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Moving Toward Cultural Competency

Healthcare professionals have to deal with an increasing level of diversity within their patient populations. This burden is felt more heavily in some states, such as California, than in others. With more state governments, the federal government, accrediting bodies, and the media focusing their attention on the necessity of cultural competency in health care, physicians are under enormous pressure to develop their cultural competency skills. Because many people within the aforementioned organizations felt that diversity issues were not being addressed with the specific goal of closing the gap between minority and traditional cultures quickly enough, legislation was and continues to be proposed to force the closure. New Jersey was the first state to pass legislation in the area of cultural competency training as a condition of licensure.

It is obvious from the review of the literature that cultural competence in health care is an evolving and ongoing process, however, mandates and legislation alone are not going to result in culturally competent care. In addition, understanding all the behaviors and beliefs that affect a specific culture's view of health and health care would be impossible to comprehend.1,2,3 Tools are required to aid physicians in the development of their skills that go beyond the traditional illness explanatory model (EM),2 which was designed to help healthcare providers gain an understanding of a patient's perception of his or her illness.

In this issue, we provide a framework on the culture competency legislation in New Jersey and provide a comprehensive list of resources to assist New Jersey physicians to continue to do what they do best: deliver quality, patient-centered care.

Happy reading,

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

References
When I was considering my final article as president for Perspectives, I was somewhat saddened to realize that my term of office was concluding when there is still so much more to do. Then I realized that the Academy will continue to have excellent leadership under our new president, Dr. Marty Sweinhart, and a board of trustees comprised of physicians dedicated to family medicine and the New Jersey Academy of Family Physicians.

As family physicians who provide the best possible comprehensive and efficient primary care to our patients, we fully understand and experience all the obstacles placed in the way of the delivery of that special care. As president, I embarked on a mission to try and resolve as many as I could within my year and am happy to report that the Academy has had some successes.

As we “live in interesting times,” there were several critical issues that we faced that affected us specifically and our profession in general. I have had the pleasure to meet with several of the key legislators, both in Trenton and in their District offices, promoting legislation that will be beneficial to us and our patients. I’ve also been able to lobby against adverse proposed legislation. Claudine Leone, Esq., has been the intricate catalyst, working with our Government Affairs Committee, for these meetings and their for their success. The NJAFP must continue to pursue legislative actions to improve the poor ranking that New Jersey has in health care.

Our leadership will continue its ongoing dialogue with the Department of Banking and Insurance (DOBI) to help gain regulatory relief from insurance hassle factors which affect our patients’ health and the efficiency of our offices, taking time away from patient care. We have reached out to our membership for help in providing data for presentation to our government officials to bring to light these dilemmas.

Our dialogue with Horizon, our major medical insurance company, has finally been successful on several fronts. The relationship between NJAFP and Horizon has become stronger with the ability of NJAFP to have input in policy making.

The patient-centered medical home concept and its introduction as the new paradigm of medical delivery for better outcomes and increased reimbursements for primary care physicians continues to be a major topic of discussion. I encourage all of you to log on to the AAFP Web site for more information and to get acquainted with this exciting concept. All primary care organizations support the concept, insurance companies have a great interest, and Congress is being lobbied. I believe it will be beneficial not only to us and our patients, but for the nation as well.

As I leave office, I am happy to report that much has been accomplished this year. Though there is much to do, the future looks brighter. This year the match for family medicine has taken an upturn, which is encouraging. Our voice is being heard in Trenton as well as with our congressional delegation. We have input to our regulatory agencies and insurance companies. To continue these advances, your new president will need your help. We need all members to step up to the plate and participate in our future by becoming active members by making political contributions to our NJAFP PAC and to the AAFP MedPAC. We need each of you to be involved with the Academy and to send us documentation of your problems with insurance companies. And you must begin to enlist your patients to aid and assist us in our ability to provide them with the best comprehensive care possible.

Without our excellent staff, led by our executive vice president, Ray Saputelli, CAE, my term as president would have been impossible. I extend my thanks to him and the rest of the NJAFP staff on behalf of myself and all of our members. Each member of our staff has played a major role in the success of the New Jersey Academy of Family Physicians, and we could not do what we do without them.

