

NJDOH Sports Pre-Participation Module is Now Available!

VOLUME 14, ISSUES 1 & 2 • 2015

Perspectives

A VIEW OF FAMILY MEDICINE
IN NEW JERSEY

NJAFP TO GATHER AT CAESARS

Time for the 2015 Scientific Assembly
The New Jersey Family Medicine Conference

Journal of the New Jersey
Academy of Family Physicians

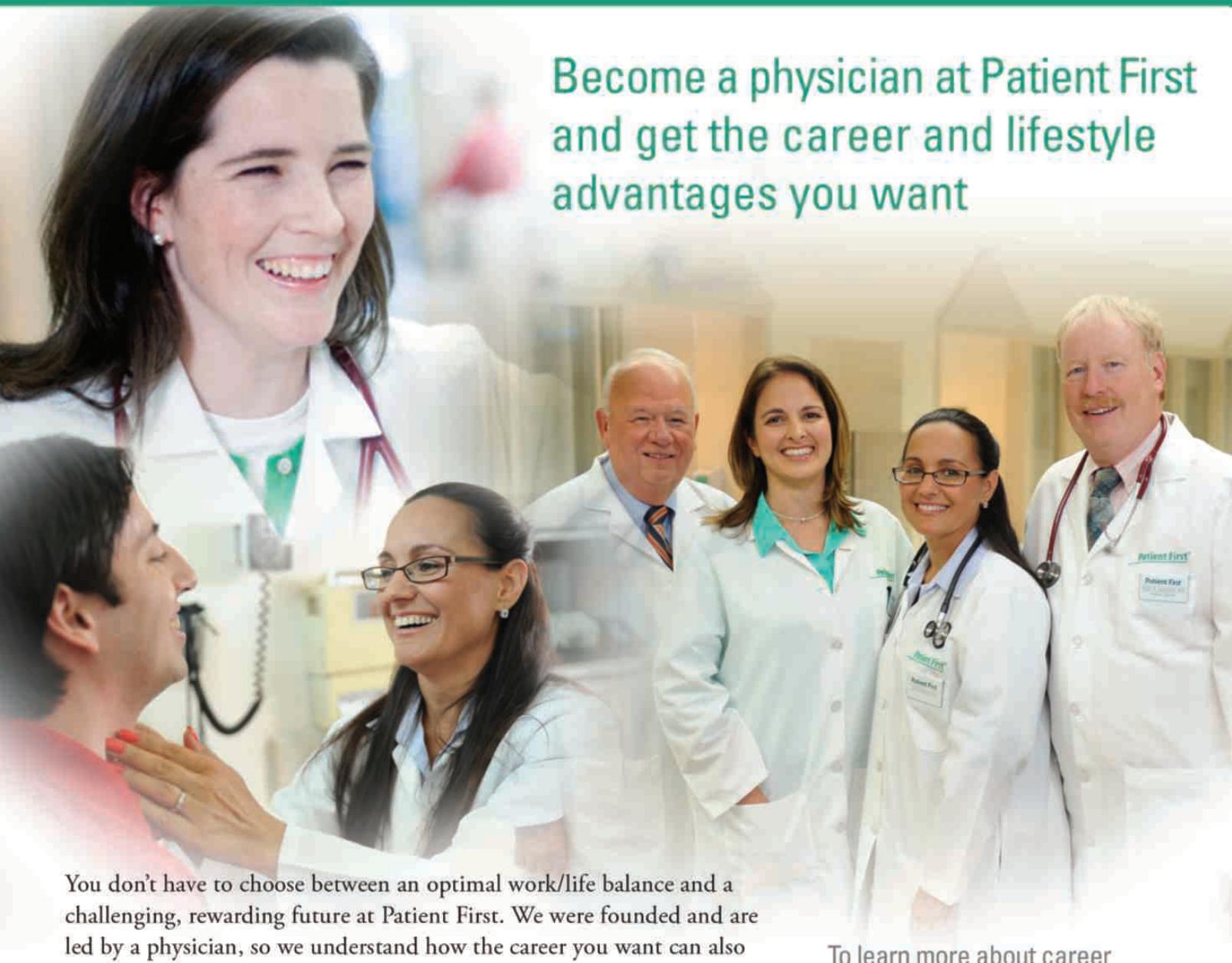


NJAFP

Permit # 220
Belmar, NJ
PAID
U.S. POSTAGE
FIRST CLASS MAIL

There are WORKPLACES. And there are FAMILIES.

Become a physician at Patient First
and get the career and lifestyle
advantages you want



You don't have to choose between an optimal work/life balance and a challenging, rewarding future at Patient First. We were founded and are led by a physician, so we understand how the career you want can also include work flexibility, a family atmosphere, a great salary, and outstanding benefits. We're one of the leading primary and urgent care providers throughout the mid-Atlantic—and continuing to grow. Patient First is looking for full and part-time primary care physicians who want:

- Competitive salary
- Team-oriented environment
- Flexible schedule
- Career advancement opportunities
- Excellent malpractice insurance
- Health, dental, vision, life, and disability insurance

To learn more about career opportunities at Patient First, contact Recruitment Coordinator Eleanor Dowdy at 804-822-4478 or eleanor.dowdy@patientfirst.com or visit prcareers.patientfirst.com/

Patient First®



NJAFP
New Jersey Academy of Family Physicians
SCIENTIFIC ASSEMBLY

June 12-14
CAESARS
ATLANTIC CITY

June 11
Pre-Conference Symposium:
Advanced Topics in Healthcare Delivery

REGISTER TODAY at www.njafp.org/scsa

Register TODAY for the largest CME

conference in New Jersey completely dedicated to **Family Medicine**. Network with friends and colleagues to learn and explore the exciting topics we've prepared for you to help you deliver the best quality care for your patients! New this year are two hands-on workshops!

Cheer on your favorite team as they compete for the Coveted NJAFP Resident Knowledge Bowl Cup. 2014 defending champs, *Inspira of Woodbury* stand proud and at the ready. Who will win the honor in 2015? Come see the excitement.

Visit our **Exhibit Floor** to learn what's new in the industry to enhance coordinated care and build on quality outcomes.

Bring your insights to the **House of Delegates** on Friday, June 12 and help us forge a purposeful plan for 2015.

Dine and dance the night away to the awesome sounds of the *Kenny I Orchestra* at the President's Gala.

Finish your weekend with the **SAM Study Hall** on Mental Health. It's all here for you at the beautiful

CAESARS Atlantic City Hotel !



**"You don't get medals for trying,
you get medals for results."**

BILL PARCELLS

Hall of Fame Coach

Now Powered by Liberty Mutual

Bill Parcells understands what it takes to win. After all, he has had his share of success facing the highest levels of competition during his career. That's why it's no surprise Coach Parcells has selected to endorse NJ PURE as the leading medical professional liability insurer in New Jersey. Born and raised in New Jersey, like NJ PURE, he believes that integrity, transparency and stability are the ingredients it takes to make a champion. "With a track record of hard work and dedication to physicians, NJ PURE's rise to the top of the insurance field is no surprise to me," says Bill Parcells.

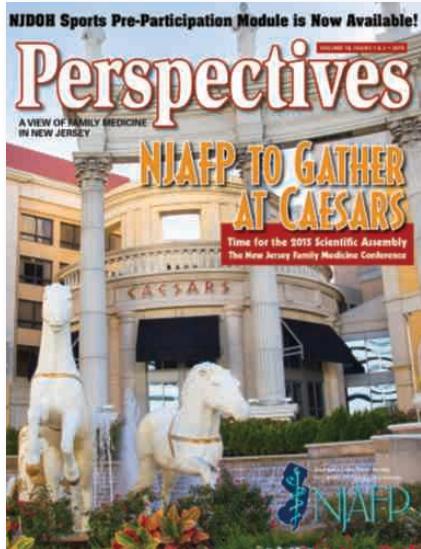
Experience what it's like to be insured by a championship team, contact NJ PURE directly for more information and a quote.

Call 877.2NJ.PURE (877.265.7873) or visit NJPURE.com

NJ PURE
Integrity • Transparency • Stability

IN THIS ISSUE

Volume 14, Issues 1 & 2 • 2015



On the Cover

Register today for the 2015 NJAFP Family Medicine Conference. This CME event was designed with you in mind. Join us to learn, network and celebrate. Register at www.njafp.org

President's View	6
Executive Vice President's View	7
Academy View	9
Clinical View	10
CME Quiz	17
Quality View	18
Government Affairs View	19
New Jersey View	20
Practice Management View	23
Resident View	25
Physician Profile View	27
Special Projects View	28
Closing View	30
Foundation View	31

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

MCKELLA280

Printed by McKella280, Pennsauken, NJ 08109

856-813-1153 • www.mckella280.com

©2015 New Jersey Academy of Family Physicians

Pack your Bags. We've been summoned to the Palace

It is hard to believe that we are getting ready to head to the shore in just a few short weeks we will be heading to Atlantic City for the annual meeting. You might notice a few changes to this year's meeting. We have retired the flip flops, and while we still plan to celebrate, we realized that celebrating was just one part of the entire annual meeting experience.

So we have embarked on the journey of re-vamping and re-energizing the annual meeting. This is not a quick process, nor is it something that can be done without your input. We hope to send out a member survey after this year's meeting to hear from you what you think the meeting should be. Whether you choose to attend the meeting or not, we hope you will take the time to complete the survey when it shows up in your inbox.

Our first step on the journey to a new experience is a name change. Mark your calendar for June 12 to 14 and plan to attend the **2015 Scientific Assembly: The New Jersey Family Medicine Conference**. While many things will remain the same, we also have some new experiences planned.

One new experience is the location of the meeting. For the first time in many years, are going to a brand new venue for the NJAFP. Caesar's Atlantic City will be home for this year's meeting. We think you will be very pleased with this venue. Not only are the boardwalk and The Pier a few steps away, award-winning chef Gordon Ramsay has opened his first restaurant in Atlantic City, Gordon Ramsay's Bar and Grill.

However, the highlight of the meeting are the educational sessions the committee has put together. We will not only have a range of clinical topics from experts in their fields to help you stay up-to-date on advances in patient care, we have also added two new skill building workshops to the agenda. Jeff Zlotnick, MD who holds a CAQ in sports medicine will be reprising his very popular casting and splinting skills clinic and dermatologist, Maria Abello-Poblete, MD will be hosting a dermatology workshop.

We also have two exciting plenary speakers. Mike Sevilla, MD, a family physician in Ohio and a nationally known social media expert who was dubbed the "King of Family Medicine Social Media" by then AAFP President, Glen Stream, MD - will be discussing how family physicians can use social media in their practices. And speaking of Dr. Stream, he will be joining us to provide an update on the "Health is Primary" campaign and Family Medicine for America's Health. You don't want to miss these two very engaging and informative presenters.

The pre-conference, *Advanced Topics in Healthcare Delivery* is returning for its third year. This very popular symposium will give you access to experts in the delivery of advanced patient-centered care models. In addition to the education, the winners of the Annual NJAFP Patient-Centered Innovation Awards will be announced. These awards recognize New Jersey practices and care teams who have had a positive impact on patient care through their unique and innovative programs and projects.

continued on page 28



REFLECTIONS

Krishna Bhaskarabhatla, MD, MSc, FAAFP

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



HE ON-GOING DISRUPTION in health care can bring anxiety to anyone, myself included. However, I had a lucky escape to Kansas City in late April, representing NJAfp at the AAFP Annual Chapter Leadership Forum. What a wonderful, rejuvenating experience. Several hundred family physicians, from seasoned veterans to those still early in their careers or in training, along with many

chapter staff leaders converged on Kansas City to learn how to become better in our role as leaders. For the last 25 years, AAFP has been providing leaders in family medicine opportunities to enhance their skills through ACLF and the concurrent National Conference of Constituency Leaders (NCCL) – a leadership and policy development event for women, minorities, new physicians, international medical graduates, and GLBT physicians, as well as several constituencies based on practice patterns, environments, and models.

Being @aafpACLF was quite an experience! What a vibrant group of talented human beings. The energy was everywhere and it was infectious! Each time I have come to Kansas City it is a new and better experience. On day one, Dr. Robert Wergin, our AAFP

entered my vocabulary. R&D – translated to “Rip off and Duplicate” - and “no need to re-invent” were phrases that resonated through the speech of AAFP President Dr. Wergin. The networking brought me to peers from Montana to Maine. The rooms and hallways were buzzing with the themes of leadership, governance, various models of care, and new and value-based payments. There were also “Ask the experts” sessions” and “office hours” to meet

panel members and speakers. On the last day, I could not stop from bragging about our annual Resident Knowledge Bowl which then became a favorite topic at the Presidents’ (networking) breakfast.

Several well-crafted sessions gave me insight into the ongoing healthcare transformation, leadership opportunities and challenges, issues in governance, communication and advocacy, patient engagement and GME funding and training. Colonel Mike Mullane, a former space shuttle astronaut, in his awesome keynote reflected on his NASA experiences and gave sound advice: to counter “Normalization of Deviance” in teamwork and safety. He cautioned us to remember our vulnerability, and reminded us that if it happened to NASA it can happen to anyone. Mr. Steve Gutzler’s talk on the impact of emotional intelligence on personal and leadership development was also very inspiring.

On my way home, I was thinking about the opportunities and concerns in this new era of health care. On the positive side, there is overwhelming evidence that strong primary care is associated with better outcomes at lower cost. However, we see continued expansion of the income gap between primary care physicians and subspecialty physicians. How can we motivate medical students to embrace primary care careers when they face huge financial debts? The income gap also limits the ability of family physicians to invest in and sustain practice transformation. The continued delay in the development of new payment models is not helpful. Some silver lining: early innovations and primary care transformation projects have demonstrated successful ways to improve primary care effectiveness and efficiency and, if done well, to return joy to practice.

As we face the new realities, our strategy must reflect a fundamental purpose. We must ask what is it that we are trying to achieve and for whom? As Family Medicine for America's Health evolves, we have to make changes and adapt to the



AS WE FACE THE NEW REALITIES, OUR STRATEGY MUST REFLECT A FUNDAMENTAL PURPOSE. WE MUST ASK WHAT IS IT THAT WE ARE TRYING TO ACHIEVE AND FOR WHOM?

