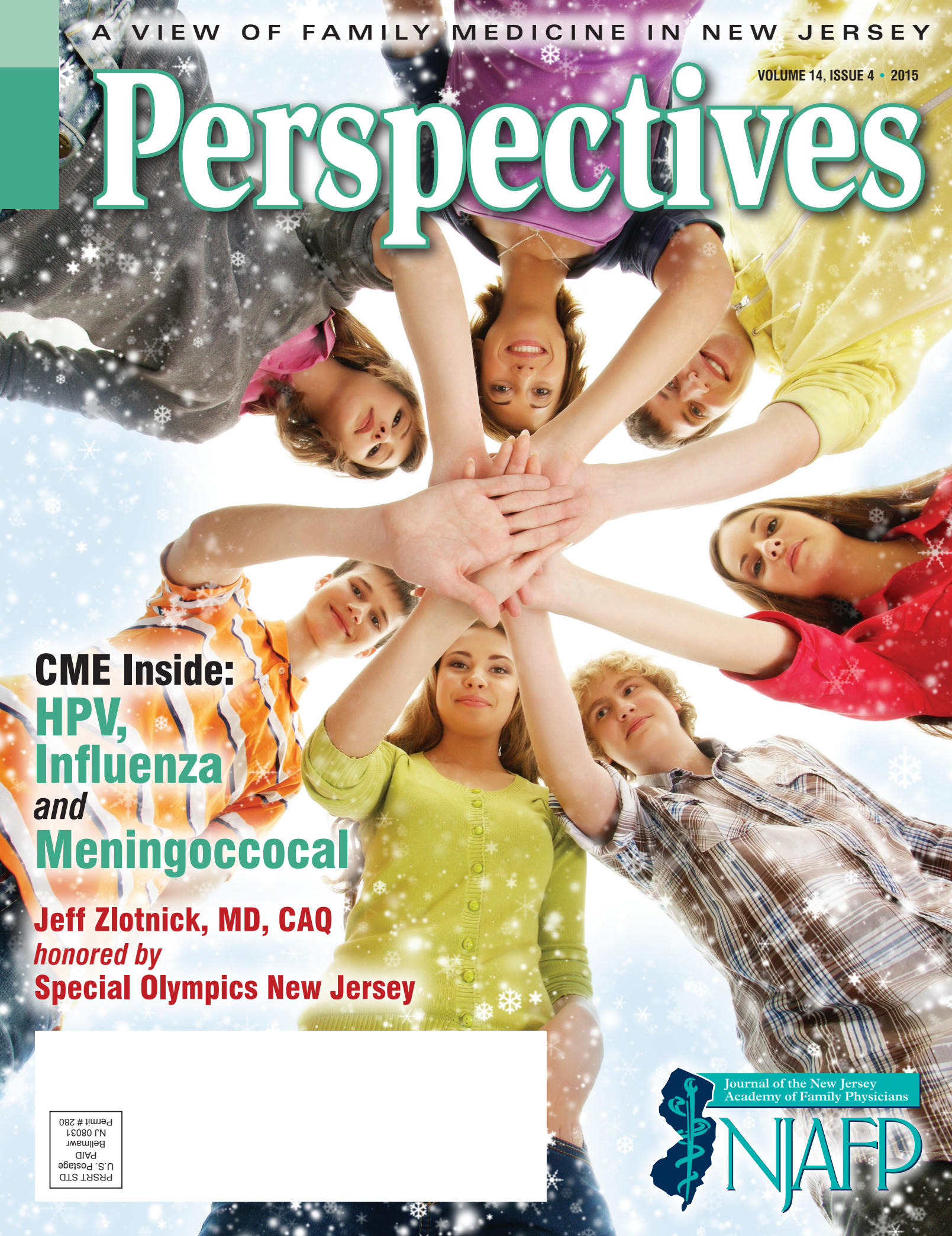

CME Inside:
HPV, Influenza *and* Meningoccocal

Jeff Zlotnick, MD, CAQ *honored by* Special Olympics New Jersey

Journal of the New Jersey Academy of Family Physicians
NJAFP

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Call for New Jersey Family Physician Of The Year

The **New Jersey Family Physician of the Year Award** embodies the principles of excellence, combined with comprehensive and compassionate care, for which family physicians are known.

Guidelines for Selection

- Provides his/her community with compassionate, comprehensive and caring medical service on a continuing basis
- Is directly and effectively involved in community affairs and activities that enhance the quality of life in his/her home area
- Provides a credible role model, emulating the family physician as a healer and human being to his her community, and as a professional in the service and art of medicine to colleagues, other health professionals, and especially to young physicians in training and to medical students.

Specific to New Jersey:

- Has been in Family Medicine in NJ for at least 10 consecutive years
- Must be Board Certified in Family Medicine
- Must be a member in good standing in his/her community

Full details on how to nominate a colleague for this award are available on the NJAFP website at **http://www.njafp.org/SCSA** . Click on the **2016 Call for Family Physician of the Year** link on the left menu bar.

The recipient of the NJAFP Family Physician of the Year Award also is presented to the AAFP for consideration for the AAFP Family Physician of the Year Award.

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Members wishing to place a candidate in nomination should submit materials to:

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224 W State St., Trenton, NJ 08608

Nominations must be received by **April 30, 2016**

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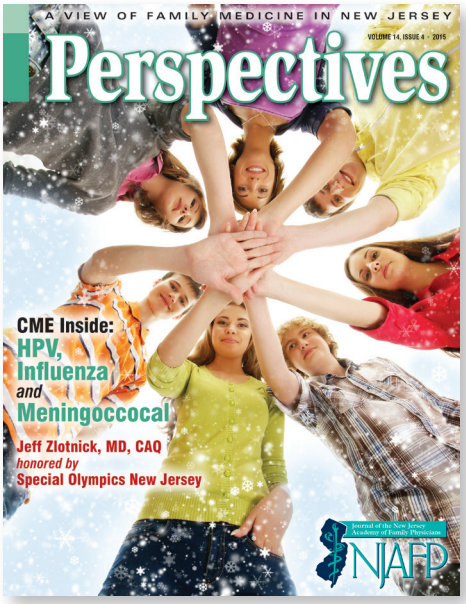
IN THIS *Issue*

Volume 14, Issues 4 • 2015



On the Cover

New Jersey ranks high among the number of younger children who are vaccinated, but could drastically improve immunizations in adolescents and older adults. Read about updates to HPV, Influenza and Meningococcal immunization schedules.

Keep *Perspectives* fresh by sending us new ideas and articles. Let us hear from you, tell us what you would like to see featured in this journal. If you are interested in becoming a contributor to *Perspectives*, a peer-reviewed CME publication, please contact the NJAFP office (609/394-1711) or email editor@njafp.org

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Five Seconds

THERESA BARRETT, PHD, CMP, CAE *Managing Editor*

I **RECENTLY ATTENDED** a conference where author and CNN analyst, Mel Robbins was the closing keynote speaker. I found Robbins' perspective on change interesting. She stated that we know we can do anything we want to do – start a business, write a book, transform a practice - and we know exactly how to do it or find out how to do it (thank you, Google). The problem comes down to having the will to make the changes necessary to accomplish it. According to Robbins, you are either going to do "it" (fill in whatever "it" means to you) or you are not.

What keeps us from making the change to tackle the "its" in our life? There is a lot of brain science out there that explains why we avoid change. Change equals danger. Our brains evolved to scan the environment and recognize any change that might pose a threat to survival…movement in the tall grass might be the wind or it might be a tiger looking for lunch. Everything we are today is built upon the need for survival. While the chance of being a tiger's lunch is relatively slim these days, our brain still scans the environment, sees any change to the status quo as a threat, and reacts accordingly – activating the fight or flight response. We are hard-wired to have a negative reaction to change, at least until we have more information.

If we want to change we need to act quickly, before our brain can talk us out of it. The brain will always act to maintain homeostasis. Robbins' solution – adopt the "5 second rule." The minute you want to change something, you have 5 seconds to act on it.[1] Take any longer than that and your brain will tell you all the reasons why it is a bad idea.

So the next time you want to change something in your life, whether finding more time to spend with family, learning a new skill, becoming a contributor to *Perspectives* (yes, shameless plea here) or getting more involved in the Academy act – immediately. Write it down, pick up a pen, or send an email. Outsmart your brain by taking an action to make your change real in the world. Once you do that, it will be much easier to change and accomplish your goal.

Happy Reading. ▲

Photo: www.melrobbins.com

Reference

1. Robbins, M. Mel Robbins: *Follow the Five-Second Rule*. Success, 2012.

Working to Improve Family Medicine

ROBERT T. GORMAN, MD

I JUST CONCLUDED a visit with a longtime patient during which I was regaled with stories about grandchildren; given a homemade apple pie, and a great big hug. Reluctantly, I then turned back to my computer to translate the 8 medical problems we addressed from ICD-9 into ICD-10 codes. This exemplifies the sharp contrast of the things we love about being family doctors, and the ever increasing list of things we need to get through to complete our daily work.

At the end of October, I had the pleasure of attending the Tennessee Academy of Family Physicians annual meeting. I represented New Jersey at their meeting, and I presented a CME talk on SGL2 inhibitors in the treatment of diabetes, which was developed by the NJAFP. The day I presented, the conference attendees were asked to wear a Halloween costume depicting one of their heroes. I dressed as Marcus Welby, MD from Santa Monica, California. Dr. Welby was a big hit. My television hero was part of a two doctor group that practiced the full scope of Family Medicine across the entire lifespan, and in every healthcare setting imaginable. He was faithfully assisted by only one support staff, Consuelo. The good doctor was never challenged or harried by such things as meaningful use, EHR, MACRA, APMs, MIPS, or narrow networks, and Consuelo was blissfully ignorant of pre-certs. It was a pleasant time warp trip back to simpler days, but as I look at the security fob on my desk, which I will now need to e-prescribe scheduled medications, I am rudely jolted back to 2015, mindful of all that we must deal with in present day.