President opened the sessions with the ecstatic words: “We did it” and “SGR is dead!” It was also announced that, “We are the largest professional organization in the nation with 120,900 members!” Opportunities to continue to dialogue and socialize with new and long-time friends and colleagues abounded.

It did not take long to become a Twitter follower of @HealthisPrimary and #aafpACLF. The terms “unconference” and “flipped classrooms”

continued on page 24

DING DONG, THE WITCH IS DEAD...

Raymond J. Saputelli, MBA, CAE

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 New Jersey.

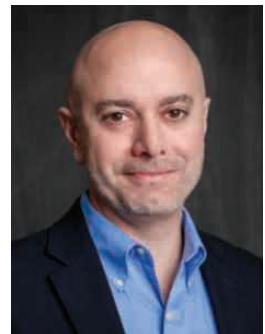
The SGR is dead and Family Medicine, the primary care community, and to some degree the greater universe of organized medicine, rightfully celebrate the victory of an almost 20 year advocacy struggle to repeal what many knew was a flawed system at its inception. Unfortunately, it's not often we get a "win" in family medicine these days. I sometimes equate the struggle to the card player who is on such a tough streak that he celebrates a "push." So I am all in favor of waving the flag whenever we get the opportunity. Still, I can't help but be reminded of the classic movie, *The Wizard of Oz*, when the leaders of Munchkinland realize that Dorothy's house has landed on the Wicked Witch of the East and break out in celebratory song, only to find that the evil sister is still lurking – and she is none too pleased. So the SGR is gone, but what is lurking in the background and what does it mean? There are things we know, things about which we have less detail but are apparent, and

“ ...it's not often we get a 'win' in family medicine these days. So I am all in favor of waving the flag whenever we get the opportunity.

things that are simply myth. There is also one clear truth; while we have true reason to celebrate – remember that the alternative was a 25% reduction in SGR (Medicare) payments - there is still much work to be done.

So what do we know? Essentially we know that the SGR has been repealed and the annual fear of sharp, in many cases, untenable decreases in payment will no longer be a part of our dialogue. We know that all physicians participating in the Medicare program will receive an annual 0.5% update, with a 2.5% cumulative increase through 2019. We know that for those five years the Physicians Quality Reporting System (PQRS),

Meaningful Use (MU), and Value-Based Modifier (VBM) programs will continue, and maximum penalties will exceed 10% by 2018. We know that for years 2020-2025 the annual update is set at 0.0%. We know that for years 2026 and forward the annual update is set at 0.75% qualifying Alternative Payment Models (APMs) participants and 0.25% for all other physicians.



We also know that the new law continues the recent trends of prioritizing primary care, codifies the patient-centered medical home, emphasizes care coordination, and recognizes the contributions of primary care toward achieving the triple aim. Finally, we know that beginning in 2019 there will be two distinct payment pathways: Alternative Payment Models (APMs), such as participation in ACOs or PCMH practices, or the Merit-Based Incentive Payment Program (MIPS), which will remain fee-for-service based. While much of the details are still subject to regulatory definition, it is clear that the MIPS program will consolidate the existing programs – MU, PQRS, and VBM into one single program, and Medicare payments made to practices that are not qualifying or partially qualifying APMs participants will be adjusted upward or downward based on performance. Alternatively, practices that receive a substantial share of their revenue through APM(s) that bear more than nominal financial risk, and have a quality measurement and an EHR component would receive a 5% annual bonus each year from 2019-2024. Moreover, practices that receive a substantial share of their Medicare / Medicaid revenue through a medical home expanded under CMMI are eligible to be a qualifying APM, without bearing financial risk, and these qualifying and partial qualifying APMs are exempt from the reporting and performance thresholds established by MIPS. Cutting through the smoke, what this means to most family physicians is that PCMH practices are exempt from MIPS. NJAFP's Practice Transformation team, led by Cari Miller, stands ready to assist those practices who wish to choose the PCMH path.

There are also several myths that need to be clarified, perhaps the most important of which is that MACRA (the law that eliminates the SGR) eliminates fee-for service. This is not the case. Under MACRA, fee-for-service remains a payment system for Medicare Part B services under the Medicare Physician Fee Schedule, although it will be greatly influenced by the MIPS program. Another misperception on the part of some is that MACRA mandates participation in MOC. In reality, it merely suggests that the newly established Clinical Quality Improvement (CQI) component of the MIPS program

continued on page 8

Perspectives: A View of Family Medicine in New Jersey

The Journal of the New Jersey Academy of Family Physicians



Managing Editor

Theresa J. Barrett, PhD, CMP, CAE

Medical Editor

Sara B. Leonard, MD

Editorial Board

Everett Schlam, MD
Adity Bhattacharyya, MD
Richard L. Corson, MD

Contributing Photographers

Theresa J. Barrett, PhD, CMP, CAE
Candida Taylor

STAFF

Executive Vice President

RAYMOND J. SAPULETTI, MBA, CAE
Ray@njafp.org

Deputy Executive Vice President

THERESA J. BARRETT, PhD, CMP, CAE
Theresa@njafp.org

Senior Project Facilitator

CATHY CARDEA, RN, MSN, PCMH, CCE
Cathy@njafp.org

Accounting Manager

ROBBIN COMISKI
Robbin@njafp.org

Insurance Programs Administrator

JOHN ELTRINGHAM, CPCU
Insurance@njafp.org

Project Facilitator

KAREN FOSTER, RN, MSA
Karen@njafp.org

Administrative Associate

NATALIE GILLETTE
Natalie@njafp.org

Project Support Associate

PAMELA JOYCE
Pam@njafp.org

Government Affairs Director

CLAUDINE M. LEONE, Esq.
Claudine@njafp.org

Director, Private Sector Advocacy and Project Operations

CARI MILLER, MSM, PCMH CCE
Cari@njafp.org

Project Facilitator

TARA PERRONE, MHA
Tara@njafp.org

Office Manager & Membership Services

CANDIDA TAYLOR
Candida@njafp.org

OFFICERS

President

KRISHNA BHASKARABHATLA, MD
973/812-1010

President Elect

ROBERT T. GORMAN, MD
973/239-2600

Vice President

ADITY BHATTACHARYYA, MD
609/815-2671

Treasurer

PETER LOUIS CARRAZZONE, MD
973/636-9000

Secretary

LAUREN CARRUTH, MD
609/788-4419

BOARD MEMBERS

Board Chair

THOMAS A. SHAFFREY, MD
732/560-0490

Board of Trustees

Max Burger, MD 2015
Michael A Cascarina, MD 2016
Maria F. Ciminelli, MD 2016
Frank Iannetta, MD 2015
Christina Medrano-Phipps, MD 2016
Anthony G. Miccio, MD 2017
Jeffrey S. Rosenberg, MD 2017
Kathleen Saradarian, MD 2015
Kelly G. Ussery-Kronhaus, MD 2017

New Physician Trustees

Sara B. Leonard, MD 2016
Lisa W. Lucas, DO 2016

Resident Trustees

Gerald C. Banks, MD 2015
Robert Kruse, MD 2016

Student Trustees

Cheryl Monteiro 2016
Rodrick L. Stewart 2015

Voting Past Presidents

Thomas S. Bellavia, MD 2015
Joseph W. Schauer, III, MD 2015

AAFP Delegates

Mary F. Campagnolo, MD 2015
Arnold I. Pallay, MD 2016

AAFP Alternates

Salvatore Bernardo, Jr., MD 2015
Terry E. Shlimbaum, MD 2016

New Jersey Academy of Family Physicians

224 West State Street
Trenton, NJ 08608
Phone: 609/394-1711
Fax: 609/394-7712

E-mail: office@njafp.org
Web site: www.njafp.org

Subscriptions for non-NJAFP members are available for \$50 per year. Contact the NJAfp office for information.

Perspectives: A View of Family Medicine in New Jersey is published four times a year by the New Jersey Academy of Family Physicians. Deadlines for articles and advertisements may be obtained from the NJAfp office. The editors reserve the right to accept or reject any article or advertising material. Some material may be submitted to the Board of Trustees for review.

The views, opinions, and advertisements in this publication do not necessarily reflect the views and opinions of the Board of Trustees, members or staff of the New Jersey Academy of Family Physicians unless stated.

Copyright © 2015 New Jersey Academy of Family Physicians

DING DONG, THE WITCH IS DEAD... *continued from page 7*

will include a menu of recognized activities and that within the specified subcategory of patient safety and practice assessment, one of the possible activities that CMS may establish for achieving MIPS points is through practice assessments related to maintenance of certification. The important takeaway here is that this is not a mandated activity, but rather one that may be eligible to meet certain requirements of MIPS. Essentially, most family physicians are already participating in MOC programs for their boarding, and these MOC programs may help them meet certain requirements in MIPS, but even that is only relevant to those family physicians who don't follow the Alternative Payment Model pathway where PCMH would exempt them from MIPS anyway.

Finally, many believe that MACRA does nothing to assist small independent and solo practices. Again, not true. In fact there are three important provisions of the law that are designed to assist small and solo practices in remaining independent. The first of these provisions will allow unaffiliated physicians to be evaluated in the MIPS as a part of a virtual group. The second allows independent physicians to share risk without having to affiliate with a large system or Accountable Care Organizations (ACOs), and the third, and perhaps most important of the three for most family physicians requires an evaluation of fraud and abuse laws like the Anti-Kickback Statute which may unintentionally be making it difficult for physicians – particularly independent physicians – to share risk in value-based models. Each of these

provisions, like much of the law, is subject to regulatory action, and as we all know too well the devil often hides in the details, but the Academy nationally and here in New Jersey will be vigilant in working with CMS and other regulatory agencies to ensure that the spirit of the new law is maintained in its final implementation.

I've heard it said that stealing from one source is plagiarism, but stealing from many sources is research. If that is the case, much of this article was blatantly plagiarized from Shawn Martin, AAFP Vice President of Practice Enhancement and Advocacy, and as such I extend my gratitude. Moreover, the AAFP has compiled significant resources on MACRA including a list of FAQ's that are updated as more information becomes available. Those resources can be found at <http://www.aafp.org/practice-management/payment/macra-payment.html>.

As I said at the outset, we have won a battle, and as such there is cause for celebration, but the war is far from over. Family physicians across the country still face an uphill climb to see the value they bring to the system appropriately recognized. Nowhere is that more true than in New Jersey, where the practice environment for most is near, if not completely, untenable. The NJAfp remains committed to changing that so that every patient in New Jersey continues to have access to a family physician – the physician who provides the highest quality, most cost effective care available. ▲



EBOLA UPDATE

WHILE EBOLA has faded from the U.S. national news cycle, it still remains a threat to many in West Africa. While Liberia has been declared ebola free, Guinea and Sierra Leone remain the countries with the most widespread transmission of Ebola. As of May 12, 2015 the number of suspected, probable, and confirmed cases of Ebola was 16,151 with the number of deaths at 6,303. Fortunately, progress is being made in fighting the virus, in the beginning of 2015 these numbers were 24,202 and 9,936, respectively.

Source: <http://www.cdc.gov/vhf/ebola/outbreaks/2014-west-africa/case-counts.html>.
Photo credit: <http://absolute-news.com/2014/07/ebola-virus-pictures-images/>

What Have You Done For Me Lately?

NJBIZ ran an article earlier this year entitled, "Medicare initiative is paying off in terms of cost and care, particularly in New Jersey," which detailed the Comprehensive Primary Care Initiative (CPCI).¹ New Jersey is one of the states participating in this program.

CMS reported that at the end of the project's first year (September 30, 2013), hospital admissions decreased 2% and emergency department visits decreased 3%. Overall, the entire program almost broke even on cost. However, New Jersey did better than break-even, achieving a 3% reduction in Medicare spending after the additional funds were provided to primary care practices who were participating in the project.

The NJAfp has been working with practices for the last seven years to help physicians transform their practices. Ray Saputelli, MBA, CAE, Executive Vice President of the NJAfp was quoted in the article saying, "One of the things we have learned is that a lot of this work is difficult and time consuming and resource intensive. So there is going to need to be continued attention paid to ensuring that, as we change the payment model, the payments keep up with the level of resources required to do this kind of work."

The full article can be found at <http://www.njbiz.com/article/20150129/NJBIZ01/150129703/Medicare-initiative-is-paying-off-in-terms-of-cost-and-care-particularly-in-New-Jersey>

Reference

1. Fitzgerald B. Medicare initiative is paying off in terms of cost and care, particularly in New Jersey. In: NJBIZ; 2015.

New Jersey Medicaid ICD-10 Update

THE CMS MANDATE for ICD-10 Diagnosis and Surgical Procedure code implementation has been postponed until October 1, 2015. Below is the latest notice we have received from CMS concerning ICD-10:

On April 1, 2014, the Protecting Access to Medicare Act of 2014 (PAMA) (Pub. L. No. 113-93) was enacted, which stated that the Secretary may not adopt ICD-10 prior to October 1, 2015. Accordingly, the Department of Health and Human Services expects to release an interim final rule in the near future that will include a new compliance date that would require the use of ICD-10 beginning October 1, 2015. The rule will also require HIPAA-covered entities to continue to use ICD-9-CM through September 30, 2015.

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

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

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

AACE/ACE Issues New Guidelines for Type 2 Diabetes

New, more comprehensive guidelines on optimal care for patients with type 2 diabetes have been issued by the American Association of Clinical Endocrinologists (AACE) and American College of Endocrinology (ACE). To aid physicians and other healthcare professionals an easy-to-use algorithm has been included.

This guideline updates the 2011 guidelines and 2013 algorithm. Included with this guideline are significant changes related to choosing antihyperglycemic agents and managing hypertension, hypoglycemia and nephropathy in patients with type 2 diabetes. Also covered in the new guidelines is information on how to help manage patients who have occupations where hypoglycemia can pose a significant risk.

More information can be found at:
<http://www.medscape.com/viewarticle/842957>.



PAIN MANAGEMENT AT END OF LIFE

Stephen Goldfine, MD, DABFP, CAQGM, DABHP

Dr. Stephen Goldfine is the full-time chief medical officer for Samaritan Healthcare & Hospice in Marlton, NJ, the first and largest hospice in southern New Jersey.

Dr. Goldfine has nothing to disclose relevant to this article.

Pain is a common symptom near the end of life. In fact, in the final two days of life, 50% of patients experience moderate to severe pain.¹ But with proper pain management, patients' suffering can be minimized and their quality of life can be improved.

Pain management involves four steps:

- Identify pain
- Assess the pain
- Develop and implement a Plan of Care
- Evaluate the Plan of Care and revise as needed²

To understand and treat pain, we must first define it. The International Association for the Study of Pain explains it as "an unpleasant sensory and emotional experience associated with actual or potential tissue damage."³ Palliative medicine takes a more expansive view, describing pain as "whatever the person experiencing it says it is."⁴ Pain affects people on multiple levels: physical, emotional, spiritual, functional, and social. It can trigger a cascade of adverse effects, including decreased autonomy, challenges to the patient's dignity, fear, anxiety, and depression. Accordingly, all disciplines can be involved in treating the multi-dimensional experience of pain.

Barriers to Pain Relief

Despite pain's negative impact and the existence of effective treatments, many barriers can block access to pain relief. These barriers have three main sources: healthcare professionals, health care systems, and patients/families.

Professional barriers include lack of training in pain management, lack of knowledge about current therapies, fear of prescribing schedule II drugs, concerns about addiction, worries about side effects, and the subjective nature of pain. Patients and families often create barriers by hesitating to report pain. They may view pain as inevitable, or simply a sign of advanced disease, so they suffer in silence. They may be reluctant to take pain medication due to fear of addiction or concern about appearing "weak." There may be cultural barriers or religious concerns. Other barriers include discomfort with the route of medication administration, or fear of unmanageable side effects.

Nevertheless, providers have a moral and ethical responsibility to address patients' pain. Providers must bear in mind three

ethical principles surrounding pain management: beneficence (doing good), non-maleficence (avoiding harm), and autonomy (self-determination). These tenets are linked to a legal principle called the "double effect," which involves taking an action intended to have a good effect, but with a known bad effect. The good effect must be produced by the *action*, not by the bad effect. For example, giving morphine can have the bad effect (or side effect) of decreasing respirations. However, we give it for the good effect of pain control, not for the bad effect.

Identify and Assess

To identify and assess pain, the physician should conduct a pain history, physical exam, and laboratory/diagnostic evaluation. The physical exam should include:

- Location (site of pain/adjacent sites)
- Description/quality of pain
- Intensity (1-10 pain scale, faces pain scale)
- Onset, duration, variations
- What relieves/increases the pain
- Effect on function
- Previous interventions and efficacy of treatment⁵

Providers must also pay attention to nonverbal cues, including fatigue, grimaces, moaning, and new irritability. Pain assessments should be conducted at regular intervals (during each visit), with new reports of pain, and after a change in therapy. Ask the patient to use a pain diary, and review it at each assessment. Those most at risk for under-treatment for pain include children and older adults, veterans (who may be stoic), non-verbal or cognitively impaired patients, people who deny pain, non-English speaking patients, those from other cultures, and patients with a history of addictive disease.

Substance Abuse Issues

Many providers are concerned about treating patients with a substance-abuse history. But pain must be treated, regardless of a patient's history. In fact, higher doses may initially be required, due to preexisting individual differences or drug-induced neuroadaptations.⁶ Family physicians can also help prevent, identify and treat substance abuse. When managing such patients' pain, physicians should monitor drug-seeking behaviors. Use a team-based approach with written contracts, and watch for the signs of addictive drug use, including resistance to changes in therapy despite adverse side effects, drug hoarding, and noncompliance. Also, note that the patient may attempt to control the assessment and apply psychological pressure on the

healthcare provider.

All healthcare providers are involved in the assessment, medication, and direct care of drug seekers. However, the provider is obligated to do no harm. For instance, to knowingly support addictive or illegal behaviors is unethical and illegal. Do not remain a silent objector. At the same time, a provider must accept the patient's report of pain. It's better to err on the side of providing adequate pain relief than to let patients suffer for fear of promoting addiction.^{7,8,9}

Physicians can help prevent substance abuse by following these guidelines for outpatients:

- When opioid analgesics are required, select long-acting formulations
- When possible, prescribe drugs with a slow onset of action, which tend to have a low street value
- Order only a one-week supply of analgesics at a time if you suspect drug diversion
- Use less-frequent dosing, which may increase patient adherence to the plan of care

Treatment

Providers should help patients make their own decisions and determine their own actions with regard to pain management. Within my palliative and hospice practice, our goal is to reduce pain as quickly as possible, and preferably to a comfortable level within 48 hours of admission to a hospital, hospice or other facility.

Several narcotics can be highly effective at relieving pain. These include, from most to least potent: fentanyl, hydromorphone, morphine, methadone, and oxycodone. All opioids behave similarly, while having marked differences between dosing routes, dose ceilings, toxicity, onsets, peaks and durations, costs, and even stigmas.

Patients whose pain is managed with opioids can still experience breakthrough pain – a flare-up of sudden, moderate-to-severe pain. Breakthrough pain typically occurs one to four

times per day and is of relatively short duration. It can be related to "end of dose" failure. Breakthrough pain can be managed with a variety of non-pharmacologic treatments, including cognitive-behavioral therapies (relaxation, imagery, distraction, support groups, pastoral counseling), physical measures (heat, cold, massage), and/or complementary therapies.

A patient may become physically dependent on an opioid or other medication, so these drugs must be stopped gradually to avoid withdrawal symptoms like nausea, sweats, anxiety, and tremors. Patients may also build up tolerance to pain medications, so that a larger dose is needed to produce the same level of relief. This is common with non-malignant pain syndromes. Many options are available to manage pain near the end of life. Pain relief is a moral and ethical responsibility for all healthcare providers, at any stage of their patients' lives.

References

1. SUPPORT principal investigators (1995). A controlled trial to improve care for seriously ill hospitalized patients: The study to understand prognoses and preferences for outcomes and risks of treatments (SUPPORT). *JAMA*, 274 (20):1591-1598.
2. Hanks G, Cherney NI, Christakis NA, Fallon M, Kaasa S, & Portenoy RK. (eds.) (2010). *Oxford Textbook of Palliative Medicine* (4th ed.), New York: Oxford University Press.
3. Merskey H, & Bogduk N. (eds) (1994). Part III: Pain Terms, A Current List with Definitions and Notes on Usage. *Classification of Chronic Pain* (2nd ed.), International Association for the Study of Pain Taxonomy, Seattle: IASP Press, 209-214.
4. McCaffery M. & Pasero, C. (2010). *Pain Assessment and Pharmacologic Management*, St. Louis, Missouri: Mosby Elsevier, July 3, 2010.
5. Bial A, & Levine S. (2008) Assessment and Treatment of Physical Pain Associated with Life-Limiting Illness. (3rd ed.) *Hospice and Palliative Care Training for Physicians: A Self-Study Program*, Storey CP, Jr. Levine S, & Shega JW. (Eds.).
6. Dotts T. (2011). Access to pain management hampered by addiction fears, government regulations. *HemOnc Today*, July 10, 2011.
7. Prater CD, Zylstra RG & Miller KE. (2002). Successful pain management for the recovering addicted patient. *Primary Care Companion, Journal of Clinical Psychiatry*, 4 (4), 125-131.
8. Reisfield GM, Wilson GR, & Paulian GD. (2009). Substance Use Disorders in the Palliative Care Patient. *Fast Facts* (2nd ed.), Marks S. & Rosielle DA. (Eds.). #127, April 2009. www.cpc.org
9. Weissman DE. (2009). Pseudoaddiction. *Fast Facts*, Marks S. & Rosielle DA. (Eds.). #69, April 2009. www.cpc.org



Indicators of and Screening for OSA

Matthew Scharf, MD, PhD and Ilene M. Rosen, MD, MSCE

Ilene Rosen, MD, MSCE serves on the board of directors for the American Academy of Sleep Medicine (AASM) and is board-certified in sleep medicine, internal medicine and pulmonary medicine. She is the program director for the University of Pennsylvania Sleep Fellowship and an associate professor of clinical medicine in the Perelman School of Medicine.

Dr. Matthew Scharf received his MD and PhD from the University of Pennsylvania where he subsequently completed a residency in neurology and a fellowship in sleep medicine. He has published numerous articles on behavioral neuroscience. He is currently studying the link between sleep disturbance and dementia.

Drs. Rosen and Scharf have nothing to disclose relevant to this topic.

Case: A 49 year old man with a history of GERD and depression presents for his annual physical. He denies any significant complaints except that he is exhausted which he attributes to increased demands at work. He reports difficulty staying awake at meetings and when working on his computer. He notes a 10-pound weight gain over the past 6 months. On further questioning, he admits to loud snoring and nocturnal gasping for air. Upon awakening, he sometimes finds that his wife has left the bedroom. His medications include omeprazole and escitalopram. His current blood pressure is 148/102, and his body mass index is 31.71 kg/m². A fasting comprehensive metabolic panel is normal except for a glucose of 104 (normal=70-99). He is started on hydrochlorothiazide and referred to a sleep specialist.

OBSTRUCTIVE SLEEP APNEA (OSA) is a common condition in the United States and worldwide. Prevalence estimates range from 2-7% in the general population¹ but is particularly high in certain cohorts. A prevalence of OSA of over 70% has been reported in obese type 2 diabetics,² in patients undergoing bariatric surgery,^{3,4} and with drug-resistant hypertension (HTN).⁵ The prevalence of OSA is also high in patients following acute stroke⁶ and acute coronary syndrome,⁷ as well as in the elderly.⁸⁻¹⁰ However, the majority of cases of OSA in the US remain undiagnosed.^{11,12}

OSA is not a benign condition. It is a systemic disorder since the repetitive falls in oxygen levels affect all organ systems. Untreated OSA can result in serious morbidity and mortality. OSA is associated with hypertension,¹³ impaired glucose control,¹⁴ congestive heart failure,¹⁵ coronary heart disease,¹⁵ mild cognitive impairment or dementia,¹⁶ depression,¹⁷ atrial fibrillation,¹⁸ and stroke.¹⁹ Particularly severe OSA, is also associated with increased mortality.²⁰

In addition to the health risks, OSA may cause problems in everyday life. Loud snoring may cause the bed partner to sleep in a separate room. Significant sleepiness may interfere with the ability to participate in social activities and work performance. Sleepiness is particularly concerning when operating motor vehicles. In fact, OSA has been shown to cause significant impairments in the ability to carry out a simulated driving task²¹⁻²² and has a two-fold increased risk of motor vehicle accidents among impaired drivers.²³

There are a number of risk factors for OSA including obesity, increasing neck size (greater than 17 inches), male gender, craniofacial features (e.g. retrognathia and macroglossia) and increasing age.²⁴ It is important for providers to ask about common presenting symptoms such as snoring, witnessed apneas, nocturnal gasping, morning dry mouth, feeling unrefreshed on awakening from sleep, and excessive daytime sleepiness (e.g. as measured by the Epworth Sleepiness Scale).²⁵ Particular attention should be paid to patients with a history of stroke, refractory hypertension, coronary artery disease, as well as to obese type 2 diabetic patients and individuals with depression or new onset atrial fibrillation.

Case Discussion: *The patient is obese, has loud snoring and is sleepy to the point that it is interfering with his work. He likely has OSA. This corresponds with his weight gain and sleep problems in the past 6 months, and may contribute to his borderline hyperglycemia and HTN. He requires a sleep study and would likely benefit from treatment.*

While a clinical scenario may be strongly suggestive of OSA, the diagnosis of OSA is made by polysomnography. Polysomnography is typically performed in a sleep laboratory and includes electroencephalographic (EEG), electromyographic, respiratory and electrocardiographic measurements. Portable studies can be done at home as well using devices that provide respiratory and ECG monitoring, but not EEG recording. An event is considered obstructive if there is continued respiratory effort observed in the thoracic or abdominal sensors with absent airflow. Apneas are scored as >90% reduction in breathing, and hypopneas are scored as a >30% reduction in breathing associated with an oxyhemoglobin desaturation of 3%.²⁶ In-laboratory polysomnography can also utilize EEG arousals

following a >30% reduction in airflow to score hypopneas. Both apneas and hypopneas last for at least 10 seconds in duration. The number of respiratory events per hour is called the apnea-hypopnea index (AHI). An AHI<5 is considered normal, 5-15 is considered mild, 15-30 is considered moderate, ≥30 is considered severe. In general, the adverse health consequences of OSA are higher with increasing AHI.

Home sleep studies are appropriate for patients with a high pre-test probability of OSA. In-lab polysomnography should be used for individuals with moderate pre-test probability of OSA and may also be indicated in patients for whom there is a concern of another sleep disorder (such as central sleep apnea or a parasomnia) or nocturnal hypoventilation. As the sensitivity of unattended studies is lower than in-lab studies for OSA, in-lab studies can be considered in patients for whom an unattended study is negative, but a high clinical suspicion for OSA remains. Treatment of OSA will be discussed in a separate article.