While I was in Denver for the COD and the FMX meetings, I had the opportunity to participate in an "Ideas Summit on Delivery System Reform and Alternative Payment Models." This was attended by leaders from a number of state chapters, insurance company executives and key representatives from the AAFP. HHS and CMS are looking to the AAFP for input on how to make MACRA work in a way to sustain a healthy primary care base, which our country so desperately needs.

In early November, AAFP board chair, Dr. Robert Wergen summarized a number of our concerns in a letter to Andy Slavitt, Acting Administrator of CMS. Some of the points that were made include:

Measure Harmonization to streamline, harmonize, and reduce the complexity of quality reporting in the MIPS and APM programs.

Define PCMH according to the "Joint Principles of the Patient-Centered Medical Home" as they were defined in 2007, and not to require a physician to pay a third party to secure recognition to participate in a Medicare program.

Comprehensive Primary Care Payment Reform to move away from fee for service and toward quality over volume. There should also be a combination of a global payment for direct patient care services and a global care management fee.

Virtual Groups should be used as a means of allowing solo and small practices to aggregate patient populations, align resources, and form a structure to help them to improve their performance while maintaining their independence.

Patient Attribution tools have been used in the CPCI program which has been piloted here in NJ and recommendations on improving accuracy and fairness are included.

Meaningful Use has become a huge obstacle that most of us have been unable to overcome, and it needs to be improved if it is to be used as a MIPs performance tool.

Clinical Practice Improvement Activities should be offered with multiple options for completing them. PCMH certification is one path already defined, and those practices should be given maximum points. However, there should be other methods available to measure practices that are not PCMH certified.

Health Disparities of practice panels need to be accounted for, so that physician performance can be properly measured.

These issues are very complex, and we need the depth of talent available to us with AAFP resources to have our voices heard. The board of the NJAFP reviewed these issues at our December meeting in order to keep ourselves up to date and educated about all of these national developments.

Here in NJ, we have also focused our advocacy resources on improving the new law requiring prescribers to consult the Prescription Monitoring Program (PMP). We recognize the importance of such a program, and we also understand the work flow issues required for it to work well. We are pleased that the requirement for checking the PMP is limited to Schedule II CDS prescribed for acute and chronic pain at the initial visit, and then at least quarterly for patients requiring ongoing prescriptions for pain management. The comment period for this new law ended January 15, 2016. Having the option to delegate the ability to look up a patient record in the database is invaluable. Requiring that the staff member be a "Certified Medical Assistant" who has clinical training does seem to be an unnecessary requirement to simply check a database for us. An employee who is covered by the practice HIPAA privacy rules and who demonstrates an understanding of these rules should be able to perform that function too, allowing the clinically trained medical assistant to directly assist in patient care.

All of the issues I have mentioned above play a role in our Academy members working to achieve the "Quadruple Aim." I am continuing to explore educational tools addressing physician burnout, which I mentioned in my address to the House of Delegates in June and in my last article in *Perspectives*.

I want to thank all who do the work of the NJAFP. We have a dedicated and tireless staff and an engaged and committed leadership on the Executive Committee and Board of Trustees. May we all enjoy a happy and healthy 2016. ▲

Robert T. Gorman, MD is President of the New Jersey Academy of Family Physicians and a practicing family physician in Verona, NJ.

Watson can sing too

RAY SAPUTELLI, MBA, CAE

IN 2012, the amount of data that crossed the Internet every second exceeded the total size of all the data stored on the Internet 20 years earlier. One data junkie recently told me that the amount of data in bytes (or gigabytes or terebytes or petabytes or whatever-bytes) that Walmart collected every two days in 2015 exceeded the total amount of data collected and warehoused in the entire world in 2003. Anecdotal to be sure, but it is also entirely believable when you consider Moore's Law (for the non-data junkies among us, Moore's Law states that the number of transistors on an affordable CPU would double every two years.[1])

With the data junkie conversation still fresh in my mind, I was recently part of a conversation between several physicians focused on telemedicine. A few of those in the conversation seemed highly concerned at the possibility that telemedicine would lead to poor care, while others suggested that for certain cases it could be useful, appropriate, and cost-effective. Most of the participants were, with good reason, concerned with how physicians who do tele-visits would be compensated, noting appropriately that the payment issues surrounding this and other technology-driven innovations further highlight the need to move from our fee-for-service based system to one that is more value-based where innovation and processes that add value are simply in the equation, not an "add-on" to be negotiated. One physician even offered his colleagues the familiar caution that they all would be wise to embrace technology, especially consumer-friendly technology, lest they all be left behind.

What if that's already happening?

If you've watched any television lately, you've probably seen the IBM/Watson commercial featuring Bob Dylan. After you got over the shock of simply seeing a counter-culture hero and poet of the 1960's doing a television commercial, you may have given just a little thought to what the commercial was really about. Technology and data are coming together right now in a way that was the stuff of the science fiction worlds created by people like Gene Roddenberry only a few decades ago. There is no doubt that the delivery of, and access to healthcare services is about to change dramatically. Perhaps it already has. How far-fetched is it to imagine basic screenings being done in the home with smart technology? What about an on-line patient interview that not only gathers answers, but provides a potential diagnosis and list of next steps? Impossible you say? In his book "Health Attitude: Unraveling and Solving the Complexities of Healthcare," former VP of Internet Technology at IBM, John R. Patrick suggests that the modern consumer does not need to be pushed to embrace (or at least try) new technology.[2] He notes the huge number of mobile-health devices being approved by the FDA, and offers the Cedars-Sinai decision to connect more than 80,000 patient EHRs with the Apple Health app as evidence of the speed with which consumer (patient)-focused technology is reshaping healthcare delivery. Still, he and others are quick to point out what to many of you reading this may be obvious: that flashy and futuristic technology gets headlines and garners attention, but what can truly change healthcare delivery by improving cost, outcomes, and the patient and physician experience – the quadruple aim – is the data that these devices collect and the new data-driven relationship between physician and patient. Patrick notes that Phillips North America recently surveyed more

Continued on page 22

One physician offered his colleagues the familiar caution that they all would be wise to embrace technology lest they all be left behind.

Healthy Pets, Healthy People

APPROXIMATELY 75 percent of recently emerging infectious diseases that affect humans began as diseases in animals. Recently, the Centers for Disease Control and Prevention (CDC) has been responding to many disease outbreaks that have been associated with animal contact. These diseases include Ebola, avian influenza, and salmonella, among others.

To help protect both people and their pets, the CDC developed a website. Healthy Pets, Healthy People is a website where pet owners and their physicians can find information about diseases people can catch from pets, farm animals, and wildlife. This "one-stop-shop" allows users to search alphabetically by animal, learn which zoonotic diseases the animal may carry, and find simple actions they can take to protect themselves – and their pets.

The website features:

- An alphabetized list and description of diseases that can spread from animals to humans
- A list of animal species with the description of diseases associated with the animal
- Specific groups of people that may be more susceptible to diseases from animals
- Tips for preventing illnesses acquired from pets and other animals
- Detailed information about the health benefits of owning a pet

The "Animal Tales" section of the website takes a closer look at how animals are positively affecting human lives. Visitors will find stories that explore the rich connections between animals and people and will learn tips and valuable information on how to protect against diseases that can spread from pets and other animals. The site also includes specific precautions that people with weakened immune systems, children, and pregnant women should take when interacting with animals.

Healthy Pets, Healthy People can be found at www.cdc.gov/healthypets

ADULTS AGE 50 TO 59 NOW LARGEST AGE GROUP IN OPIOID TREATMENT PROGRAMS

Drug use patterns are changing, especially among older adults. It has been shown that admissions to substance abuse treatment centers and increased injection drug use have been rising among those over the age of 50.

In a study entitled, "Demographic Trends of Adults in New York City Opioid Treatment Programs - An Aging Population," researchers used data collected by New York State's Office of Alcoholism and Substance Abuse Services (OASAS). Their analysis found that in 1996 adults aged 50-59 made up 7.8% (N= 2,892) of the total patient treatment population. In 2012 that same age group represented 35.9% (N= 12,301) of the population.

Patients aged 60-69 who were in opioid treatment programs also saw a dramatic increase in numbers. Originally constituting 1.5% of patients (N= 558) in 1996 to to 12.0% of patients (N= 4,099) in 2012. During the same period, those age 40 and below, who in 1996 accounted for 56.2% of patients (N=20,804), were a fraction of that in 2012, responsible for 20.5% of total patients (N= 7,035).

Benjamin Han, MD, MPH, an instructor at New York University School of Medicine and the study's principle investigator stated, "These increases are especially striking, considering there was about a 7.6% *decrease* in the total patient population over that period of time, and suggests that we are facing a never before seen epidemic of older adults with substance abuse disorders and increasing numbers of older adults in substance abuse treatment. Unfortunately there is a lack of knowledge about the burden of chronic diseases and geriatric conditions or the cognitive and physical function of this growing population."

It is suspected that the increased utilization of opioid treatment programs by older adults is likely to continue into the next decade. The researchers called for further studies to better understand unique and specific health needs of this growing population from a geriatric perspective. More information regarding the study can be found at http://bit.ly/1PIDT2T

Perspectives

A View of Family Medicine in New Jersey

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Naloxone nasal spray provides important new alternative for family members, first responders and physicians

THE FDA recently approved the use of Narcan nasal spray (naloxone) (a version of naloxone hydrochloride). Narcan is a life-saving medication that can stop or reverse the effects of an opioid overdose. When administered quickly, naloxone can counter-act the overdose effects of opioid abuse, usually within two minutes. Up until this approval, the drug was only available to be delivered via injection.