References

1. Punjabi NM. The epidemiology of adult obstructive sleep apnea. *Proc Am Thorac Soc*. 2008;5(2):136-43.
2. Foster GD, Sanders MH, Millman R, Zammit G, Borradaile KE, Newman AB, Wadden TA, Kelley D, Wing RR, Sunyer FX, Darcey V, Kuna ST; Sleep AHEAD Research Group. Obstructive sleep apnea among obese patients with type 2 diabetes. *Diabetes Care*. 2009;32(6):1017-9.
3. Frey WC, Pilcher J. Obstructive sleep-related breathing disorders in patients evaluated for bariatric surgery. *Obes Surg*. 2003;13(5):676-83.
4. Lopez PP, Stefan B, Schulman CI, Byers PM. Prevalence of sleep apnea in morbidly obese patients who presented for weight loss surgery evaluation: more evidence for routine screening for obstructive sleep apnea before weight loss surgery. *Am Surg*. 2008;74(9):834-8.
5. Logan AG, Perlikowski SM, Mente A, Tisler A, Tkacova R, Niromand M, Leung RS, Bradley TD. High prevalence of unrecognized sleep apnea in drug-resistant hypertension. *J Hypertens*. 2001;19(12):2271-7.
6. Turkington PM, Bamford J, Wanklyn P, Elliott MW. Prevalence and predictors of upper airway obstruction in the first 24 hours after acute stroke. *Stroke*. 2002;33(8):2037-42.
7. Yumino DI, Tsurumi Y, Takagi A, Suzuki K, Kasanuki H. Impact of obstructive sleep apnea on clinical and angiographic outcomes following percutaneous coronary intervention in patients with acute coronary syndrome. *Am J Cardiol*. 2007;99(1):26-30.
8. Ancoli-Israel S, Kripke DF, Klauber MR, Mason WJ, Fell R, Kaplan O. Sleep-disordered breathing in community-dwelling elderly. *Sleep*. 1991;14(6):486-95.
9. Ancoli-Israel S, Klauber MR, Butters N, Parker L, Kripke DF. Dementia in institutionalized elderly: Relation to sleep apnea. *J Am Geriatr Soc*. 1991;39(3):258-63.
10. Aoki K, Matsuo M, Takahashi M, Murakami J, Aoki Y, Aoki N, Mizumoto H, Namikawa A, Hara H, Miyagawa M, Kadotani H, Yamada N. Association of sleep-disordered breathing with decreased cognitive function among patients with dementia. *J Sleep Res*. 2014;23(5):517-23.
11. Young T1, Evans L, Finn L, Palta M. Estimation of the clinically diagnosed proportion of sleep apnea syndrome in middle-aged men and women. *Sleep*. 1997;20(9):705-6.
12. Kapur V1, Strohl KP, Redline S, Iber C, O'Connor G, Nieto J. Underdiagnosis of sleep apnea syndrome in U.S. communities. *Sleep Breath*. 2002;6(2):49-54.
13. Marin JM, Agusti A, Villar I, Forner M, Nieto D, Carrizo SJ, Baró F, Vicente E, Wei Y, Nieto FJ, Jelic S. Association between treated and untreated obstructive sleep apnea and risk of hypertension. *JAMA*. 2012;307(20):2169-76.
14. Babu AR1, Herdegen J, Fogelfeld L, Shott S, Mazzone T. Type 2 diabetes, glycemic control, and continuous positive airway pressure in obstructive sleep apnea. *Arch Intern Med*. 2005;165(4):447-52.
15. Gottlieb DJ, Yenokyan G, Newman AB, O'Connor GT, Punjabi NM, Quan SF, Redline S, Resnick HE, Tong EK, Diener-West M, Shahar E. Prospective study of obstructive sleep apnea and incident coronary heart disease and heart failure: the sleep heart health study. *Circulation*. 2010;122(4):352-60.
16. Yaffe K, Laffan AM, Harrison SL, Redline S, Spira AP, Ensrud KE, Ancoli-Israel S, Stone KL. Sleep-disordered breathing, hypoxia, and risk of mild cognitive impairment and dementia in older women. *JAMA* 2011;306(6):613-9.
17. Wheaton AG, Perry GS, Chapman DP, Croft JB. Sleep disordered breathing and depression among U.S. adults: National Health and Nutrition Examination Survey, 2005-2008. *Sleep*. 2012;35(4):461-7.
18. Mehra R, Benjamin EJ, Shahar E, Gottlieb DJ, Nawabt R, Kirchner HL, Sahadevan J, Redline S. Sleep Heart Health Study. Association of nocturnal arrhythmias with

- sleep-disordered breathing: The Sleep Heart Health Study. *Am J Respir Crit Care Med.* 2006;173(8):910-6.
19. Redline S1, Yenokyan G, Gottlieb DJ, Shahar E, O'Connor GT, Resnick HE, Diener-West M, Sanders MH, Wolf PA, Geraghty EM, Ali T, Lebowitz M, Punjabi NM.. Obstructive sleep apnea-hypopnea and incident stroke: The sleep heart health study. *Am J Respir Crit Care Med.* 2010;182(2):269-77
 20. Young T, Finn L, Peppard PE, Szklo-Coxe M, Austin D, Nieto FJ, Stubbs R, Hla KM. . Sleep disordered breathing and mortality: Eighteen-year follow-up of the Wisconsin sleep cohort. *Sleep.* 2008;31(8):1071-8
 21. George CF1, Boudreau AC, Smiley A. Simulated driving performance in patients with obstructive sleep apnea. *Am J Respir Crit Care Med.* 1996;154(1):175-81.
 22. Hoekema A1, Stegenga B, Bakker M, Brouwer WH, de Bont LG, Wijkstra PJ, van der Hoeven JH. Simulated driving in obstructive sleep apnea-hypopnoea; Effects of oral appliances and continuous positive airway pressure. *Sleep Breath.* 2007;11(3):129-38
 23. Tregeair S, Reston J, Schoelles K, Phillips B. Obstructive sleep apnea and risk of motor vehicle crash: Systematic review and meta-analysis. *J Clin Sleep Med.* 2009;15(5):573-81.
 24. Punjabi NM. The epidemiology of adult obstructive sleep apnea. *Proc Am Thorac Soc.* 2008;5(2):136-43.
 25. Murray W Johns. A new method for measuring daytime sleepiness: The Epworth Sleepiness Scale. *Sleep.* 1991; 14 (6): 540-545.
 26. Berry RB, Brooks R, Gamaldo CE, Harding SM, Marcus CL and Vaughn BV for the American Academy of Sleep Medicine. The AASM Manual for the Scoring of Sleep and Associated Events: Rules, Terminology and Technical Specifications, Version 2.0. www.aasmnet.org, Darien, Illinois: American Academy of Sleep Medicine, 2012.

This article was developed through the National Healthy Sleep Awareness Project, a joint effort of the Centers for Disease Control and Prevention (CDC), American Academy of Sleep Medicine (AASM) and the Sleep Research Society (SRS). Visit www.sleepeducation.org for more information.

This article was supported by the cooperative agreement number 1U50DP004930-01 from the Centers for Disease Control and Prevention (CDC). Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the CDC.



Promoting Safer Sleep

Stephanie Newell McCabe, MS, CCC-SLP, COM and Emmy Lustig, BA

Stephanie Newell McCabe, MS, CCC-SLP, COM is the Director of Therapy Services & Speech Language Pathologist at Pathway.org
Emmy Lustig, BA is a Communications Associate at Pathways.org
The authors have nothing to disclose relevant to this article.

While the incidence of SIDS has decreased since the launch of the American Academy of Pediatrics *Back to Sleep* campaign in 1994,¹ the number of infant deaths resulting from accidental suffocation, asphyxia, and entrapment has increased in recent years.² In 2011, the American Academy of Pediatrics expanded its recommendations to promote a safer sleep environment for infants. However, a recent study presented at the Pediatric Academic Societies' annual meeting in Vancouver, British Columbia indicated that a significant number of parents continue to use high-risk sleeping behaviors for their infants.³ Of the 1,030 mothers surveyed, almost 20% reported sharing a bed with their infant and 10% reported routinely putting their infant to sleep on their stomach.

Physicians and hospital staff should set a clear example of safe sleep practices in the inpatient setting. Parents and caregivers are more likely to model the actions demonstrated by their healthcare providers rather than follow verbal instructions, and it is important for parents to adhere to these guidelines through the baby's first year.⁴ Encourage caregivers to practice the ABC's of safe sleep: Alone, Back, Crib. These suggestions, along with proper infant care devices, will help ensure the baby's safety and encourage healthy development.

Sleeping Alone

The safest place for an infant to sleep is in the same room as their caregiver, but not on the same bed or sofa. Babies are at a greater risk for suffocation and entrapment when they sleep

on the same surface as a family member, and young infants 0-3 months old have the highest medical risk associated with bed-sharing.⁵ Research concludes that the danger of bed-sharing is increased for infants when one or both parents are smokers, or when caregivers have consumed alcohol.² Parents should be assured by doctors that they can effectively monitor their baby while sleeping in the same room and on different surfaces. Some caregivers position the crib next to their bed to easily maintain physical contact with their infant and encourage bonding. Infants can be brought into bed for feeding or comforting, however, parents should return them to their crib after these activities.

Back to Sleep

Infants should be placed on their backs to sleep and their tummies to play. Positioning infants to sleep on their stomach can increase the risk of SIDS by seven to eight times compared to infants placed in the supine sleeping position. Researchers believe this is because infants are prone to rebreathing expired gases, which can cause conditions such as hypercapnia and hypoxia.² In addition to placing infants on their back to sleep, parents should be reminded to change their baby's position in the crib, thereby encouraging infants to rest on different sides of their head. Plagiocephaly and brachycephaly can develop if an infant does not change sleeping or resting positions with enough frequency. Engaging in tummy time activities can also help prevent these conditions because the baby will build a stronger core.⁶

Proper Infant Bedding

It is important for parents to use a crib or bassinet that meets current safety standards. Infants should not be placed to sleep on soft surfaces such as pillows and quilts, because they are at a greater risk of entrapment with these materials.² Blankets used in the baby's crib must be thin and tucked under the mattress to avoid covering the baby's head or face.⁷ Parents should be

reminded by their doctor that soft toys do not belong in the infant's sleeping area as babies sometimes roll over while sleeping. Infants older than three months are more likely to roll onto objects in their crib.⁵

Medical professionals can educate parents about refraining from sleep positioning devices. The American Academy of Pediatrics advises against positioning devices that are marketed to reduce the risk of SIDS, because there is no evidence that these devices are effective. Some of them are constructed of soft materials that also pose the danger of entrapment and suffocation if the baby changes positions or slips out of the device. Positioning devices used in hospital settings for physical therapy should be removed before the infant is discharged.²

Overheating

Infant clothing is designed to keep babies warm without placing the baby in a dangerous sleep environment with blankets and bedding. Studies have shown that laying infants on their side to sleep increases their risk for overheating, because the body does not release heat as effectively as infants in the supine position.⁵ Parents should place infants in properly sized clothing and on their backs to reduce overheating while sleeping.

Pacifier Use

Research has suggested that using pacifiers can help reduce the risk of SIDS by 50 - 60% and is safe for infants to use while sleeping, especially when in an adverse sleep environment.² Although the reason for this reduced risk is unknown, scientists believe that there is a correlation to infants having higher oxygen levels when pacifiers are used during sleep time.⁸ Parents should not force their baby to use a pacifier if he or she is resistant. It is important for families to use one piece pacifiers, because pacifiers that are two pieces can become a choking hazard for children if they fall apart. Parents should consult with their pediatrician about weaning their child off their pacifier.

Medical professionals should demonstrate safe sleep guidelines for infants and discuss proper conduct with parents and caregivers. Infants should be placed on their backs to sleep and in a safe sleeping environment. Parents can begin safe sleep practices as soon as they bring their baby home from the hospital to reduce the risk of SIDS and other sleep-related medical conditions. For more information on infant development, visit www.pathways.org or email friends@pathways.org. ▲

Founded in 1985, Pathways.org empowers parents and health professionals with free educational resources on the benefit of early detection and early intervention for children's motor, sensory, and communication development. Pathways.org is a 501(c)(3) not-for-profit organization.

References

1. American Academy of Pediatrics. Profile of SIDS Risk Shifts After Launch of Back-to-Sleep Campaign. 2012. Accessed April 2015, <https://www.aap.org/en-us/about-the-aap/aap-press-room/pages/Profile-of-SIDS-Risk-Shifts-After-Launch-of-Back-to-Sleep-Campaign.aspx>
2. Moon Rachel Y. SIDS and Other Sleep-Related Infant Deaths: Expansion of Recommendations for a Safe Infant Sleeping Environment. Task Force on Sudden Infant Death Syndrome. 2011; 128; 1341-1358.
3. Colson E, et al. Reports of infant sleep behaviors from a national sample of mothers: the study of attitudes and factors affecting infant care (SAFE). Platform session presented at: Pediatric Academic Societies Annual Meeting; 2014 May 3-6; Vancouver, British Columbia.
4. The Changing Concept of Sudden Infant Death Syndrome: Diagnostic Coding Shifts, Controversies Regarding the Sleeping Environment, and new Variables to Consider in Reducing Risk. *Pediatrics*. 2005; 116(5): 1245-1255.
5. Colvin J, Collie-Akers V, Schunn C, and Moon R. Sleep Environment Risks for Younger and Older Infants. *Pediatrics*. 2014; 134(5): 406-412.
6. Pin T, Eldridge B, and Galea MP. A review of the effects of sleep position, play position and equipment use on motor development of infants. *Development Medicine and Child Neurology*. 2007; 49: 858-67
7. Otway C. Plagiocephaly: awareness, prevention and treatment: plagiocephaly appears to be increasing in incidence and health visitors have a key role to play in supporting and advising parents. *Community Practitioner*. 2008; 81(4): 38-40.
8. Franco, Patricia, et al. The influence of a pacifier on infants' arousals from sleep. *The Journal of Pediatrics*. 2000; 10(4): 775-779.

Using New Guidelines for Administering Pneumococcal Vaccinations in Adults

Cari Miller, MSM, PCMH CCE

Cari Miller, MSM, PCMH CCE is the Director of Private Sector Advocacy and Project Operations.

The author has nothing to disclose relevant to this article.

The Advisory Committee on Immunization Practices (ACIP) has recommended the use of two pneumococcal vaccines (PCV13 [conjugate] and PPSV23 [polysaccharide]) depending on the age and health conditions of patients. Its recommendations have been supported by the Centers for Disease Control and Prevention (CDC) and the Centers for Medicare & Medicaid Services (CMS), which has included payment for both under Medicare Part B, if they are given according to an approved schedule.

A downloadable 2015 Recommendation Immunization Schedule is available at <http://www.cdc.gov/vaccines/schedules/downloads/adult/adult-schedule-easy-read.pdf>. While the schedule provides a summary of numerous vaccinations by age and health condition, it is designed for patient education and does not address provider information for vaccine administration. The following sections provide additional direction for the administration of pneumococcal vaccines.

Recommended Administration in Patients Ages 19-64 Years^{1,2}

ACIP does not recommend pneumococcal vaccines for everyone in the age group of 19-64 years. Only persons in risk groups with certain underlying conditions should receive one or both of the pneumococcal vaccines (Table 1). Patients in three risk groups (immunocompetent persons, persons with functional or anatomic asplenia, and immunocompromised persons) should be given the PPSV23 vaccine. However, only those with cerebrospinal fluid (CSF) leaks, cochlear implants, Sickle cell disease/other hemoglobinopathies, and immunocompromised conditions should have the PCV13 vaccine, as well.

For high risk, pneumococcal vaccine-naïve patients, ACIP recommends a dose of PCV13 be administered first, followed by a dose of PPSV23 at least eight weeks later. The two vaccines should not be co-administered and the minimum acceptable interval is eight weeks.