Drug overdose deaths have surpassed motor vehicle crashes as the leading cause of injury or death in the United States. The FDA acknowledged that naloxone will not solve the underlying problems created by opioid abuse, but it will save lives that might have otherwise been lost due to overdose. Narcan nasal spray delivers a consistent, measured dose when used as directed and can be used on adults and children. The drug is sprayed into one nostril while the patient is lying on his or her back, and can be repeated if necessary. It is important to note that the administration of Narcan is not a substitute for immediate medical care.

The FDA granted fast-track designation and priority review for Narcan nasal spray. Fast-track is a process designed to facilitate development and expedite review of drugs intended to treat serious conditions and that demonstrate the potential to address an unmet medical need.

The agency's priority review program provides for an expedited review of drugs that offer a significant improvement in the safety or effectiveness of the treatment, prevention, or diagnosis of a serious condition.

For information on the use of Narcan in New Jersey, visit the NJ Department of Health website at http://www.state.nj.us/health/ems/naloxone_info.shtml. Additional information of the FDA approval of Narcan can be found on the FDA website at http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm473505.htm ▲

CME Vaccine View

THERESA J. BARRETT, PHD, CMP, CAE

Theresa Barrett, PhD is the Deputy Executive Vice President for the New Jersey Academy of Family Physicians

This article was made possible through a grant from the New Jersey Department of Health Vaccine Preventable Disease Program.

Introduction

The role of the Advisory Committee on Immunization Practices (ACIP) is to provide guidance to the Director of the CDC on vaccine-preventable diseases and vaccinations for the civilian population of the U.S. When recommendations are adopted, they are published as official recommendations in the Morbidity and Mortality Weekly Report (MMWR). ACIP has recently updated their recommendations for several vaccines, including HPV, Influenza, and Meningococcal.[1]

Human Papillomavirus (HPV) Vaccine

There are over 40 types of Human Papillomavirus (HPV) which can be spread through direct sexual contact.[2] These types fall into low-risk HPVs (non-cancer causing) and high-risk HPVs (cancer causing). In females, HPV is associated with vaginal, vulvar, and cervical cancer[3] and in males, penile cancer.[4] In both male and females, HPV is associated with anal and oropharyngeal cancer.[5] While over a dozen high-risk HPVs have been identified, HPV types 16 and 18 are responsible for the majority of HPV-caused cervical cancers.[6]

There are three types of HPV vaccines available in the U.S. – bivalent (HPV2), quadrivalent (HPV4), and 9-valent (9vHPV).[7-9] Both HPV2 and HPV4 provide protection against HPV types 16 and 18, which are responsible for 70% of cervical cancers.[9] HPV4 provides additional protection from HPV types 6 and 11, the cause of 90% of genital warts.[10] In February of 2015, ACIP recommended the vaccine 9vHPV, which includes HPV types 6, 11, 16, and 18, and five additional oncogenic types (31, 33, 45, 52, and 58) as one of the three vaccines for use against HPV.[8,11]

In February 2015, ACIP included 9vHPV as one of three HPV vaccines that can be used for routine vaccination.[11] ACIP recommends routine HPV at age 11 or 12 years.[12] Vaccination is also recommended for females aged 13 through 26 years and males aged 13 through 21 years not vaccinated previously and through age 26 years for men who have sex with men and for immunocompromised persons (including those with HIV infection) if not vaccinated previously.[12]

Supplemental information and guidance for vaccination providers regarding use of 9-valent HPV vaccine can be found on the CDC website - http://www.cdc.gov/hpv/downloads/9vHPV-guidance.pdf

Influenza

In August of 2015, ACIP updated its recommendations on the use of seasonal influenza vaccines. The update for the 2015–16 season focused on four areas:[13]

1. Antigenic composition of U.S. seasonal influenza vaccines
2. Information on influenza vaccine products expected to be available for the 2015–16 season
3. An updated algorithm for determining the appropriate number of doses for children aged 6 months through 8 years
4. Recommendations for the use of live attenuated influenza vaccine (LAIV) and inactivated influenza vaccine (IIV) when either is available, including removal of the 2014–15 preferential recommendation for LAIV for healthy children aged 2 through 8 years

ACIP recommends that all persons six months and older, who do not have any contraindications be vaccinated for influenza.[13] Ideally, immunization should occur before the start of flu season, but should be offered as long as flu is active in the community.[13] When the vaccine is available, vaccination should be offered to all unvaccinated persons six months and older during routine healthcare visits and hospitalizations to avoid missed opportunities to immunize patients.

The full ACIP recommendation for influenza can be found in the August 7, 2015 edition of MMWR (http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6430a3.htm).

Meningococcal

ACIP now recommends that adolescents and young adults aged 16–23 years be vaccinated with a serogroup B meningococcal (MenB) vaccine to provide short-term protection against most strains of serogroup B meningococcal disease.[14] The preferred age for immunization is 16 to 18 years.[14] While current data seems to indicate that the vaccine will provide protection against most circulating strains, they are not expected to protect against all serogroup B strains circulating in the United States.[14]

ACIP determined that there is insufficient evidence to recommend all adolescents be vaccinated with the MenB due to the current low prevalence of meningococcal disease and because evidence for making policy recommendations for MenB is not yet available.[14] As meningococcal disease is recognized as serious and given the fact that vaccines are available, ACIP has concluded that there is sufficient evidence to encourage individual clinical decision making.[14]

The full ACIP recommendation on the use of serogroup B meningococcal vaccines can be found in the October 23, 2015 edition of the MMWR (http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6441a3.htm).

The Physician's Role in Immunization

There are several steps you can take to ensure your patients are immunized. One important step is to participate in the New Jersey Immunization Information System (NJIIS). Immunization information systems are confidential, state-based, digital information systems designed to collect vaccination data for children and adolescents, and to provide vaccination reminder notifications.[15] Physicians wishing to leverage the NJIIS can find more information, including enrollment information, on the NJIIS website (https://njiis.nj.gov/njiis/). Participation is free and does not require the purchase or use of software or other programs. The NJIIS website encourages provider participation "to meet the full potential and functionality of the system for your office and your patients."[16]

References

1. CDC. (2015). ACIP Vaccine Recommendations. Vaccine Recommendations of the ACIP Retrieved October, 2015, from http://www.cdc.gov/vaccines/hcp/acip-recs/index.html
2. National Cancer Institute. (2015). HPV and cancer. About cancer,

from http://www.cancer.gov/about-cancer/causes-prevention/risk/infectious-agents/hpv-fact-sheet
3. Muñoz, N., Bosch, F. X., Sanjosé, S. D., Herrero, R., Castellsagué, X., Shah, K. V., . . . for the International Agency for Research on Cancer Multicenter Cervical Cancer Study Group. (2003). Epidemiologic classification of human papillomavirus types associated with cervical cancer. *N Engl J Med*, 348, 518-527. doi: 10.1056/NEJMoa021641.
4. Dahlstrom, K., & Sturgis, E. (2014). Other HPV-Associated Cancers (Oropharyngeal and Penile). In R. Yarchoan (Ed.), Cancers in People with HIV and AIDS (pp. 289-297): Springer New York.
5. Chaturvedi, A. K., Engels, E. A., Pfeiffer, R. M., Hernandez, B. Y., Xiao, W., Kim, E., Gillison, M. L. (2011). Human papillomavirus and rising oropharyngeal cancer incidence in the United States. *J Clin Oncol*, 29(32), 4294-430. doi: 10.1200/JCO.2011.36.4596
6. Lowy, D. R., & Schiller, J. T. (2012). Reducing HPV-associated cancer globally. *Cancer Prev Res* (Phila), 5(1), 18-23.
7. Hariri, S., Markowitz, L. E., Bennett, N. M., Niccolai, L. M., Schafer, S., Bloch, K.,...Group, H.-I. W. (2015). Monitoring effect of Human Papillomavirus Vaccines in US population, Emerging Infections Program, 2008–2012. *Emerging Infectious Diseases*, 21(9), 1557-1561. doi: 10.3201/eid2109.141841.
8. Joura, E. A., Giuliano, A. R., Iversen, O.-E., Bouchard, C., Mao, C., Mehlsen, J.,...for the Broad Spectrum HPV Vaccine Study. (2015). A 9-Valent HPV vaccine against Infection and intraepithelial neoplasia in women. *NEJM*, 372, 711-723. doi: 10.1056/NEJMoa1405044.
9. Stokley, S., Jeyarajah, J., Yankey, D., Cano, M., Gee, J., Roark, J.,...Markowitz, L. (2015). Human papillomavirus vaccination coverage among adolescents, 2007-2013, and postlicensure vaccine safety monitoring, 2006-2014 - United States. *MMWR*, 63(29), 620-624.
10. CDC. (2010). FDA licensure of bivalent human papillomavirus vaccine (HPV2, Cervarix) for use in females and updated HPV vaccination recommendations from the Advisory Committee on Immunization Practices (ACIP). *MMWR*, 59(20), 626-629.
11. Petrosky, E., Bocchini, J. A., Hariri, S., Chesson, H., Curtis, C. R., Saraiya, M.,...Markowitz, L. E. (2015). Use of 9-valent human papillomavirus (HPV) vaccine: Updated HPV vaccination recommendations of the Advisory Committee on Immunization Practices. *MMWR*, 64(11), 300-304.
12. Markowitz, L. E., Dunne, E. F., Saraiya, M., Chesson, H. W., Curtis, C. R., Gee, J.,...Unger, E. R. (2014). Human Papillomavirus Vaccination: Recommendations of the Advisory Committee on Immunization Practices (ACIP). *MMWR*, 63(RR05), 1-30.
13. Grohskopf, L. A., Sokolow, L. Z., Olsen, S. J., Bresee, J. S., Broder, K. R., & Karron, R. A. (2015). Prevention and Control of Influenza with Vaccines: Recommendations of the Advisory Committee on Immunization Practices, United States, 2015-16 Influenza Season. *MMWR*, 64(30), 818-825.
14. MacNeil, J. R., Rubin, L., Folaranmi, T., Ortega-Sanchez, I. R., Patel, M., & Martin, S. W. (2015). Use of serogroup B meningococcal vaccines in adolescents and young adults: Recommendations of the Advisory Committee on Immunization Practices, 2015. *MMWR*, 64(41), 1171-1176.
15. CDC. (2012). What is IIS? About Immunization Information Systems, from http://www.cdc.gov/vaccines/programs/iis/about.html
16. NJDOH. (n.d.). New Jersey Immunization Information System, from https://njiis.nj.gov/njiis/html/join.html

CME Strategies to Prevent Delayed Diagnosis in Turner Syndrome

CHAYIM Y. NEWMARK, MD

Chayim Y. Newmark, MD was a pediatric endocrinologist at Saint Barnabas Medical Center in Livingston, NJ and Assistant Professor of Pediatrics for the Rutgers NJ School of Medicine. He passed away 2010. Dr. Newmark had nothing to disclose relevant to this article.

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Editor's Note: February is Turner Syndrome Awareness month.

TURNER SYNDROME occurs in about 1:2000 live female births.[1] It is characterized by the absence of all or part of the normal second sex chromosome, and presents with a constellation of physical findings that often includes congenital lymphedema (puffy hands and feet), short stature, and gonadal dysgenesis.

Diagnosis

Puffy hands and feet (congenital lymphedema) alerts one to the diagnosis of Turner Syndrome (TS) in about one quarter of affected girls.[2] Some infant girls may have webbed neck. Occasionally, infants receive the diagnosis because of the presence of coarctation of the aorta. However, many girls with TS do not have any obvious stigmata. One third of girls with Turner Syndrome are diagnosed in mid-childhood on investigation of short stature. Most of the remaining females with Turner Syndrome are diagnosed in adolescence when they fail to have normal pubertal breast development and/or fail to have initiation of menses. In rare cases, the diagnosis is not made until adulthood, because of recurrent pregnancy loss.

Typically, the diagnosis is confirmed by standard cytogenetic analysis (karyotype). There are faster and less expensive methods for diagnosing TS, using the detection of single nucleotide polymorphisms (SNPs) on the X chromosome.[3] Approximately half of the karyotypes in females with TS reveal a single X chromosome (45, X) in all cell lines. Others have mosaicism, meaning that they have additional cell lineages besides 45, X. It is important to know the exact cell lines present, since girls with mosaicism for a cell population with a Y chromosome are at increased risk for malignancy (gonadoblastoma) in the streak gonads.[4]

Manifestations and Management

Short Stature

Women with Turner Syndrome reach an adult height of 20 cm below their expected mid-parental height.[5] The mean final adult height is about 143 cm, which is about 4 feet, 8 inches.[5] At birth, the length tends to be close to the normal range. However, by 18 months of age, many girls with Tuner Syndrome will have a decrease in their growth velocity. Approximately 2% of girls whose height is below the 5th percentile have a diagnosis of Turner Syndrome. It is important to point out that children with Turner Syndrome may not be very short; however, they will be shorter than expected for their mid-parental target height.

Treatment with recombinant human growth hormone is now the standard of care for girls with Turner Syndrome. Data reported from the National Cooperative Growth Study (NCGS) indicate that from 1995 to 2000, girls with Turner Syndrome were not started on growth hormone until an average age of 9.0 ± 3.8 years. Furthermore, their height at initiation of growth hormone therapy was -2.9 ± 0.9 SDS (Standard Deviation Scores), which is approximately the 0.1%.[6] This delay in starting growth hormone therapy is likely related to delayed diagnosis of Turner Syndrome in some girls, and in others it is due to delay in referral to a pediatric endocrinologist. The later growth hormone therapy is started, the longer it will take for the patient's height to improve to the normal range, and the less likely she will be to reach a final adult height within the normal range.

A recent randomized controlled trial evaluated the effect of early growth hormone therapy in the toddler years in girls with Turner Syndrome. During this two year study, the control group had progressive growth failure, with a decrease in height from -1.8 ± 1.1 SDS (at baseline) to -2.2 ± 1.2 SDS (after 2 years). This is in contrast to the growth hormone treated girls, whose mean height score increased from -1.4 ± 1.0 SDS (at baseline) to -0.3 ± 1.1 SDS (after 2 years).[7] This means that after 2 years, the untreated girls were at about the 1% and the growth hormone treated girls were at about the 40%.

Gonadal Failure

The ovarian cells in females with Turner Syndrome undergo premature cell death. By 20 weeks gestation, 70% of ovarian germ cells were apoptotic in those with Turner Syndrome, compared to 3% in age-matched normal XX ovaries.[8] The ovarian failure manifests itself as both estrogen deficiency as well as a lack of fertilizable ovum.

Girls with Turner Syndrome tend to have normal pubic and axillary hair development, as these are due to adrenal androgens, rather than ovarian estrogens. However, most girls with TS will not have full breast development nor menstrual cycles. Occasionally, there is enough residual ovarian function for breast development and/or menstrual periods. Because of the ovarian failure, natural fertilization is quite rare in women with TS.

The estrogen deficiency is treated with replacement estrogen, either as pills or estrogen patches. Studies show that estrogen patches have the advantage of not causing liver enzyme elevations[9] and promote increased growth factor (IGF-1) levels.[10] There are various estrogen replacement regimens that are used, but the common point among all of them is to start with low dose estrogen, and slowly increase the dose over a couple of years. This allows for normal uterine and breast development.

There is much research looking into various forms of assisted reproductive technologies to help women with TS carry a pregnancy. There have been reports of ovarian tissue wedge freezing as well as oocyte cryopreservation in young women with Turner Syndrome, in order to preserve fertility.[11]

Developmental and Learning Issues

In general, most people with TS have normal intelligence. Some of the deficits that are more common in females with TS include: visuospatial organization, social cognition, and math abilities. Attention deficit disorders are also more common in these individuals.[2] As with anyone with learning disabilities, early diagnosis and interventions are very important.

Cardiovascular Issues

Approximately one quarter to one half of all females with TS have congenital heart disease. Therefore, all individuals with TS should at least have an echocardiogram at the time of the diagnosis of TS. Typically the malformations are left-sided defects, with coarctation of the aorta and bicuspid aortic valve being the most common. There seems to be an increased risk of aortic root dilatation and subsequent aortic aneurysms in individuals with TS.[12]

Endocrine Issues

Acquired hypothyroidism is more common in females with TS. Approximately, 41% of women with TS have anti-thyroid antibodies, with about one-third of these women having hypothyroidism, requiring thyroid replacement. Interestingly, 83% of the women with the particular karyotype, X-isochromosome, have anti-thyroid antibodies. The hypothyroidism tends to occur in the 20s and the 30s, but a few percent of cases present in early childhood.[13]

Some studies have found an increased incidence of obesity, insulin resistance, and type 2 diabetes in women with TS.[2]

Otological Concerns

Recurrent ear infections are quite common in females with TS. By a mean age of 2 years, over 50% of girls already had a history of recurrent otitis media.[14] This increased incidence of infection is due to a shorter, more horizontal eustachian tube, interfering with middle ear drainage and causing nasopharyngeal reflux.

Approximately, one-quarter of girls with TS will have hearing loss, typically conductive hearing loss related to the middle ear dysfunction and chronic ear infections. However, sensorineural hearing loss is also more common in females with TS.[14]

Renal Concerns

Approximately, one third of females with TS have kidney malformations.[15] These anomalies include: horseshoe kidney, single kidney, duplicated collecting system, and pelvic kidney. Therefore, a renal ultrasound is recommended at the time of diagnosis of TS.[15]

Musculoskeletal and Orthopedic Concerns

Commonly, increased carrying angle of the arm is found, due to malformation of the ulnar head. Congenital dislocation of the hip and scoliosis tend to be more common in girls with TS. Other malformations that occur in TS are: webbed neck, widely spaced nipples, nail dysplasia, high arched palate, and short forth metacarpal.

Dermatological Concerns

The congenital edema of the hands and feet tend to resolve on their own within the first couple years of life. Nevi tend to be more common in females with TS. There also seems to be an increased incidence of keloid formation in these individuals.

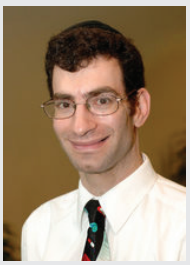
Strategies to Prevent Delayed Diagnosis

One study found that girls with TS were not diagnosed until an average of five years from the time that their height fell below the 5th percentile.[16] The authors of that study proposed the following guidelines for screening for TS:

- Any girl with one or more of the following:
  - Short stature (height <5th percentile),
  - webbed neck,
  - peripheral lymphedema,
  - coarctation of the aorta, or delayed puberty, should be screened for TS.
- Additionally, any girl who has at least two or more of the following:
  - nail dysplasia,
  - high arched palate,
  - short fourth metacarpal, and strabismus, should be screened for TS.[16]