A one-time revaccination of PPSV23 should be given five years after the first vaccination, but only to high-risk patients with immunocompromising conditions, functional or anatomical asplenia, or Sickle cell disease/other hemoglobinopathies. Patients with CSF leaks or cochlear implants should not receive second dose.^{1,2}

Recommended Administration for Patients ≥ 65 Years³

The updated ACIP recommendations state that all adults

Table 1: Medical Conditions or Other Indications for Administration of PCV13 and Indications for PPSV23 Administration and Revaccination for Adults 19 Years or Older¹⁻³

Risk Group	Underlying Medical Conditions	PCV13 Recommended	PPSV23* Recommended	Revaccination at 5 Years After First Dose
Immuno-competent persons	Chronic heart disease [†]		✓	
	Chronic lung disease [‡]		✓	
	Diabetes mellitus		✓	
	CSF leaks	✓	✓	
	Cochlear implants	✓	✓	
	Alcoholism		✓	
	Chronic liver disease, cirrhosis		✓	
	Cigarette smoking		✓	
	Sickle Cell disease/other hemoglobinopathies	✓	✓	✓
Persons with functional or anatomic asplenia	Congenital or acquired asplenia	✓	✓	✓
Immuno-compromised persons	Congenital or acquired immunodeficiencies [§]	✓	✓	✓
	HIV infection	✓	✓	✓
	Chronic renal failure	✓	✓	✓
	Nephrotic syndrome	✓	✓	✓
	Leukemia	✓	✓	✓
	Lymphoma	✓	✓	✓
	Hodgkin disease	✓	✓	✓
	Generalized malignancy	✓	✓	✓
	Iatrogenic immunosuppression [¶]	✓	✓	✓
	Solid organ transplant	✓	✓	✓
	Multiple myeloma	✓	✓	✓

* All adults 65 years of age or older should receive both PCV13 and PPSV23 in a series.

† Including congestive heart failure and cardiomyopathies.

‡ Including chronic obstructive pulmonary disease, emphysema, and asthma.

§ Includes B- (humoral) or T-lymphocyte deficiencies, complement deficiencies (particularly C1, C2, C3, and C4 deficiencies), and phagocytic disorders (excluding chronic granulomatous disease).

¶ Diseases requiring treatment with immunosuppressive drugs, including long-term systemic corticosteroids and radiation therapy.

65 years or older should receive both PCV13 and PPSV23 vaccinations. For pneumococcal vaccine-naïve persons or for those with unknown pneumococcal vaccine histories, the PCV13 vaccine is administered first, followed by a dose of PPSV23 six to 12 months or later. As with adults ages 19-64 years, the two vaccines should not be co-administered and the minimum acceptable interval is eight weeks.

If a patient has already had a PPSV23 vaccination, he/she should receive a dose of PCV13. The PCV13 should be administered at least one year after the PPSV23 was given.

Patients who received a PPSV23 vaccination before they reached the age of 65 years for any indication should receive another dose of the vaccine at age 65 or older if at least five years has passed since the first dose. Those ≥ 65 years who were given the PPSV23 vaccine should receive only a single dose.⁴

ACIP recommendations for the routine use of PCV13 in adults 65 years or older will be reviewed in 2018 and revised as necessary.

Medicare Part B Coverage⁵

CMS has updated its Medicare coverage requirements to align with the new ACIP guidelines effective February 2, 2015. Medicare will now cover:

- Under Medicare Part B, an initial pneumococcal vaccine to all Medicare beneficiaries who have never received the vaccine, and
- A different, second pneumococcal vaccine one year after the first vaccine was administered (i.e., eleven full months following the month in which the last pneumococcal vaccine was given)

Since the updated ACIP recommendations are specific to vaccine type and sequence of vaccination, prior pneumococcal vaccination history should be taken into consideration. Receiving multiple vaccinations of the same vaccine type is not recommended.

For more information, link to <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9051.pdf>.

References

1. CDC. PCV13 (Pneumococcal Conjugate) vaccine: recommendations, scenarios, and Q&As for healthcare professionals about PCV13 for adults. Available at: <http://www.cdc.gov/vaccines/vpd-vac/pneumo/vac-PCV13-adults.htm>. Accessed April 16, 2015.
2. CDC. Use of 13-valent pneumococcal conjugate vaccine and 23-valent pneumococcal polysaccharide vaccine for adults with immunocompromising conditions: recommendations of the Advisory Committee on Immunization Practices (ACIP). *MMWR Morb Mortal Wkly Rep.* October 12, 2012; 61(40):816-819. Available at: <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6140a4.htm>. Accessed April 16, 2015.
3. CDC. Use of 13-valent pneumococcal conjugate vaccine and 23-valent pneumococcal polysaccharide vaccine for adults aged ≥ 65 years: recommendations of the Advisory Committee on Immunization Practices (ACIP). *MMWR Morb Mortal Wkly Rep.* September 19, 2014; 63(37):822-825. Available at: <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6337a4.htm>. Accessed April 16, 2015.
4. CDC. Updated recommendations for prevention of invasive pneumococcal disease among adults using the 23-valent pneumococcal polysaccharide vaccine (PPSV23). *MMWR Morb Mortal Wkly Rep.* September 3, 2010; 59(34):1102-1106. Available at: <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5934a3.htm>. Accessed April 19, 2015.
5. CMS. Modifications to Medicare Part B coverage of pneumococcal vaccinations. *MLN Matters.* Available at: <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9051.pdf>. Accessed April 16, 2015.

Erratum

The NJAfp would like to readers to be aware that the clinical article "Meeting Healthy People 2020 Adult Immunization Goals in New Jersey" which appeared in *Perspectives* 4Q14 was made possible by the New Jersey Department of Health Vaccine Preventable Disease Program. A summary of the article appears below. To access the original article visit http://www.njafp.org/sites/ethos.njafp.org/files/perspectives_4q_2014update_0.pdf

Despite overwhelming evidence that immunization reduces the risk of contracting a serious disease, infectious diseases remain a major cause of morbidity and mortality in the United States. This article referenced the 2014 adult immunization and highlighted the adult goals for Healthy People 2020, and presented adult vaccine facts (such as: Between 3,000 and over 49,000 people die from influenza each year). The article went on to review the common vaccine preventable diseases in adults, reviewed the barriers to immunizations in adults, and concluded with recommendations on how to overcome those barriers along with resources to assist physicians to improve immunization rates.



NJAfp offers CME online

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





QUIZ

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, Prescribed credit earned must be reported as Prescribed credit, not as category 1.

Members – To obtain credit:

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

Nonmembers – To obtain credit:

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

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

Name: _____ AAFP Membership Number: _____

Street Address: _____

City/State/Zip: _____

Email Address: _____

Phone: _____ Fax: _____

1. **True or False:** In the final two days of life, 10% of patients experience moderate to severe pain.
2. **True or False:** One barrier to pain relief for patients is a lack of training among healthcare professionals.
3. **True or False:** A patient with a history of past substance abuse may apply psychological pressure on the healthcare provider in order to obtain pain medication.
4. **True or False:** Patients managed on opioids seldom have breakthrough pain.
5. **True or False:** A patient requiring larger doses of medication in order to produce the same level of relief is known as dependence.
6. **True or False:** Obstructive Sleep Apnea (OSA) is a systemic disorder that affects all organ systems.
7. **True or False:** Studies have shown OSA to be associated with significant impairments in the ability to perform simulated driving tasks.
8. **True or False:** An apnea-hypopnea index (AHI) of >25 is considered severe OSA.
9. **True or False:** The rate of SIDS has decreased, the number of infant deaths from accidental suffocation, asphyxia, and entrapment has increased.
10. **True or False:** Caregivers should be encouraged to follow the ABCs of safe sleep: Always Back Care
11. **True or False:** Soft toys have no place in a child's crib
12. **True or False:** Advisory Committee on Immunization Practices recommends use of pneumococcal vaccines (PCV13 [conjugate] and PPSV23 [polysaccharide]) depending on the age and health conditions of patients.
13. **True or False:** The updated ACIP recommendations state that all adults 65 years or older should receive PCV13 or PPSV23 vaccinations.
14. **True or False:** Under Medicare Part B an initial pneumococcal vaccine will be covered for all beneficiaries who have never received the vaccine.
15. **True or False:** The updated ACIP recommendations are specific to vaccine type and vaccination sequence therefore prior pneumococcal vaccination history need not be taken into consideration.

ANSWERS ON PAGE 29

Primary Care Practices Take Steps to Increase Pneumococcal Vaccination in New Jersey

Cari Miller, MSM, PCMH CCE

Cari Miller, MSM, PCMH CCE is the Director of Private Sector Advocacy and Project Operations.

In 2012 the New Jersey Academy of Family Physicians (NJAFP) received a grant from the Pfizer Medical Education Group to work with a group of primary care practices on increasing pneumococcal immunization rates for adults in New Jersey. The objectives of the Pneumococcal Vaccination Quality Improvement Collaborative included:

- Addressing and overcoming practice and patient barriers contributing to low immunization rates
- Developing or expanding activities across vaccine providers and healthcare settings
- Fostering communication and coordination of vaccination by creating patient-centered medical communications
- Identifying and implementing interventions to address and overcome financial barriers related to pneumococcal vaccinations
- Disseminating educational information via publications, presentations, and development of an online tool kit.

NJAFP recruited 20 National Committee of Quality Assurance (NCQA) recognized Patient-Centered Medical Home (PCMH) practices throughout the state. All used EHR systems and varied in size and type. For example, while some were private practices, others were integrated delivery systems or residency practices.

Participant practices were divided into an intervention group and a control group. While the control group submitted pneumococcal immunization data and a survey at the start and end of the collaborative, the intervention group submitted the data and surveys in the same time frames and formed a collaborative to explore and identify best practices through attending three NJAFP-developed learning sessions; received change packages; had site visits with NJAFP Project Facilitators during action periods; identified a community partner with whom to work; and developed and implemented quality improvement plans.

NJAFP Project Facilitators assisted intervention group practices with project activities throughout the collaborative, collected and analyzed baseline and remeasurement data, and are in the process of developing and posting an online best practices tool kit.

One of the more unique aspects of this project was the work practices conducted with their local community partners. Intervention group practices identified a community partner who provides pneumococcal immunizations to patients in an effort to foster communication and collaboration across settings regarding patients' immunization status. The goal was to encourage sharing, as appropriate and allowed. Many practices focused on working with a local hospital to identify patients who received

pneumococcal vaccinations during an inpatient stay. Often primary care practices were not being made aware of inpatient immunizations. Practices worked to ensure immunizations given during an admission were included on discharge summaries provided to the practice. In addition, several practices implemented internal awareness campaigns to promote the importance of pneumococcal immunizations to their patients and encouraged patients to ask about getting immunized. Some conducted population health outreach to patients who needed to get immunized. NJAFP would like to thank all participating practices and encourage all readers to visit the NJAFP website (www.njafp.org) and review the best practices tool kit, which will be posted in summer 2015.



Results of the Collaborative

While data for the control group are being collected and analyzed at the time this article is being written, NJAFP has analyzed baseline and remeasurement data from nine of the ten intervention group practices. Based on data from nine practices, an increase of 9.5% was seen in pneumococcal vaccination rates for patients 65 years or older (baseline data year 2012; remeasurement data year 2014). The improvement rate for patients ages 19-64 was 0.2% for this time period, but this increase does not reflect the true improvement seen with this age group and is due to a limitation in how data can be collected using EHR systems. Data reports that would be able to provide the total number of patients ages 19-64 who have conditions that make them eligible for pneumococcal vaccinations were not able to be generated from EHR systems. Therefore, the total number of patients ages 19-64 comprised all 19-64 year-old patients in the practice, and not just those eligible for a pneumococcal vaccine. This is a flaw that needs to be addressed by EHR vendors, and possibly future quality improvement initiatives. However, it is important to note the number of patients in this age group who received a pneumococcal vaccine during the study time period from nine of the practices increased by 789 patients (from 2,772 at baseline to 3,561 at remeasurement).

In summary, notable increases in pneumococcal vaccination rates appeared to be a result from the quality improvement activities developed by the intervention group practices and the assistance provided by the NJAFP team. The improvement in patients \geq 65 years (9.5%) was important and the increase in the number of patients ages 19-64 receiving pneumococcal vaccinations during the collaborative (789) was impressive. ▲

SPORTS PRE-PARTICIPATION PHYSICALS

State's Professional Development Module Finally Available

Claudine M. Leone, Esq.

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

THE NEW JERSEY DEPARTMENT OF EDUCATION has finally released the professional development module required by the Scholastic Student Athlete Safety Act. **The module can be found at <http://www.nj.gov/education/students/safety/health/services/athlete/PDModule.shtml>. You can also find the module at <http://www.njafp.org/node/9025>**

Effective with the start of the 2015-2016 school year, physicians, advanced practice nurses (APN) and physician assistants (PA) are required to complete the module before performing any student-athlete's physical examination. The module will take

about 35-45 minutes to complete. **This is a ONE TIME requirement for physicians, APNs and PAs.** So, maintaining copies of the printable certificate of completion at your office is very important. The Department of Education is also recommending attaching your certificate to each pre-participation form for the first six months of implementation to save your staff the hassle of producing it upon request of a school district.



The Scholastic Student Athlete Safety Act requires that:

- The PD module must be completed by the physician, APN, or PA who performs a student-athlete's annual physical examination prior to the student's participation on a school-sponsored interscholastic or intramural athletic team or squad in grades six through 12;
- Upon performing a physical examination, the physician, APN or PA shall sign the certification statement on the Pre-participation Physical Evaluation (PPE) form attesting to the completion of the PD module. This certification can be found on page four of the PPE form, and is available at <http://www.state.nj.us/education/students/safety/health/records/athleticphysicalsform.pdf>
- A contract of employment between a school district and a school physician shall include a statement of assurance that the school physician has completed the PD module and read the Sudden Cardiac Death in Young Athletes pamphlet; and
- Each board of education and charter school or nonpublic school governing authority must retain the original signed certification to attest to the qualification of the healthcare provider to perform the exam. The certificate may be obtained at the conclusion of the PD module by downloading and printing when prompted.