References

1. Nielsen J, Wohlert M. Chromosome abnormalities found among 34,910 newborn children: results from a 13-year incidence study in Arhus, Denmark. *Hum Genet*. May 1991;87(1):81-83.
2. Sybert VP, McCauley E. Turner's syndrome. *N Engl J Med*. Sep 16 2004;351(12):1227-1238.
3. Meng H, Hager K, Rivkees SA, Gruen JR. Detection of Turner syndrome using high-throughput quantitative genotyping. *J Clin Endocrinol Metab*. Jun 2005;90(6):3419-3422.
4. Gravholt CH, Fedder J, Naeraa RW, Muller J. Occurrence of gonadoblastoma in females with Turner syndrome and Y chromosome material: A population study. *J Clin Endocrinol Metab*. Sep 2000;85(9):3199-3202.
5. Lyon AJ, Preece MA, Grant DB. Growth curve for girls with Turner syndrome. *Arch Dis Child*. Oct 1985;60(10):932-935.
6. Parker KL, Wyatt DT, Blethen SL, Baptista J, Price L. Screening girls with Turner syndrome: the National Cooperative Growth Study experience. *J Pediatr*. Jul 2003;143(1):133-135.
7. Davenport ML, Crowe BJ, Travers SH, et al. Growth hormone treatment of early growth failure in toddlers with Turner syndrome: a randomized, controlled, multicenter trial. *J Clin Endocrinol Metab*. Sep 2007;92(9):3406-3416.
8. Modi DN, Sane S, Bhartiya D. Accelerated germ cell apoptosis in sex chromosome aneuploid fetal human gonads. *Mol Hum Reprod*. Apr 2003;9(4):219-225.
9. Jospe N, Orlowski CC, Furlanetto RW. Comparison of transdermal and oral estrogen therapy in girls with Turner's syndrome. *J Pediatr Endocrinol Metab*. Apr-Jun 1995;8(2):111-116.
10. Janssen YJ, Helmerhorst F, Frolich M, Roelfsema F. A switch from oral (2 mg/day) to transdermal (50 microg/day) 17beta-estradiol therapy increases serum insulin-like growth factor-I levels in recombinant human growth hormone (GH)-substituted women with GH deficiency. *J Clin Endocrinol Metab*. Jan 2000;85(1):464-467.
11. Oktay K, Rodriguez-Wallberg KA, Sahin G. Fertility preservation by ovarian stimulation and oocyte cryopreservation in a 14-year-old adolescent with Turner syndrome mosaicism and impending premature ovarian failure. *Fertil Steril*. Feb 24.
12. Sybert VP. Cardiovascular malformations and complications in Turner syndrome. *Pediatrics*. Jan 1998;101(1):E11.
13. Elsheikh M, Wass JA, Conway GS. Autoimmune thyroid syndrome in women with Turner's syndrome--the association with karyotype. *Clin Endocrinol (Oxf)*. Aug 2001;55(2):223-226.
14. Davenport ML, Roush J, Liu C, et al. Growth Hormone Treatment Does Not Affect Incidences of Middle Ear Disease or Hearing Loss in Infants and Toddlers with Turner Syndrome. *Horm Res Paediatr*. Apr 27.
15. Lippe B, Geffner ME, Dietrich RB, Boechat MI, Kangarloo H. Renal malformations in patients with Turner syndrome: imaging in 141 patients. *Pediatrics*. Dec 1988;82(6):852-856.
16. Savendahl L, Davenport ML. Delayed diagnoses of Turner's syndrome: proposed guidelines for change. *J Pediatr*. Oct 2000;137(4):455-459.



Dr. Chayim Y. Newmark was a pediatric endocrinologist at St. Barnabas Medical Center in Livingston, NJ. He graduated from Washington University School of Medicine in St. Louis and completed his pediatric and endocrinology residency at St. Louis Children's Hospital.

Dr. Newmark was a very active researcher and a principal investigator of many diabetes and growth hormone studies. One of his passions was caring for young women with Turner Syndrome, and Dr. Newmark served on the Medical Advisory Board of the Turner Syndrome Foundation, Inc. (TSF), from its onset. Dr. Newmark was determined to overcome ignorance and stigma related to Turner Syndrome and worked with TSF to generate awareness and to enhance medical care for patients affected with the syndrome. He utilized modern therapies to assist young women in achieving normal adult development and was a strong advocate for early use of growth hormone. The material he developed for TSF continues to be an important part of TSF information packets today!

He died tragically at the age of 38 in 2010.

CME Importance of Play in Children's Development

DANIELLE DIETZ, MA, CCC-SLP, EMMY LUSTIG AND LISA RUBIN, MA, CCC-SLP

Danielle Dietz, MA, CCC-SLP is a Speech/Language Pathologist at the Pathways Center in Glenview, IL.

Emmy Lustig is a Communications Associate at Pathways.org who focuses on researching and writing about children's developmental delays.

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The authors have no relevant financial conflicts to disclose.

PLAY IS CRITICAL for children's development because it provides time and space for children to explore and gain skills needed for adult life. Children's playtime has steadily decreased due to limited access to play spaces, changes in the way children are expected to spend their time, parent concerns for safety, and digital media use. Between 1981 and 1997, the amount of time children spent playing dropped by 25 percent.[1] During this same time period, children ages 3-11 lost 12 hours a week of free time and spent more time at school, completing homework, and shopping with parents.[2]

Play can be defined as "any spontaneous or organized activity that provides enjoyment, entertainment, amusement or diversion."[3] When children play, they engage with their environment in a safe context in which ideas and behaviors can be combined and practiced. Children enhance their problem solving and flexible thinking, learn how to process and display emotions, manage fears and interact with others.[4] Free, unstructured play allows children to practice making decisions without prompted instructions or the aim of achieving an end goal. They can initiate their own freely chosen activities and experiment with open-ended rules.

Social changes and new technologies have greatly impacted the way children play and the amount of free time they are given. Children's playtime continues to decrease as a result of:

- Emphasis on academic preparation at an early age - 30% of American kindergarteners no longer have recess.[1]
- Electronic media replacing playtime - 8-10 year olds spend nearly 8 hours a day engaging with different media, and 71% of children and teenagers have a TV in their bedroom[5]
- Less time spent playing outside - a study following young children's play found that kids under 13 years old sometimes spend less than 30 minutes a week outside.
- Perceived risk of play environments - in one study, 94% of parents cited safety concerns, e.g. street traffic and stranger danger, as a factor influencing where their children play.[1]
- Limited access to outdoor play spaces - only 20% of homes in the U.S. are located within a half-mile of a park.[1]

As a result of reduced playtime, children are spending less time being active, interacting with other children, and building essential life skills, such as executive functioning skills, that they will use as adults.[6] During well-child visits, healthcare professionals can inquire about children's playtime and media usage, and provide suggestions to promote quality playtime. The American Academy of Pediatrics recommends health professionals pick two targeted questions to ask parents at well-child visits such as:

1. The number of hours the child spends engaged in screen time
2. Whether there are digital devices in the child's bedroom.[5]

Children's play behaviors may vary based on cultural norms and family preferences. While some cultures emphasize individualism and independent play, others engage in more parent-directed play and activities. This can influence how children play with toys and interact with their peers and family members.[7] To help provide advice to families with different values, styles of play, and communication, health professionals can offer these recommendations from the American Academy of Pediatrics:

- Allow for 1 hour a day of unstructured, free play[5]
- Limit child's media time to less than 1 to 2 hours a day
- No media usage for children under two
- Establish "Screen free zones" by keeping TVs, computers and video games out of children's bedrooms
- Limit "background media" use during playtime and family activities because it is distracting for children and adults
- Establish a plan for media use, e.g. when and where media is used and length of time child uses media

For more tips on how to encourage children's play time Pathways.org offers a free brochure entitled "Play: It's More Than You Think." The brochure is available at http://pathways.org/print/

About Pathways.org:

Pathways.org is a national not-for-profit dedicated to maximizing children's development by providing free tools and resources for medical professionals and families. To help parents learn about important topics in development and milestones for their child, Pathways.org provides free supplemental materials for well child visits and parent classes. ▲

References

1. Bishop, Ronald. Go out and play, but mean it: Using frame analysis to explore recent news media coverage of the rediscovery of unstructured play. *The Social Science Journal*. 2013; 50(4): 510-520.
2. Hofferth, S. L. (2009). Changes in American children's time – 1997 to 2003. *Electron Int J Time Use Res*, 6(1), 26-47.
3. Parham, D & Fazio, S. Play in Occupational Therapy for Children: Second Edition. Mosby, Inc; 2008.
4. Ginsburg, Kenneth R. "The importance of play in promoting healthy child development and maintaining strong parent-child bonds." *Pediatrics*. Jan. 2007: 182. Academic OneFile. Web. 23 Feb. 2015.
5. Children, Adolescents, and the Media. From the American Academy of Pediatrics: Policy statement. *Pediatrics*. 5 Nov. 2013; 132 (5): 958-961.
6. Lillard, A. Peterson, J. The immediate impact of different types of television on young children's executive function. *Pediatrics*. 1 Oct. 2011.
7. Farver, J.M, Y.K., & Lee, Y. Cultural differences in Korean- and Anglo-American preschoolers' social interaction and play behavior. *JSTOR*. Aug 1995: 66(4); 1088-1099.

CME Quiz

True or False:

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.

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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: _____

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1. *True or False:* HPV types 16 and 17 are responsible for the majority of HPV-caused cervical cancers.
2. *True or False:* ACIP recommends routine HPV at age 11 or 12 years.
3. *True or False:* Men who have sex with men may be vaccinated with HPV vaccine up to age 21.
4. *True or False:* One reason ACIP determined that there is insufficient evidence to recommend all adolescents be vaccinated with the MenB due to the current low prevalence of meningococcal disease.
5. *True or False:* The NJIIS encourages practices meet the full potential and functionality of the system for the benefit of the office and its patients.
6. *True or False:* Puffy hands and feet (congenital lymphedema) is an indicator of Turner Syndrome (TS) in about one quarter of affected girls.
7. *True or False:* Diagnosis of Turner Syndrome is usually confirmed by clinical symptoms.
8. *True or False:* Ovarian failure in Turner Syndrome manifests as both estrogen deficiency as well as a lack of fertilizable ovum.
9. *True or False:* Children aged 8-10 spend nearly 8 hours a day engaging with different media.
10. *True or False:* Children's media time should be limited to no more than 3 hours a day.

ANSWERS ON PAGE 22

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

NJAFP's New and Expanding Healthcare Transformation Team!

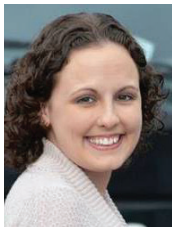
THE NJAFP has redesigned its Practice Transformation Team into the Healthcare Transformation and Quality Improvement Team. While continuing to assist physician practices with the transition to patient-centered care and attaining NCQA recognition, the team will also focus on combining CME and quality improvement to further enhance outcomes for patients. The expansion of the Healthcare Transformation Team will also allow NJAFP to engage in regional quality improvement efforts, to reach practices that work across state borders. Joining the existing team of Karen Foster, Tara Perrone, Jessica Runyon, and Pam Joyce, are:

Sandi Selzer, MSHQ - *Vice President, Healthcare Transformation and Quality Improvement*. Sandi worked with NJAFP member Jeff Brenner, MD (Camden) as Director of the Camden HIE, and spent almost 15 years at the American Board of Internal Medicine (ABIM). Sandi leads the strategic and tactical elements of the NJAFP's healthcare transformation and quality improvement service offerings, and guides strategic planning for the division.

Angie Halaja-Henriques - *Program Director*. Angie's experience includes over 15 years of communications and grant writing both of which led to her work in public health and quality improvement programming while at the PAFP Chapter, and oversees NJAFP's quality improvement, public health and continuing education programs.

Kristine Samara - *Program Manager*. Kris has over 24 years of healthcare experience including provider education, recruitment, and credentialing. Kris will be managing QI projects, including the Organ Donor initiative.

Suzanne Hockenberry - *Healthcare Transformation Specialist*. Sue's experience includes hands-on facilitation of work flow redesign and the implementation of electronic health records, as well as supporting practices in Meaningful Use and Patient Centered Medical Home recognition. Sue is a National Committee for Quality Assurance (NCQA) PCMH-Certified Content Expert.



Angie, Sue, and Kris were formally with the Pennsylvania AFP Foundation.

Congratulations to...

Past NJAFP President, **Jeff Zlotnick, MD, CAQ** was recognized by Special Olympics New Jersey (SONJ) for his 20 years of service to the organization and its athletes. He was inducted into the SONJ Hall of Fame, credited with the development of MedFest and the countless pre-participation exams he has completed over the years. Dr. Zlotnick is the first volunteer physician to receive this honor. To read more about Dr. Zlotnick, see the Physician Profile View on page 21.

In the News

Vikram Gupta, MD *(Clifton)* was featured in an EIN News piece entitled "Northern NJ Primary Care Physician, Says Chronic Disease Management is Crucial for Those with Chronic Kidney Disease." Read the full article at http://bit.ly/NJAFPGupta.

2014-2016 Legislative Session

NJAFP Government Affairs State Advocacy

CLAUDINE M. LEONE, ESQ.

NJAFP continues to work on your behalf to monitor, promote and oppose legislation that impacts the practice of family medicine, the education and training of family physicians and your patients' access to health care. NJAFP regularly works on the issues below with other physician specialty societies with common advocacy goals as NJAFP. January 2016 is the start of a new two-year legislative session and many of these issues may continue to be debated.

We have compiled a list of bills that are currently pending (not law) or some that have been signed in the last two years' sessions. This list is not exhaustive of NJAFP's advocacy efforts, but provides a good sampling of the issues that come up in Trenton every day.

HEALTH INSURANCE

- Out of Network Legislation (A-4444/S-20)
  NJAFP continues to ensure that in-network family physicians and primary care physicians are not impacted with additional administrative responsibilities in the disclosure section on this new bill. We have been successful with the sponsors thus far in concept, but the bill continues to have language that may impact family physicians. NJAFP remains active on behalf of its members and patients. *This is a significant lame duck issue and we will not know the outcome until early January. It is likely this issue will be revisited in the new legislative session.*

- Patient Data (support) (S562/A3322)
  The *Governor signed* S562/A3322, which was a response to the Horizon data breach of patient information on laptops. The law requires health insurance carriers to encrypt certain information. NJAFP supported this bill through the legislative process.

- Standard Explanation of Benefits Forms (support) (A1447/S1384)
  This is a bill that NJAFP has supported for many legislative sessions. The Assembly Financial Institutions Committee approved A-1447, which requires health insurance carriers to use a standard explanation of benefits form. NJAFP will continue to support this bill and other similar measures. *The bill will not likely be approved in this legislative session.*

SCOPE OF PRACTICE

- Advanced Practice Nurses
  Independent Practice (oppose) - After many legislative sessions, the effort to push independent practice has been stalled, again. The NJ State Nurses Association and the APNs remain intent to eliminate the requirement for a joint protocol with a collaborating physician through the regulatory process. This *Diagnosis of Cause of Death* (oppose) – After two successful vetoes in 4 years and continued NJAFP opposition, the *Governor signed this bill* this spring. However, when the writing was on the wall, we were able to get amendments to narrow the circumstances under which an APN can certify diagnosis of death for the death certificate.

- Psychologists Prescribing (oppose) (A2892/S1684)
  Psychologists have been seeking prescriptive authority through legislation for several years now. *This bill with physician opposition has failed to pass in the Assembly or move in the Senate.*

- Physician Assistants (oppose – then neutral)
  PAs sought to eliminate any scope of practice in this legislation. They were seeking to have their scope exclusively delegated by their supervising physician. NJAFP worked to bring the bill down to reality and they maintained their enumerated scope in the current law, but left some flexibility for delegation at the supervising physician's discretion and lighten the load for chart review/sign offs for supervising physicians. *The PAs are actively moving this in lame duck, but at this point requires some additional action.*

PRIMARY CARE WORKFORCE

- Primary Care Loan Redemption
  We continue to work with the Program to improve access, increase approved sites and utilization. We are still working to increase funding for the program, particularly by accessing additional matching funds from the federal government, previously untapped by the state. To do this New Jersey needs key workforce data that we do not have . . . see below.

- Physician Workforce Data Collection
  Working with the NJ Council of Teaching Hospitals, we worked with the NJ BME to eliminate the ridiculously worded voluntary survey included in their license renewal and streamlined the license renewal questionnaire so that it complied with federal requirements necessary to access additional federal funds for teaching hospitals/residency programs and loan redemption.

PHYSICIAN MANDATES

- Hepatitis Testing (oppose) (S876/A2555)
  S876 would require physicians and hospitals to provide testing for Hep C for all adults born 1945-1965. The bill would require that the test be offered at every patient encounter unless the patient confirms that he/she has already been tested. NJAFP opposes this mandate, which goes beyond the CDC and Preventive Care Task Force (PCTF) recommendations. *The bill barely passed the Senate and is stalled in the Assembly Health Committee. NJAFP will continue to oppose this legislation and recommend the state continue to follow the PCTF recommendations.*

- Sports Physical Cardiac Module (implementation of law)
  NJAFP had a physician seat on the Student Athlete Cardiac Health Working Group charged with developing an educational module for physicians. While well intended the legislation that established this Working Group and the module needed to be reined in at every turn. NJAFP made sure that this was a one-time requirement

and we have continued to monitor how the Department of Education is implementing this requirement. Effective 2015-2016 school year, when you fill out a student's sports physical form you will have to attest that you completed the module on the bottom of the form.

• All Physicals Cardiac Module (oppose – successfully amended)

NJAFP had to jump into action again when the Legislature wanted to extend the requirements for sports physicals (module) to all children's physicals. When we saw there was no stopping this bill, we were able to reduce its impact, which, as proposed, would have required physicians, PAs, and APNs to take the cardiac module as a condition of their license renewal and file their completed certificates with the BME. *NJAFP narrowed the bill to be a one-time requirement and you will only have to attest on your BME license that you completed the module. This bill was signed by Governor Christie.*

• Suicide Prevention CME (oppose) (A3834/S3068)

A bill was considered by the Assembly Education Committee with a lot of requirements on suicide prevention CME for physicians. We successfully worked with the sponsor to recognize that the bill, while well intended, wasn't quite right. *The bill has been stalled in the Assembly to date, but we have captured the interest of the sponsor to address some other mental healthcare issues and, particularly, insurance barriers and coverage for mental illness.*

PUBLIC HEALTH

• Limiting Exemptions for Vaccinations (support) (A1931/S1147)

NJAFP continues to support legislation that would narrow the religious exemptions for childhood vaccinations. With the recent measles outbreaks, we finally have the Legislature's ear on the concept of herd immunity and importance of vaccinating according to CDC guidelines. *This bill is still pending approval.*

PRESCRIPTION DRUG

• Naloxone and Civil Immunity (support) (S2378/A3720)

NJAFP supported legislation in 2013 that authorized physicians to prescribe naloxone in the name of the person receiving the prescription (not just the end user). NJAFP has supported the BME's waiver of the physical examination requirement for prescribing naloxone as well as advocated for clarification on the provider immunity provisions of the law, including immunity from disciplinary action – not just liability. *Governor Christie signed a new bill clarifying immunity provisions.*

• Prescription Drug Monitoring Program Amendments (oppose – neutral) (S1998)

Legislation was introduced to improve the functionality of the PMP. As introduced, it was terrible. Now, after 2 years of negotiating, the PMP changes are much better, and while we did prevent the bill's "mandate to check" provision, we limited the circumstances where the mandate to check is required. As it stands, employees of physician offices (certified medical assistants) and residents will now be able to access the PMP database. There will be increased operability with other states' databases; it increases the AGs ability to send reports to physicians and pharmacies, and reduces pharmacy data submission timeline from one month to one week to make the PMP more current. The mandate to check will be for prescribing a schedule II pain medication for a NEW patient and quarterly thereafter if the prescriber continues that course of treatment. The original language was a full blanket mandate for all medications at every prescription - not just for pain. *The Governor signed this bill and the State has proposed regulations to implement, however, have tried to limit some of the legislative intent as it relates to non-physician access to the PMP (medical assistants).*

• Medication Disposal (support with amendments)

This bill requires physicians and pharmacies when dispensing CDS to inform patients about proper and safe disposal. With clarification that this was only for CDS dispensing from a physician practice and pharmacy, this has very limited impact on family physician practices.