The state recognizes that there are physicals that have been performed and forms already submitted to schools that will still be effective for the start of the 2015-2016 school-year. During this period of transition, it is reasonable for schools to accept the pre-participation physical form without the healthcare provider's attestation to completion of the module.

Questions and concerns may be directed to schoolhealthservices@doe.state.nj.us or to Claudine Leone at Claudine@njafp.org. ▲



Pack Your Bags

We've been summoned to the Palace

WE ARE HEADED BACK TO ATLANTIC CITY for the 60th annual NJAfp Scientific Assembly. While you may not see any flip flops this year, that doesn't mean we aren't gearing up to have fun and to present you with a great conference.

What is going to be happening at this year's conference? It's probably easier to ask what isn't happening. We will be featuring conversation, resolutions, clinical education, skills workshops, competitions, a SAM (on mental health), and so much more. Register today at www.njafp.org Don't miss this exciting event!

The Advanced Topics in Healthcare Delivery Symposium

The third annual Advanced Topics in Healthcare Delivery Symposium will be held on Thursday, June 11, 2015 from 8:00am - 4:30pm at Caesar's Atlantic City. This symposium will focus on critical topics necessary to enhance and foster delivery of advanced patient-centered care models. Session topics have been selected based on NJAfp's extensive experience with Patient-Centered Medical Home (PCMH) and practice transformation concepts, as well as feedback from more than 1,000 clients we have assisted with transforming care, enhancing practice culture, and receiving PCMH recognition.

For more information go to www.njafp.org/SCSA and click on Advanced Topics Symposium or contact Pam Joyce at pam@njafp.org or 609-394-1711.

NEW THIS YEAR

Skill Building Workshops

This year the Assembly will feature two skills workshops:
Casting and Splinting and **Dermatology**.

Space is limited, so sign up now.

MDAdvantage

**WE PROVIDE
VALUE BEYOND INSURANCE.**

MDAdvantage® provides customized on-site practice assessments and local education programs.

Sponsors and supports the *Edward J. III Excellence in Medicine Awards®* and Scholarship Fund.

Publishes *MDAdvisor: A Journal for the Healthcare Community*.



Advocates for all
New Jersey physicians.

**MD
ADVANTAGE®**
VALUE BEYOND INSURANCE

**Want to know more?
Visit www.MDAdvantageonline.com**

End-Of-Life Care CME

At this year's Assembly you will have the opportunity to fulfil The New Jersey Board of Medical Examiners requirement for 2 CME category 1 credits in End-Of-Life Care prior to the end of the biennial renewal period which occurs on July 1, 2015. The following courses will meet this requirement:

- **Facilitating Advanced / End-of-Life Care Planning in Primary Care Practice**

Thursday, June 11, 2015

(This session is part of the preconference symposium)

- **Pain Management and End-Of-Life Care**

Friday, June 12, 2015 4:30pm

Check Out Some of This Year's Speakers

Mike Sevilla, MD

Dr. Mike Sevilla is a family physician in Salem, OH and a social media expert. He is the founder of the former "Doctor Anonymous" blog which was nominated for Best New Medical Blog in 2006. He has written and presented extensively on how social media may be utilized to enhance the practice of medicine and the doctor/patient experience. In addition, he presently serves on the External Advisory Board for the Mayo Clinic Center for Social Media.

Glen R. Stream, MD, MBI, FAAFP

Dr. Stream is a family physician in Rancho Mirage, California, past president of the AAFP and chair of the board of Family Medicine for America's Health. He will be talking about the Health is Primary Campaign and what it means to family medicine and family physicians.

Joseph Tollison, MD

Senior Advisor to the President of the American Board of Family Medicine and will be updating members on the ABFM Maintenance of Certification Program.

Dina Rose, PhD

Sociologist, parent educator, feeding expert, and author will be helping attendees learn how they can help change the way kids eat.

Karl Doghramji, MD

An expert in sleep medicine, will talk about the latest advancements in understanding sleep disorders.

Mafudia A. Suaray, MD, MPH

Will provide a new perspective on Ebola and the global spread of disease.

Become an Academy Leader

"If your actions inspire others to dream more, learn more, do more and become more, you are a leader." – John Quincy Adams

Do your colleagues or your community consider you a leader? If so, we need you. The NJAJP is seeking member family physicians to lead the Academy and support family medicine in New Jersey. Interested members should review the nomination criteria at <http://www.njafp.org/SCSA>. Click on the Call for Resolutions and Nominations link on the left menu bar, and scroll down to nominations.

Nominations are being sought for the following positions:

- **Board Trustees:** three positions
- **Student Trustee:** one position
- **AAFP Alternate Delegate:** one position
- **Resident Trustee:** one position
- **AAFP Delegate:** one position

Contact EVP Ray Saputelli, MBA, CAE, at ray@njafp.org for information

Dates to Remember

Thursday, June 11, 2015

- Pre-Conference Symposium: Advanced Topics in Healthcare Delivery
- Town Hall

Friday, June 12, 2015

- House of Delegates
- Scientific Assembly Begins
- Resident Knowledge Bowl
- Research Poster Contest

Saturday, June 13, 2015

- Scientific Assembly Continues
- President's Gala
- Research Poster Contest Concludes

Sunday, June 14, 2015

- Scientific Assembly Continues to 1:00pm
- Skills Workshops
- SAM Study Hall

Information on the conference is posted on the NJAJP website and updated as more information becomes available. Visit www.njafp.org/SCSA

More Congratulations

Cari Miller, MSM, PCMH CCE (Trenton), NJAJP's Director, Private Sector Advocacy and Project Operations has been selected as a presenter and participant in the inaugural NCQA PCMH Congress to be held this October in San Francisco. Ms. Miller will be presenting two topics - the first will be an advanced session that focuses on the preparation necessary to become PCMH CCE. The second session, developed for those in the early phases of PCMH recognition and transformation provides learners with information on patient empanelment, risk stratification and care management activities for high(er) risk patients.

In the News...

Ray Saputelli, MBA, CAE (*Trenton*), NJAfp's Executive Vice President, provided comment on healthcare predictions for 2015. <http://www.njbiz.com/article/20150105/NJBIZ01/150109985/Health-care-predictions-for-2015>. Mr. Saputelli was also included in a story on the healthcare industry's reaction to the news of a new Hackensack University Health Network – Seton Hall Medical School. <http://www.njbiz.com/article/20150115/NJBIZ01/150119858/1040/Updated:-Health-care-industry-reacts-to-news-of-new-medical-school>

Claudine Leone, Esq. (*Trenton*), NJAfp's Government Affairs Director, was quoted in a *NewWorks* article focused on the proposed New Jersey law which would require doctors to talk with patients about drug addiction. Ms. Leone was also quoted in a *NJ Spotlight* article on this same topic, stating "mandating a state-scripted conversation between a physician and patient is just not the solution."

NewWorks: <http://www.newworks.org/index.php/local/new-jersey/80102-proposed-nj-law-requires-doctors-to-talk-with-patients-about-drug-addiction>.

NJSpotlight: <http://www.njspotlight.com/stories/15/03/16/public-want-doctors-to-talk-more-with-patients-about-dangers-of-opioids/>

Mitch Kaminski, MD, (*Hammonton*), authored an article entitled "A doctor discovers an important question patients should be asked." The article appeared in the *Washington Post* (http://www.washingtonpost.com/national/health-science/how-i-discovered-an-important-question-a-doctor-should-ask-a-patient/2015/03/09/ca350634-bb9c-11e4-bdfa-b8e8f594e6ee_story.html) and *Pulse*, a New York-based online magazine that publishes personal accounts of illness and healing.

"Don't raise your voice, improve your argument."

— Desmond Tutu

NOW MORE THAN EVER, family medicine in New Jersey needs your voice and your arguments to improve the practice of family medicine in the state. From the stasis surrounding distressed practice environments to Senator Sweeny's proposal to cut healthcare costs, there is not an aspect of practicing medicine in this state that would not benefit from your insight and opinions.

Help the NJAfp improve its arguments. Consider writing a resolution and plan to attend this year's House of Delegates. Resolutions authored at the House of Delegates have the opportunity to be submitted to the AAFP for consideration at the Congress of Delegates.

The House of Delegates will convene at 8:00am on Friday, June 11, 2015 at Caesars Atlantic City.



NJAfp Leaders at AAFP Congress of Delegates (From l to r) Mary Campagnolo, MD, Tom Shaffrey, MD Arnie Pallay, MD, Rodrick Stewart, Sal Bernardo, MD, Terry Shlimbaum, MD, Krishna Bhaskarabhatla, MD and Gerald Banks, MD

Around the State

The NJAfp received an Outstanding Chapter Award from the AAFP for having 100% Resident Membership for 2014-2015, based upon membership records on February 28, 2015. The chapter was recognized for these achievements at the AAFP Annual Chapter Leadership Forum (ACLF) in Kansas City.

Congratulations It's a Boy!

Congratulations to NJAfp project facilitator, Tara Perrone, MHA and her husband Michael on the birth of **Carmine Nino Perrone**. Carmine was born February 12th and weighed in at 8lbs and 13oz.



Carmine Perrone

My TOP 10

Watch List

Susan B. Orr, Esq.

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

EVERY YEAR some organization decides it's time to develop a "Top 10 List" of things to watch out for. Even the OIG comes out with its yearly work plan and let's not forget the finalized Medicare Fee Schedule, which physicians are sitting on the edge of their seat waiting for. It's no surprise then that the AMA comes out with its *Top 10 Issues for Physicians to Watch* in 2015 and not to be

Congress Permanently Repeals the SGR

On April 20, 2015, the Senate voted overwhelmingly to permanently repeal Medicare's sustainable growth rate formula for physician payments that had been in place since 1997, ending more than a decade of legislative gridlock on the issue.

The bill was approved 92-to-8 vote in the Senate, following passage in the House last month by a vote of 392 to 37. President Obama has endorsed the bill, saying it "could help slow healthcare cost growth."

Without passage by Congress, physicians would have faced a 21% cut in Medicare fees starting Wednesday or Thursday, April 15 or April 16, 2015.

The bill provides physicians an annual 0.5% pay raise for five years, starting July 1, 2015. In 2020, Medicare payments to physicians will be frozen for five years and physicians will be asked to participate in programs that pay bonuses to physicians who meet quality-of-care targets.

Starting in 2026, Medicare reimbursement to physicians will again rise by at least a quarter of a percentage point per year. The thrust of the bill is to move away from fee for service payments based on volume of visits to physician payments based on the quality and value of the services they provide.

It is anticipated that this bill would save \$70 billion by limiting or cutting some payments to hospitals and other healthcare providers and requiring Medicare recipients with incomes of more than \$85,000 a year to pay higher Medicare Part B premiums starting in 2018.

outdone by the AMA, MGMA reports the *Top 10 Physician Group Practice Policy Issues to Watch* in 2015.

So really, what are the top issues that physicians and medical practices should be watching out for? The big items on the list have to do, of course, with reimbursement and the various administrative and regulatory requirements thrust upon physicians. I decided to prepare my own list of the Top 10 Issues, some of which made it on both the AMA and MGMA lists, and they are as follows:

1. Physicians who did not take advantage of the EHR incentive program or participate in the PQRS program will see their Medicare Part B payments reduced by up to 2.5% in 2015.
2. Failure to participate in the various Medicare's quality reporting initiatives in 2015 will result in an 11% cut in Medicare payments in 2017.
3. The sustainable growth rate (SGR) always makes the top 10 of everyone's list. (See the side bar for the update.)
4. ICD-10 is once again looming around the corner in 2015 and physicians need to start preparing for the October 1, 2015 compliance date.
5. Stage 2 requirements for Meaningful Use posed numerous problems for providers in 2014 and it's not going to get any better in 2015. However, the pressure is on to meet the requirements in order to avoid a penalty in 2017.
6. Fraud and abuse is another frequent guest on the Top 10 list. Government auditors will continue to audit physicians seeking returns of overpayments due to billing irregularities. But now, billing patterns that are not in compliance with Medicare requirements are grounds for denial or revocation of Medicare enrollment. Note that any self-identified overpayments need to be reported and repaid to Medicare within 60 days.
7. Medical practice integration continues to be on the forefront of physicians' minds. Those in small to midsize practices continue to ponder whether to sell to the hospital or to join or form an integrated medical group. Many groups have started with good intentions, but never seem to come to fruition. Let's see if we can change that during this year.



8. Since the death of Governor Christie's friend this past spring of an overdose, he has been speaking to New Jersey physicians on how to prevent drug addiction. The AMA is also seriously looking to develop policies and engage physicians in practical activities to prevent prescription drug abuse and allow pain management for patients who need them.

9. CMS has authorized a new chronic care management service (CCM). Physicians can provide and be reimbursed for non-face-to-face services to Medicare patients who have a minimum of two chronic conditions. At least 20 minutes of CCM services per month are required in order to bill using CPT Code 99490. Requirements are extensive so make sure that staff understands what is needed in order to bill for these services.

10. No annual Top 10 would be complete without a challenge to the ACA. The Supreme Court will look at insurance subsidies in states such as New Jersey that have federally facilitated insurance exchanges. A ruling is expected at the end of its term, in late June or early July. If the Supreme Court decides that the IRS may not provide them, consumers who rely on them will be unable to afford coverage.

I'm sure that many of you have already come up with your own Top 10 list for yourself and your practice. But if you find yourself not sure how to develop a *Top 10 List*, there is always the Top 10 List on *How to Create a Top 10 List* to help you.

If you have any questions or would like to discuss any of these issues, please contact Susan Orr, Esq. of Rhoads & Sinon LLP at 610-423-4200 or by email sorr@rhoads-sinon.com. ▲

REFLECTIONS

continued from page 6

healthcare transformation that has already begun. We have to better communicate the value and benefits of family medicine and the important role family physicians play in meeting the healthcare needs of the US population to relevant stakeholders. We have to strive for the changes in the continuum of education (from medical school, through residency, and into continuing professional development) to train the family physicians that are needed in the new healthcare system. It is important to invest time in developing and nurturing relationships with nurses, nurse practitioners, pharmacists, social workers, behavioral specialists, public health staff and most importantly our patients so that we leverage each other's skills to deliver high-quality, efficient patient-centered care. Future success depends on our ability to create value for our patients. That time has come. We have to rise to the occasion and respond to the challenges of an evolving healthcare system so that we all can meet the needs of our patients and our nation now and well into the future.