• Informed Consent (oppose))(A3712/S2366)

We continue to successfully oppose legislation that would require healthcare practitioners (physicians, PAs, APNs) to inform patients in writing - on a form developed by the State and based on guidelines developed by the State - of addictive potential of all CDS prior to issuing the prescription. While NJAFP is not opposed to the concept, the requirements of this bill and the legal implications of the proposal, as written, interfere with the practice of medicine. *This is another lame duck issue and, while it appears to be stalled, anything can happen.*

• Addiction Treatment (support)

NJAFP is supporting legislation that would prohibit utilization management review for behavioral health treatment.

• Mental Health Services (support)

The Governor signed two bills which require Department of Human Services and Corrections to coordinate to ensure provision for mental health services to inmates. The Governor also signed a bill that requires the Department of Human Services to make public an annual report on substance abuse providers. ▲

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Are you an "Applicable Large Employer" under the Affordable Care Act?

SUSAN B. ORR, ESQ.

APPLICABLE LARGE EMPLOYERS under the Affordable Care Act (the "ACA") are required to offer substantially all (95%) of their full time employees and dependents health coverage that is affordable and of minimum value to avoid monetary penalties. Therefore, it is important for employers to determine whether they meet the definition of an Applicable Large Employer and if they meet the definition to understand their obligations under the ACA.

Applicable Large Employers are those who employ an average of at least 50 full-time employees during the preceding calendar year. A "full-time" employee is anyone who works 30 hours or more per week or 130 hours a month which is in contrast to the 36-40 hours per week that most employers consider full-time. In determining the number of full-time employees, seasonal and part-time employees must be accounted for using the full-time equivalent (FTE) methodology. This methodology involves simply adding up the total number of hours worked by all of the part-time employees each month and dividing that number by 120, thereby giving you the number of FTEs. If your FTE employees plus your full-time employees total 50 or more, you meet the definition of an Applicable Large Employer. When calculating the number of full-time employees, include those working at all locations and those working for an affiliate company.

Once you have determined that you are an Applicable Large Employer, the next step is to determine which employees you are required to offer insurance. Those individuals clearly working over 30 hours a week are easy to track, but how do you track "variable hour" employees, which many practices have? These are employees who work different hours each week, some of whom may work hours that hover around 30 hours. To avoid penalties, an employer is required to track the hours worked for **all** variable hour employees, during a "Measurement Period" of 3 to 12 months. At the end of the measurement period, review the hours to determine which employees, if any, worked an average of 30+ hours a week. We suggest a 12-month measurement period, to allow for more consistent tracking. In month 13, determine the average hours worked and for those who worked an average of 30 or more hours, the employer must offer health insurance to the employee and his/her dependents during the next 12-month period (the "Stability Period"). Note that the length of the stability period must match the length of the measurement period. Even though you are now in the *stability*, you are required to continue to track hours worked to determine whether or not to offer insurance for the next 12-month period.

Those individuals clearly working over 30 hours a week are easy to track, but how do you track "variable hour" employees, which many practices have?

Note that insurance must be offered not only to the employee, but also to the employee's dependents, which are children under the age of 26. A spouse is not considered a dependent.

How about new hires? The ACA allows an employer to have no more than a one month orientation period and a 90-day (not 3 months) waiting period, but health insurance coverage must become effective for an eligible employee no later than the first day of the fourth month of employment. For example, if an employee is hired on January 15th, orientation would be from January 15 to February 15, a waiting period would then begin and the insurance must be effective no later than May 1. For new hires that are variable hour employees, you would simply track their hours as discussed above.

The ACA also requires that any health plan offered to employees be affordable and provide minimum essential coverage. A plan is considered affordable if the employee's required contribution for his or her coverage (do not include dependent coverage) does not exceed 9.5% of the employee's income for the year. The plan must provide certain essential health benefits, including, but not limited to preventive care, prescriptions, laboratory and hospital services and it must cover 60% of all the medical expenses incurred by the employee.

Penalties can be severe if an Applicable Large Employer does not offer a plan to at least 95% of its full-time employees and if at least one employee receives a tax credit or a cost sharing subsidy in the federal marketplace. Failure to meet this requirement will subject the employer to a penalty of $2,084 multiplied by the number of full-time employees minus 30 (the penalty is waived for the first 30 employees). For example, if the employer has 50 employees, the penalty would be $41,680 per year, that is 20 (50 minus 30) times $2,084.

For offering inadequate insurance, the penalty is less draconian and is $3,126 for each full-time employee that actually receives a tax credit or cost sharing subsidy.

There are also mandatory IRS reporting require-

Continued on page 22

For questions or assistance with policies and procedures, please contact Susan B. Orr, Esquire, Rhoads & Sinon, LLP at 610-423-4200 or sorr@rhoads-sinon.com

This next generation of physicians must be equipped to deal with an expanded skill set that goes beyond the approach to developing the traditional clinician.

A Call for Leadership: A Resident's Perspective

ROBERT R. KRUSE, MD, MPH

THE MODERN PHYSICIAN is called to provide twenty-first century health care upon the foundation of a twentieth century training. Today's physician trainees enter a world of teamwork and collaboration in healthcare delivery. Evidence-based medicine and quality initiatives reinforce the fact that better outcomes and lower costs are driven by such a team-oriented approach. Complementing these internal healthcare initiatives has been the strong response of policy reform and regulation. Together, new models for healthcare delivery facilitate patient care under the joint banner of teamwork and communication. At every step of the journey, physicians accept the role of team leader, facilitator, and communicator.

The ability for future physician leaders to embrace the role of team leader can be best cultivated and enhanced through the response of medical educators. This next generation of physicians must be equipped to deal with an expanded skill set that goes beyond the approach to developing the traditional clinician. It must also relinquish the outdated belief that physician administrators are the only group in need of leadership training. Rather, all physicians must be prepared to be active leaders. The academic medical community can go a long way to develop this sort of physician leader, one that is prepared for the challenges and successes of twenty-first century health care.

This call for a new model of leadership development in the medical academic community was recently emphasized in Academic Medicine,

"The full benefits of such a model will not be apparent for years. Early benefits, however, include reduced costs of care, increased availability of health care, improved quality, and a focus on wellness rather than disease management. Long-term benefits include increased involvement of physicians in all aspects of healthcare administration, with younger physicians leading changes in health care delivery."[1]

Research suggests that there is a link between the engagement of doctors in leadership and quality improvement- with correlative improvements in patient care.[2] It has become evident that trained physician leaders are better able to both initiate positive change as well as respond to negative or unexpected diversions. This flexibility to interact with change is crucial to the maintenance of equitable and sustainable high quality patient care. With the continued mantra of placing the patient first in health care, investment in such leadership development should be a priority.

Meanwhile, contemporary legislative and regulatory output continues to interplay with systems of development to drive the evolution of patient care around the foundation of team-based approaches. Healthcare systems continue to grow, and to further integrate the various levels of providers and practitioners, in an effort to find a cost-saving blend of quality care. The constant in all of these regulatory models remains that the physician is placed at the center of delivery and as the leader of the team. If the academic community does not strive to meet the demands of these evolving healthcare systems, perhaps other licensed providers will be offered the chance to step into the void. Physician leaders must be prepared to both interact with, as well as facilitate and lead, these future healthcare teams. Finally, perhaps the most systemic influence on leadership development will be driven by financial incentives.

Bundled reimbursements, value-based purchasing of healthcare resources, and pay-for-performance all indicate that providers will be rewarded in concert with team-based care. To complement this, several national societies, think-tanks, and government bodies have suggested stratified incentives to academic institutions that engage medical core competencies to differing degrees. All of this is indicative of a likelihood that institutions and residency programs that address necessary competencies, such as leadership development, could see greater funding.

Some would argue that the movement towards leadership development in medicine is already upon us. To be fair, much discussion has taken place and early adoption has followed in, mostly, isolated settings. But, as a profession, we must still be doing something wrong. Physician burnout is at an all-time high with studies demonstrating that 1 in 3 physicians is experiencing such burnout at any given time.[3] Further studies show that 90% of professionals, who leave their profession, either voluntarily or involuntarily, leave not because of technical incompetence, but because of a non-technical shortcoming or difficulty. Meanwhile, the most commonly raised issues in both medical student and physician performance continue to be within the domain of the non-technical competencies. These areas of concern include professionalism, ethics, and perhaps most important - interpersonal skills.[4]

The time for leadership development in medicine is at our doorstep. It is quite clear that the business community tapped in to the importance of recognizing and advancing these principles over three decades ago. In review of the literature on leadership development, it is evident that these topics have only just begun in earnest within the past five to ten years in the medical community. As a profession, physicians have likewise lagged behind - with only recent mutterings and support for the importance of structured and focused leadership in academic medicine. The necessity for developing a new generation of physician leaders is without question. The call for such leadership development is now loud and clear. However, the response of the academic community must be considered. As a profession, we cannot miss the opportunity to answer the door. ▲

References

1. Snyderman, C. Sibling, D. (2011). The physician as team leader: New job skills are required. *Academic Medicine*. 86(11):1348.
2. Ferule, E. B. Shortell. S. M. (2001). Improving the quality of health care in the United Kingdom and the United States: A framework for change. *The Milbank Quarterly: A Journal of Public Health and Healthcare Policy*. 79(2):281-315.
3. Shanafelt, T. D. (2009). Enhancing meaning in work: A prescription for preventing physician burnout and promoting patient-centered care. JAMA 302(12):1338-1340. *Medical Education*
4. Eva KW, Rosenfeld J. (2004). An admissions OSCE: The multiple-mini interview. 38:31-326.

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New Tools Available for Tobacco and Nicotine Prevention

THE AAFP HEALTHY INTERVENTIONS: Tobacco and Nicotine online toolkit is now available at www.aafp.org/tobacco-tools. The website provides office-based tools and guidance on community engagement, advocacy, and science and education. Within the site you will find:

- New and updated comprehensive resources all in one place
- Options to use just the tools you need
- Coding Reference updated with ICD-10 info on billing for tobacco cessation counseling
- Patient education handouts on e-cigarettes, 'prescriptions' to quit smoking, and guides for those who set a quit date
- Office tools for your practice including ideas for systems changes and training staff on motivational interviewing
- PowerPoint slides to educate residents and other clinicians
- The latest guidelines and policies
- Tar Wars artwork for your office and a kid's word search
- Information about your communities health status, smoking prevalence, and how your county ranks within your state
- Find out information on local, state and national tobacco-related advocacy

First Place poster in the 2015 NJ Tar Wars Poster Contest

Fifth grader, Lauren McDonough's submission from Franklin Elementary School, Westfield, NJ.

Updates on Tobacco Smoking Cessation

The U.S. Preventive Services Task Force (USPSTF) released its final updated recommendation on tobacco cessation. USPSTF gives tobacco cessation treatments an 'A' for efficacy. The Affordable Care Act requires most health insurance plans to cover all preventive services given an 'A' or 'B' recommendation by USPSTF.

AAFP Clinical Preventive Service Recommendation can be found at:

http://www.aafp.org/patient-care/clinical-recommendations/all/tobacco-use.html

The USPSTF final recommendation statement is available at:

http://www.uspreventiveservicestaskforce.org/Page/Document/final-recommendation-statement143/ tobacco-use-in-adults-and-pregnant-women-counseling-and-interventions1#Pod5

Ask your patients if they use tobacco.

Act to help them quit.

Tobacco cessation resources available at **www.askandact.org**

Family Physicians Make Competing Possible for Special Olympics Athletes

IN 2000, when Jeffrey Zlotnick, MD, CAQ was serving on the Board of Trustees of the New Jersey Academy of Family Physicians (NJAFP), the board received a phone call from Marc Edenzon, President and CEO of Special Olympics New Jersey (SONJ), requesting help. The organization was running into a problem getting athletes to complete their pre-participation physicals due to various barriers that are characteristic of the special needs population when it comes to accessing health care. Athletes had difficulty finding and making appointments with physicians, or if they were able to make appointments, they simply lacked the transportation to get them there.

As a Board Certified family physician with a background in sports medicine, the issue resonated with Dr. Zlotnick and he made finding a solution his priority. On behalf of NJAFP, Dr. Zlotnick met with SONJ athletes and their parents, as well as state legislators to determine the best way to meet the needs of all those involved. He began looking for ways to successfully see as many athletes as possible in a quick and efficient manner.

The solution was in college station exams. Using the station exam concept as a model, SONJ athletes would be seen by a physician in groups of three or four at a time, allowing the exams to be completed quickly while lessening the anxiety athletes may feel when visiting the doctor alone.

Once Dr. Zlotnick and SONJ decided on the right pre-participation exam model for the athletes, Dr. Zlotnick reached out to New Jersey's family medicine residency programs in an attempt to garner support and mobilize volunteers.

"Residency programs were ecstatic and immediately welcomed the idea," says Dr. Zlotnick. "It was a great way for family medicine residents to meet their volunteer requirements, as well as supplement their medical training with exposure to individuals with developmental delays."

With Dr. Zlotnick's research and support from the residency programs, the event known today as MedFest was born. Dr. Zlotnick, NJAFP and New Jersey family medicine residency programs held the first event in Lawrenceville, at SONJ's headquarters in March 2003. Schools from across the state provided athletes with bus transportation to MedFest, eliminating the need for athletes' families to drive.

Jeff Zlotnick, MD (r) pictured with SONJ MedFest program associates, Carmen Bannon (l) and Andrea Picariello (c). *Photo: Michael Friedman*

During MedFest, each athlete underwent a pre-participation exam that consisted of seven station stops. Before the medical examinations, athletes were first processed by SONJ volunteers who ensured all the medical history paperwork was in order so that the athletes could proceed. They were divided into small groups and began with Station # 1- Intake, where they were measured for height, weight, and a history review, followed by stations for blood pressure, heart and lungs, ear-nose-throat, abdominal, musculo-skeletal and finally, check-out.

Prior to volunteering for the event, participating resident physicians took a CME accredited training course developed by Dr. Zlotnick in order to be more familiar with the special needs population. The important mission of the pre-participation exams is not to prohibit or restrict a Special Olympic athlete, but rather to qualify the athlete for activities they CAN participate in. Per the training, nurses and medical students would complete the Intake portion of the exam; resident physicians provided the main screening stations of the pre-participation exam (History, Ear/Nose/Throat, Heart/Lung, Abdominal); and certified athletic trainers ran the musculo-skeletal portion. Dr. Zlotnick acted as the supervising physician in charge of reviewing and signing the forms to clear athletes for competition.

The MedFest program proved to be a huge success for a significant portion of New Jersey's special needs students. However, some athletes were still having trouble finding

transportation to Lawrenceville. In an attempt to reach every athlete across the state, SONJ recently took the next step and made MedFest mobile by customizing a Winnebago. The customization allowed Dr. Zlotnick to hit the road with the "MedFest Winnebago" and a handful of resident family physicians, medical students and SONJ volunteers. They are now able to visit locations throughout New Jersey to give the athletes more opportunities to receive pre-participation physicals.

To date, between 1,500 to 2,000 athletes have been able to compete in the Special Olympics Games and activities thanks to MedFest. The program has grown nationally – spreading to other states and giving Special Olympic athletes across the country the clearance to participate in the Games. No one is ruled out based on their physical limitations. Instead, family physicians identify what limitations the athlete has, and Special Olympics uses that information to adapt the activity to the athlete.

"There are a hundred different things these kids can do. Why exempt them for the one thing they can't do?" says Dr. Zlotnick.

"Family physicians are the reason that MedFest is possible. I think that's a testament to the kind of people involved in family medicine - we are willing to do whatever we can to help people make the most of their lives."

Recently, Dr. Zlotnick was recognized for his work and dedication to SONJ. At the 2015 Special Olympics New Jersey Awards Dinner, he was inducted into the SONJ Hall of Fame for his 20 years of service to the organization, the development of the MedFest program, and the countless pre-participation exams he has completed. Presented each year to an individual who has advanced the Special Olympics movement, Dr. Zlotnick is the first volunteer physician to receive this honor.

"It takes a lot to make me speechless, but receiving this honor has left me without words," says Dr. Zlotnick. "I am excited and thrilled to be honored to this degree by such a tremendous organization." ▲

than 1,000 consumers and found that one-fourth of the respondents used self-diagnostic technology as often as they visited their doctor. About the same number of patients said that they used these tools instead of visiting their doctor.

While these concepts may be frightening to some, imagine a world where physicians are able to leverage technology to gather real-time data on their patients with chronic conditions, and then get alerts on patients who are trending in the wrong direction, and then focus their attention on those patients. This is work that no person can do without the aid of technology, and I submit that when that technology is utilized to its best potential, the relationship between patient and physician will become more, not less, important. That is, provided the physician has embraced that technology and is guiding the patient toward the appropriate use and understanding of those tools.

If health care is complex now, if patients with chronic conditions are confused today, if their family caregivers are both physically and mentally exhausted from the pressure of both caring for, and understanding the needs of their loved one, and if the family physician is truly the best physician to manage care and help the patient and their family navigate the choppy and complicated waters of the healthcare system in the current environment, won't it be more important that the physician and patient cultivate that relationship to understand and sort through the noise created by the volumes of data created? Won't it be critical that patients understand not just the "what," but the "why" of the data gathered? Parenthetically, won't the e-visit or tele-visit improve the cultivation of that relationship?

The change isn't coming. It's here. The technology that we are already using in health care is just the tip of the iceberg. Consider that right now there is a little robot – coincidentally named "Opportunity" – rolling around Mars taking samples of everything it finds, analyzing it, and making determinations about what is and isn't there. Certainly, the scientists here on Mother Earth have a lot to say about the interpretations of the data that robot spits out, but the robot is making the initial diagnosis. While we are talking about the novelty of physicians connecting with their patients across video screens instead of in-person in an exam room, and while we ponder just where we will find the people to process the huge amounts of population-health data we collect in order to use that data most effectively, the leading edge is artificial intelligence that will process data and make decisions – and if we allow ourselves to believe that such artificial intelligence will capture the science but certainly never the art of medicine, guess again. Watson can sing too, and I'll bet that there are quite a few of you still reading this article who are wearing a Fitbit on your wrist. ▲

References

1. http://www.mooreslaw.org/
2. Patrick, JR. (2015). Health Attitude: Unraveling and Solving the Complexities of Healthcare. Palm Coast, FL.

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ments for both the employer and the employee. Applicable Large Employers are required to prepare and file IRS Forms 1095-C and 1094-C. Form 1095-C reports information about the health insurance coverage and enrollment information. This form is provided to all full time employees to send in to the IRS along with their tax returns. Form 1094-C is filed as a transmittal document by the employer along with Form 1095-C and provides a summary to the IRS of aggregate employer-level date. Form 1094-C helps the IRS to determine whether an employer is subject to an employer penalty.

What are your next steps?

1. Determine if you are an "Applicable Large Employer;"
2. Review your policies and procedures, including your Employee Manual to ensure that the policies are consistent with the ACA requirements;
3. Develop or obtain certain employee forms such as a Waiver Form for eligible employees who do not elect coverage;
4. Develop a communication plan to speak to your employees about who is eligible for healthcare coverage, when coverage is available and what coverage is provided;
5. Assess your ability to track variable hour employees and to prepare end of year IRS forms, look into vendors such as payroll/benefit companies to assist you with this.

For more information on Applicable Large Employers, visit: https://www.irs.gov/Affordable-Care-Act/Employers/Information-Reporting-by-Applicable-Large-Employers ▲

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CME *Quiz*

ANSWERS:

1. False - HPV types 16 and 18; 2. True; 3. False – age 26; 4. True; 5. True; 6. True; 7. False - Diagnosis is confirmed by standard cytogenetic analysis (karyotype); 8. True; 9. True; 10. False – The recommended limit is no more the 1-2 hours per day

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