Reflecting back, I have to say that I left Kansas City rejuvenated, and with great satisfaction in the realization that I met some of the finest people in family medicine; the individuals who organize these high quality events, respond to our emails, phone calls and personal requests at the national and state chapter offices. These are the silent heroes behind the Family Medicine revolution that is underway. Please join me in saluting them. I am proud to represent you, my colleagues in Family Medicine, and as I transition from President to Board Chair in the next few weeks I will remain committed to our success. Thank you for the opportunity to serve you this year. ▲

Give someone the ride of their life.



**Volunteer to drive
cancer patients.**

1.800.ACS.2345
www.cancer.org



MY INSPIRATION:

*helping medical students
achieve their dreams*



If you are a family physician with a passion for resident teaching and a commitment to excellence in patient care, then Inspira Health Network may have the ideal opportunity for you. Inspira Medical Center Woodbury, a progressive 305-bed community hospital in southern New Jersey, has an opening for a faculty position in our Family Medicine Residency Program.

The faculty role encompasses resident and medical student teaching and mentorship, curriculum development, direct patient care (both inpatient and outpatient) and areas of scholarly activity or interest. An M.D. or D.O. degree with certification by the American Board of Family Medicine is required. Salary is competitive and dependent upon experience and qualifications.

Interested applicants can find out more about us on our residency website at www.inspirahealthnetwork.org (under Medical Education: Family Medicine Residency Program Woodbury).

EOE

inspira
HEALTH NETWORK

Farewell

Gerald Banks, MD

Gerald Banks, MD is the Senior Resident Trustee for the NJAfp

HELLO fellow residents and students, as my two year term as your NJAfp Resident Trustee draws to a conclusion, I wanted to fill you in on what we have been up to as an academy and, more importantly, what lies ahead for the family medicine residents and students of New Jersey. As an NJAfp Resident Trustee, I have been able to leverage my influence to help reach hundreds of fellow family medicine residents and medical school students while promoting family medicine in the state, much of which you will see below. But it extends beyond that, it is also about conveying the resident's perspective to the NJAfp Board and bringing to light issues that are specifically oriented to residents and students, which I have been able to do.

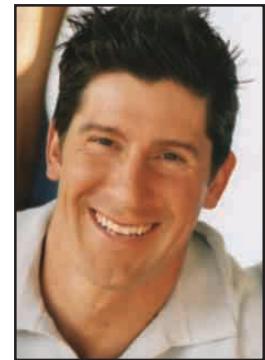
For the last two years, I joined the New Jersey delegation (made up of current and past NJAfp presidents and the executive vice president of the academy) have been traveling to Washington, DC as part of the Family Medicine Congressional Conference (FMCC), lobbying Congress on behalf of SGR repeal. I'm pleased to report that after years of lobbying by the NJAfp, AAFP, and most other medical societies, this broken antiquated payment system was finally removed. What does this mean for family medicine residents in New Jersey? A ton. First, the repeal of the "doc fix" is tantamount to job security. By rescinding Medicare's sustainable growth rate (SGR) formula for physician compensation, Congress averted a 21% pay cut to physicians this year. The bill, entitled MACRA - Medicare Access and CHIP Reauthorization Act, will freeze Medicare rates at pre-April levels through June, and then raise them 0.5% in the second half of the year. They will continue to increase 0.5% each year from 2016 through 2019. At the same time, MACRA will shift Medicare compensation from fee-for-service to pay-for-performance. This is great for the future of family medicine residents, placing an emphasis on quality of care and not labs ordered or procedures done, something we are taught early in our training. It also makes family medicine a more desirable specialty choice among medical students.

To that end, as resident and student trustees of NJAfp, we organized a conference at the Family Medicine Education Consortium (FMEC) to reach out to medical students. Here we engaged with students throughout New Jersey and abroad at this Philadelphia based meeting. We organized small group sessions and discussed topics relevant to medical student interests. The group I hosted discussed "to stay in New Jersey or not," factors affecting whether or not medical students in New Jersey medical schools choose a residency program in-state. At the conclusion of the group sessions we came together and discussed our findings. I feel that we were able to address many factors that might be keeping students away as well as keeping residents from remaining in-state post-residency. I have been working with NJAfp and the AAFP in addressing these issues going forward.

As NJAfp Resident Trustee, I also traveled to the AAFP National Conference in Kansas City, both in 2013 and 2014 as a representative to the academy. It was here I advocated on behalf of family medicine residents of New Jersey on the national level, ensuring that our issues were on the forefront of the AAFP's agenda. Being a member of a state academy gives you access and opportunity to many other

tremendous leadership positions within the AAFP. At National Conference, I ran for and was elected to the position of Resident Delegate to the AAFP Congress of Delegates. During my 14-month term, I represented resident member interests at the AAFP Congress of Delegates in 2013 in San Diego, CA and 2014 in Washington, DC by following resolutions and issues pertinent to family medicine residents. I functioned as a member of the AAFP Commission on Education and also sat on and was a voting

member on the Subcommittee on Resident and Student Issues and Subcommittee on Graduate Curriculum, for this, I also attended all AAFP Custer Meetings in Kansas City. I kept lines of communication open with resident members to facilitate dialogue on issues important to residents via AAFP listserv and social media and kept the issues germane to New Jersey family medicine residents.



Advancing family medicine in New Jersey means speaking to medical students, like our conference at FMEC. We also traveled to area medical schools. Last year, I was the key speaker to the Family Medicine Interest Group at Rowan University Medical School. I traveled to Camden to speak with 1st and 2nd year medical students on behalf of NJAfp. My aspiration was to encourage them to choose a career path in family medicine and further to pick a family medicine residency program in the state of New Jersey. The talk was well received and I had the opportunity to field a variety of email questions in the preceding months to additionally make a positive impact for the choice of family medicine in New Jersey. As trustees we also traveled to RWJ Medical School and had student trustees organize talks at NJMS.

The resident trustees also organized and were key speakers at the NJAfp Resident and Student Town Hall in conjunction with the 2014 NJAfp Scientific Assembly. We spoke with family medicine residents, medical schools students, and university students on issues related to the practice of family medicine in New Jersey, as well as the choice of a residency program and why to stay in New Jersey. We answered questions on a variety of subjects related to the advancement of family medicine in the state.

Lastly, but certainly not least, we organized the 1st Annual NJAfp Leadership Conference and Student/Resident Caucus 2014. The leadership workshop was led by Dr. Andrew Morris-Singer from Primary Care Progress. It was here we established the NJAfp Student and Resident Caucus as our voting body, operations planning, and to serve as the backbone of our communication network to New Jersey medical schools and family medicine residency programs. This year we will hold our 2nd Annual NJAfp Leadership Conference and Student/Resident Caucus. If you or anyone in your program is interested in taking a more active leadership role in New Jersey family medicine this is the opportunity for you to really make a difference. Would you like to travel to Washington, DC and caucus with national leaders; would you like to travel to the AAFP National Conference and lobby of behalf of the residents and students of New Jersey; would you love traveling

the state and expounding the virtues of family medicine in New Jersey; would you like to develop leadership skills that cannot be obtained in residency? If so, then you would make an outstanding candidate for the next NJAfp Resident or Student Trustee. Elections will be held in conjunction with the upcoming Leadership Conference and more information will be emailed to each family medicine residency program coordinator soon. It will be an exciting fun-filled conference, we look forward to having you there so I can hand you the torch!

Speaking of exciting and fun-filled, the last three years have been a wild ride. For all my fellow residents graduating in June... congratulations! And for those of you with one or two years to go, I would like to offer up this one piece of advice that I have recently found to be the most paramount of all. Eleven months ago I was diagnosed with cancer. No, this is not a pity post. Far from it, this is a celebration of life. I think all too often as residents we get so caught up in residency that we tend to let everything else fall by the wayside, family included. From 80-hour work weeks, research, call, In-Service Exams, 40 deliveries, and et cetera et cetera, everything

else just fades into the distance. When someone tells you that you have cancer, everything STOPS. As family doctors we often have to give bad news to our patients and we are trained in the art of giving such news. Yet, never, are we quite prepared to RECEIVE the bad news. After having personally gone through all of Elisabeth Kübler-Ross's stages of grieving, I can tell you as a resident I was ill-equipped for this kind of communication. What I learned is this, and I know it is going to sound trivial and cliché but...life is short. Please remember this above all else. These moments you have on this earth can be gone in an instant regardless of how healthy of a lifestyle you live. My advice: never spend one extra minute at work if that same minute could be spent hugging your kids, kissing your significant other or telling your parents that you love them. I don't portend to know what the future holds but I can assure you, I will be living each and every minute to its fullest. Please don't get so caught up in residency that you lose track of this. After all, no one ever looks back on their life, no matter how long or short it was, and thinks "I wish I would have worked more!"

Family Medicine-Public Health Integration: THE TIME IS NOW

Robert Kruse, MD, MPH

Robert Kruse, MD is a resident at the Rutgers - RWJMS Family Medicine Residency at CentraState Medical Center in Freehold and a Resident Trustee of the NJAfp.

N RECENT YEARS, leaders in the family medicine community have begun to place more emphasis on population health and community outcomes versus individual patient issues, transitioning from the traditional fee-for-service payment model to one emphasizing incentives, quality, and value. As this shift begins to take root, physicians and practices are re-evaluating their care processes in new ways, especially as they relate to a larger patient population.

Developing alongside this trend is the growing recognition of the untapped potential of how collaboration between primary care practitioners and public health officials can improve health outcomes. Integration of primary care and public health is now considered an extremely worthwhile avenue towards better chronic disease management, improved quality of care, and lower total cost. Local health departments can augment the work that primary care does on an individual basis to a community level through regulatory and legislative decisions designed to impact the health of an entire population. Clean air and water ordinances, lead prevention programs and motor vehicle laws are all examples of these types of actions that were successful in constructing an environment where the healthy choice is

the default choice. As family medicine physicians, we can and should provide input to shape these policies. Our promotion of a particular law has the potential to significantly impact its success or failure.

Family physicians and their public health peers have always had the common ultimate goal of improving the health and wellness of people, however both continually achieve this goal from different angles and with different viewpoints. With family doctors focusing on serving individuals and families, and public health professionals targeting the community as a whole, a divide has formed between the two groups. At times, this separation has led to competing objectives and created hurdles for both groups.

In December 2014, the AAFP published its own position paper entitled, "Integration of Primary Care and Public Health" which promoted the interaction between family medicine physicians and public health professionals. In the article, the AAFP "urges its members to become informed about the importance, the value, and the movement for integration of primary care and public health. Family physicians play a critical role in integration and can continue to contribute through inclusion of local, regional, state, and national public health partners within the medical neighborhood."

In my family medicine residency program, we are given the opportunity to work at the Monmouth County

Health Department, homeless shelters and local schools. Through these public engagements we learn the value of empowering communities through education, policymaking and leadership development, bridging the gap between primary care and public health.

The AAFP ends its white paper with the statement:

"The role of the Family Physician in integration will be a large one as Family Medicine is poised to be the leadership specialty of the new culture of medicine. Health systems as well as educational institutions, tasked with providing and promoting community health will undoubtedly be looking to their primary care specialties for advice. These leadership roles must start, however, at the individual physician level and move up to the practice level."

As budding family doctors, family medicine residents in the state of New Jersey need to understand the value of not only being excellent clinicians to their individual patients but also of serving the needs of the community, addressing social concerns, advocating for public policies, engaging in community-based research, and becoming change agents for better global health. ▲

Reference

1. "Integration of Primary Care and Public Health (Position Paper) - AAFP Policies." 2014 December Board, 28 Dec. 2014. <http://www.aafp.org/about/policies/all/integprimarycareandpublichealth.html>

Family Physician Gets to the Heart of the Matter

This is the first in a series of physician profiles. If you have an interesting patient story, are offering innovative services or treatment modalities in your practice or know a fellow physician who should be featured, please provide your ideas to Claudine Leone at claudine@njafp.org.

When a patient is happy with a family physician, it is typically because of a good bedside manner, a caring and compassionate nature and the feeling that the patient's concerns being heard.

Liz Thomas, 55, has been a patient of Stephen Land, MD, a family physician with Virtua Mount Laurel Family Physicians for more than 20 years for these very reasons. But 12 years ago, it wasn't Dr. Land's usual interest in what Liz had to say, but more importantly what he heard through his stethoscope, that ultimately saved Liz's life.

"I was scheduled for a routine visit and a review of my blood work. Things were heading on the right path until Dr. Land listened to my heartbeat and heard something different. Those four words, 'I hear something different,' led me on a long path of discovery that ultimately turned out to be an aortic aneurysm," says Liz.

In June of 2013, Liz had successful open heart surgery to repair the aneurysm, which if left undiagnosed and untreated, could have resulted in a rupture. Today, Liz has been given a clean bill of health and is living life to the fullest, thanks to that not-so-routine visit to Dr. Land's office.

But despite the credit Liz, her parents and daughter – all patients of Dr. Land – give the family physician, he remains humble about the role he played.

"I never call this a job; it is just what I do," he says.

The Vincentown resident found his calling in family medicine naturally. He started his medical career as an EMT with the Hampton Lakes Emergency Squad in Southampton, NJ.

When he decided to pursue a medical degree at the University of Medicine and Dentistry of New Jersey, he wasn't sure if he wanted to specialize in emergency medicine and trauma or cardiology. But during a break from medical school, Dr. Land had an opportunity to work alongside Bob Irvin, MD, a physician from Manahawkin who led a family medicine practice. He was so impressed at how well Dr. Irvin knew his patients and their families that he decided to pursue family medicine himself. Dr. Land says after that experience with Dr. Irvin, family medicine "just felt right."

Dr. Land went on to graduate from Rutgers Medical School in Camden with his medical degree and complete a residency in family medicine, with added qualifications in geriatric medicine, at Virtua Mt. Holly, formerly Memorial Hospital of Burlington County. Today,



Stephen Land, MD (l) with his patient, Liz Thomas (r).

he is a diplomat of and is certified by the American Board of Family Medicine, and he is a Fellow of the American Academy of Family Physicians.

"I love family medicine because my day is full of unusual and diverse situations – routine visits, simple illnesses and life-changing circumstances," says Dr. Land. "I know I'm seeing patients during what may be vulnerable and stressful moments in their lives. My goal in interacting with patients is to listen to them, give them a clear path to follow, and some words of encouragement along the way."

"People want a doctor they know they can trust to do what's in their best interest," says Dr. Land. "They want someone they're confident in, and it's my aim to be that kind of physician." ▲



Physician Profile will be a new and recurring View in Perspectives. If you know a family physician who has an interesting story to tell, please contact Claudine Leone at: claudine@njafp.org or by calling (609) 394-1711.

Another Free Resource from the NJAfp

Candida Taylor, Tar War Coordinator

THANKS TO A GRANT from the AAFP Tar Wars program, NJAfp has developed this informational card to help your patients quit smoking and start on a path to a healthier lifestyle. The bilingual piece (English/Spanish) has been distributed to Family Medicine Health Centers in four medically underserved communities in the state. If you would like to get copies for distribution in your office, please contact Candida Taylor at candida@njafp.org or call 609-394-1711.

QUIT NOW!
Take the right steps now to be a healthier YOU.

Did you know...

- Smoking affects Babies** - In babies aged 18 months and younger in the U.S., secondhand smoke exposure is responsible for:
 - 150,000–300,000 new cases of bronchitis and pneumonia annually
 - Approximately 7,500–15,000 hospitalizations annually
- Smoking affects Women** - Women smokers are up to 40 times more likely to develop COPD (Chronic Obstructive Pulmonary Disease) than women who have never smoked.
- Smoking affects Fertility** - 18 million males over age 20 suffer from erectile dysfunction (ED). Smoking is a cause of ED, as cigarette smoke alters blood flow necessary for an erection.
- Smoking affects Children** - 5.6 million children alive today will ultimately die early from smoking. That is equal to 1 child out of every 13 alive in the U.S. today.

Source: <http://nlobaccofree.hhs.gov/about-tobacco/facts-figures/index.html>

You are not alone. Call now to learn how to quit safely and for good.
1-800-QUIT-NOW

Tar Wars®
www.tarwars.org

This patient information page is made possible by a grant from the American Academy of Family Physicians Tar Wars Foundation, the New Jersey Academy of Family Physicians and Trenton, Inc. of Ewing, NJ.

Since Tar Wars national funding has been redirected to encourage state chapters to engage in a more direct dialogue with patients (adult and pediatric) in physicians' offices, we are challenged to continue the Tar Wars program here within New Jersey. Providing 4th and 5th graders with the important tobacco free education program and promoting the poster contest are still critical components of advancing the goal to lead younger generations toward healthier lifestyles.

We hope your students participate in the poster contest because this activity is very important. It is not just about drawing pictures. The purpose of the exercise is to encourage artistic expression in the students who have heard the Tar Wars message—to internalize

it and apply it to their own lives. Their "inner voice" should begin by saying, "if I choose to be healthy, to not harm my body and to participate in activities that will lead me on a good path... then what kinds of amazing things will I be able to accomplish?" If that message is properly conveyed by the presenter, then the posters should reflect these dreams. So the purpose of the poster contest is to reinforce the Tar Wars message, but in a deeply personal way for each student.

¡DÉJELO YA!
Tome pasos ahora para ser una persona más saludable.

¿Sabe usted...?

- Fumar afecta a los bebés** – En los EE.UU., entre bebés menores de 18 meses de edad expuestos al humo de segunda mano hay:
 - 150,000-300,000 nuevos casos de bronquitis y neumonía cada año
 - 7,500-15,000 hospitalizaciones cada año
- Fumar afecta a las mujeres** – Mujeres fumadoras tienen hasta 40 veces más probabilidades de desarrollar EPOC (enfermedad pulmonar obstructiva crónica) que las que nunca han fumado.
- Fumar afecta a la fertilidad** – Más de 18 millones de hombres mayores de 20 años sufren de disfunción eréctil (DE). El tabaquismo es una causa de disfunción eréctil, como el humo del cigarrillo altera el flujo de sangre necesario para una erección.
- Fumar afecta a los niños** – 5.6 millones de niños vivos hoy terminarán muriendo prematuramente por el tabaquismo. Eso es equivalente a 1 niño de cada 13 que está vivo hoy en los EE.UU.

Fuente: <http://nlobaccofree.hhs.gov/about-tobacco/facts-figures/index.html>

No estás solo. Llame ahora para aprender como dejar de fumar con seguridad y para siempre.
1-800-QUIT-NOW

Tar Wars®
www.tarwars.org

Este hoja de información para pacientes es posible gracias a una teca de la American Academy of Family Physicians Tar Wars Foundation, de la New Jersey Academy of Family Physicians, y de Trenton, Inc. of Ewing, NJ.

To that end we have secured space in the State House in here in Trenton for the week of June 1st – 5th for our NJ State Tar Wars Poster Contest. On Thursday, June 4th, a winner will be announced in Goldfinch Square and the artist and their poster will be celebrated, a prize will be presented, photographs taken, and press releases issued acknowledging a student's dream to live a healthy life and achieve great things as a result. Please plan to join us if you are in the area – it should be a fun day for all.

We continue to ask you to please present Tar Wars in your local school districts and share the powerful and important message of Tar Wars—that with healthy choices, great things are possible in life. ▲

Pack your Bags. We've been summoned to the Palace *continued from page 5*

We will again be hosting the very famous Resident Knowledge Bowl. We want you to know that we heard loud and clear that while this is a very popular event, it needs to be restructured to optimize the experience for all. A team of dedicated family physicians and staff are working together to make sure this event remains a highlight of the meeting.

We all know everyone loves Kenny I. He and his orchestra will be returning to help us celebrate the installation of Dr. Robert Gorman as NJAfp President, as well as recognize the new board members and 2015 award recipients. Even if you can't make the meeting, the President's Gala is an event not to be missed.

So as you can see, we have a lot planned for you at the New Jersey Family Medicine Conference. Take a moment to mark your calendar and make plans to attend The 2015 Scientific Assembly: The New Jersey Family Medicine Conference. I hope to see you there.

Happy Reading,

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

Tar Wars®

CDC LAUNCHES 2015 TIPS CAMPAIGN

The AAFP has partnered with the CDC on the 2015 *Tips from Former Smokers* campaign. The campaign launched on March 30th and features real, and harsh, stories about the consequences of smoking from former smokers. These stories focus on the not so well known consequences of smoking including patients who developed early rectal cancer and colon cancer, and a patient who began to lose their vision at the age of 56 due to macular degeneration. The campaign will run through August 16, 2015.

According to the AAFP, over the course of the campaign "... many of your patients who smoke will see the hard-hitting *Tips From Former Smokers* ads, motivating them to consider quitting. For patients who are ready to quit, your guidance and support are key to helping them become former smokers themselves."¹

CDC is asking all advocates of smoking cessation to get the word out through social media and to follow the campaign on Facebook, Twitter, YouTube, Instagram, and Pinterest for the latest updates.

CDC has a list of comprehensive resources available for you to use on the CDC Tips Health Care Professionals page. Among the resources you will find are fact sheets, handouts for your patients, FAQs, and intervention cards. You can access the site at: <http://www.cdc.gov/tobacco/campaign/tips/partners/health/hcp/index.html>.

In addition to CDC resources, the AAFP also has a variety of resources available through the Ask and Act program. The Ask and Act program encourages family physicians to ASK all patients about tobacco use, then to ACT to help them quit. More information is available at <http://www.aafp.org/patient-care/public-health/tobacco-nicotine/ask-act.html>.

Resources:

1. Tips From Former Smokers. 2015. (Accessed at <http://www.aafp.org/patient-care/inform/cdc-tips.html>).



Free Resource - 1-800-QUIT-NOW Notepads for Health Care Providers & Counselors

These 20-sheet notepads (5.5 by 4.25 inches) include the quit line number, 1-800-QUIT-NOW, and the CDC's Tips From Former Smokers campaign website address, www.cdc.gov/tips, on each page. Healthcare providers can use these to write notes and instructions for smoking patients, who may want and need resources to help them quit smoking. Available at http://nccd.cdc.gov/OSH_Pub_Catalog/SearchResults.aspx

CME Quiz Answers

1. False (50%) 2. True 3. True 4. False 5. False (tolerance) 6. True 7. True 8. False (>30) 9. True 10. False (Alone, Back, Crib)
11. True 12. True 13. False (they should receive both) 14. True 15. False (hx should be considered)

A Truly Strong Man

Sara B. Leonard, MD

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

"MY SON-IN-LAW SAYS that I have a six beer can stomach," proclaimed Mr. B as I performed an abdominal exam. While the phrase may have been a bit mixed up, I could not deny that his abdominal muscles were more toned than any other 87 year-old I had ever examined. He went on to say how his son-in-law was impressed with his ability to push the heavy lawnmower and mow the whole yard without needing to stop and take a break. "He said I could win a fight with a guy one-quarter my age." Once again, I tended to agree with Mr. B's son-in-law. Mr. B is an extraordinarily fit and healthy 87 year old gentleman. However, it is not his physical strength, but another type of strength for which I admire him most.

I first met Mr. B about six months ago when he came in to the office for an initial visit and to establish care. He and his wife both had appointments, but he came in first, alone. He was very neatly dressed in clothes that I could tell were old, but very well cared for. Perhaps a metaphor for things to come. He was extremely friendly, greeting me with a warm, sincere smile as he immediately began to tell me the reason for his visit – a speech, I was sure he had mentally rehearsed several times prior to our encounter. He told me that he and his wife had recently relocated to the area from Florida, to be closer to their children. He brought records from his former physician, but assured me that he is in excellent health. "The good Lord has blessed me," he said – an affirmation I would hear often from Mr. B. "I'm really here to talk about my wife," he said. "You're going to see her next. She was diagnosed with dementia last year. Most of the time she's pretty good, but once in a while she can be rough." Having

At that moment I looked down at his hands – hands that could tell a lifetime of stories as they sat folded neatly in his lap...

had plenty of experience with dementia both in my own family and through my patients, I felt as if he didn't need to say another word. I understood. He backtracked by saying that she is a very smart woman, as family members of those with mental illness and memory issues often do. "She still takes care of our checkbook." I nodded, and made a mental note to investigate that statement further after meeting Mrs. B.

My first meeting with Mrs. B. revealed a plump, giggly, 88 year old woman with poor insight into her general medical problems, other than being overweight. "My husband said he's okay with me getting fat as long as I'm okay with him going bald," she quipped. When asked about her memory, she said she thought it was about

as good as that of anyone else her age. Her SLUMS score would contradict that. I empathized with her husband as he sat quietly while she attempted to answer the simple-seeming questions, giggling her way through the exam. He later told me that she had gone to drafting school as a young woman, and worked for the military during the war. I couldn't help but feel sad as I thought about some of the heartbreaking changes that lie ahead for the B's as the dementia continues to run its course.

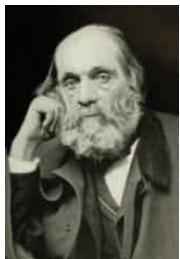


Over several months of providing comprehensive care to Mr. and Mrs. B, as we family physicians do, I gained better insight into the impact of Mrs. B's dementia on the couple's daily life. I heard of an evacuation of their senior complex after Mrs. B set the microwave on fire and I treated Mr. B's arm for an injury obtained when Mrs. B left an aerosol can too close to the stove on which she was cooking. Through my many discussions with Mr. B, I have offered caution, advice, anticipatory guidance, and understanding, but I'm not sure if I ever told him anything he didn't already know, or at least intuit. He seems to have figured out how to effectively weather the storm that is stripping the woman he married 66 years ago down to a shell of who she used to be. He seems to have figured out how to take it in stride, all the while thanking God for his many blessings.

I'm often amazed by how Mr. B works very hard to maintain his wife's dignity and preserve her subjective reality. I eventually learned that, yes, she manages a checkbook, but it is not THE checkbook. "There are so many things she can't do anymore, like driving, I just couldn't take something else away from her. It's demoralizing," he told me.

During my most recent visit with Mr. B, he was wearing a pair of boots, which he proudly told me are 45 years old, and that he used to wear them on his motorcycle. For a while, I let myself be distracted by his stories of how he and Mrs. B "went touring all over the United States" on that motorcycle. It seemed like the most therapeutic thing I could do for him at the time. Later during the visit his eyes glazed over as I spoke about focusing on him, and taking care of the caretaker. He informed me that he and Mrs. B volunteer at a soup kitchen a couple of days each week. He said, "Sometimes she acts up while we're there, but I think it's important that she gets out and does things. I'm not going to hide her away from the world just because she is the way she is." At that moment I looked down at his hands – hands that could tell a lifetime of stories as they sat folded neatly in his lap. Although I had said it many times before, I grasped his hands in mine, looked into his troubled eyes, and told him sincerely "you are taking excellent care of her and she is very lucky to have you." Then he did something only a truly strong man would do; he let me see him cry. ▲

Support Your Foundation



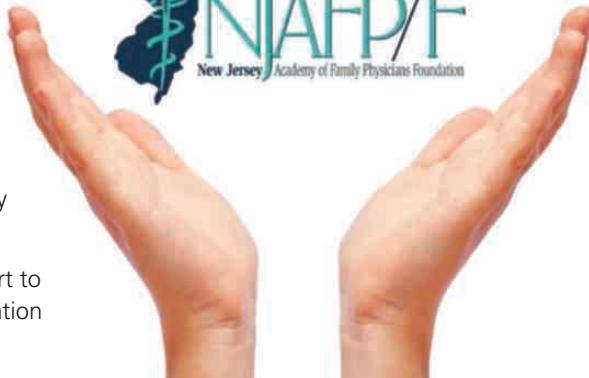
"I am only one, but I am one. I cannot do everything, but I can do something. And because I cannot do everything, I will not refuse to do the something that I can do."

– Edward Everett Hale

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

In Memoriam: _____

Card # _____ Exp. Date: _____

Name: _____

Telephone: (_____) _____

Billing/Mailing Address: _____

City: _____ State: _____ Zip: _____

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

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

Leading With Compassion.

*"We are here for you
every step of the way."*

Stephen Goldfine, MD
Chief Medical Officer

Comfort, dignity and peace of mind from South Jersey's leader.

- Samaritan Hospice Care
- Palliative Medical Partners
- SeniorWise Care Management
- Center for Grief Support



Not-for-Profit Since 1980

(856) 596-1600
SamaritanNJ.org



We Honor Veterans