Thank you for the opportunity to serve you as your president.
Transformation. It has become our new buzzword, and as buzzwords go, it's a pretty good one. After all, one of the most basic principles in life is that things change, but too often we do not feel like we are in control of the changes that affect us. On the surface, transformation is change but it implies so much more than simple change. It's a bold word that implies the existence of a process, a controlled movement from one state to another. If you allow yourself to approach the word from a child’s view - as is often useful - look for the “Transformers” either in movies, cartoons, or those irritating little toys that sit in the hallway just begging to pierce the underside of my foot. What better way to understand the severity of a term than to equate it to a man-machine that slips between action-figure and vehicle before our eyes (and saves the world in the process)!

Today, as I often do before I set out on the journey that results in the transformation of a blank screen to one filled with words hopefully suited for publication, I did a little homework. I looked at various definitions of the word “transformation.” In each definition I found more big words and important sounding concepts, each of which could ultimately be reduced to “change.” I found words like “metamorphosis” and definitions that included descriptive processes such as the “development of the germ into the embryo or the egg into the animal.” It occurred to me that while those things may be change, they are pretty serious change. Then I stumbled onto the following definition: “The change, as of an equation or quantity, into another form without altering the value.” The last part struck me. I let the words “without altering the value” bounce around in what my dad used to call the vacuum between my ears. What was it that drew me to that particular definition? Then it dawned on me, the definition highlights what I’ve considered to be one of the most important questions that family physicians - and those who work on their behalf – face in our effort to “transform” the healthcare system. Perhaps unfortunately, it’s a question that’s been asked and answered many times, often with subtle or not so subtle differences in the answer. What I believe may be even more unfortunate is that the vast majority of family physicians on the “front lines” still aren’t sure that it’s the right question to ask.

When we talk about transformation in health care, we are really talking about a staggering, and perhaps overwhelming number of changes, and frankly, not everyone agrees on each point of change, making the effort all the more difficult. Some are talking about “transformation” of the way purchasers spend their healthcare dollars. Some are interested exclusively in “transforming” the payment system that compensates physicians. Some would like to see the delivery system “transformed” in a way that eliminates commercial payers and restores the doctor-patient relationship, and some believe that the answer is in how we “transform” the practices of family physicians in both the office and the treatment room. I am beginning to believe that each of these changes, in and of themselves are not “transformation” by any of the definitions that I’ve found, but are in fact pieces of the larger transformative effort.

Which brings me back to the question that one intriguing definition inspired. I can hear you saying: “Enough already! What’s the question?” It’s this: What’s the value? Are we trying to change the “system” into another form without altering the value? I don’t think that’s the case. There seems to be general agreement that we pay more for less in terms of health outcomes in the United States than anywhere else wherein a comparison can be drawn, so I would assume that most of us want to see the value altered in that regard. So if we are not talking about the system, then are we talking about ourselves? Do we want to transform our practices without altering the value that we deliver? Good question. The often quoted work of Starfield, et al. seems to suggest that a strong primary care infrastructure adds value – better health outcomes at lower cost. family physicians are the quintessential primary care provider based on training and philosophy. If both of these statements are true, then simply adding more family physicians should go a long way toward solving the problems we face. Yet it would seem that many of us do not believe that to be the logical progression. I say that because the conversation continues to focus on the “realities” that demand that we (ok you; I still keep forgetting to enroll in medical school) “transform our practices.” If we
The New Jersey Academy of Family Physicians is pleased to support the campaign of Robert “Butch” Pallay for President Elect of the American Academy of Family Physicians.

We believe that Butch Pallay is the best candidate to represent us as the next leader of the AAFP. To understand why we feel this way, visit www.drbutch.com to read his blog or hear him speak on the important issues. You will come to understand why we feel Butch is the best candidate to bring meaningful change to Family Medicine.

Richard Cirello, MD
NJAFP Delegate

Mary Campagnolo, MD
NJAFP Alternate Delegate

Richard Corson, MD
NJAFP Delegate

Mary Campagnolo, MD
NJAFP Alternate Delegate

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What Have You Done For Me Lately? Let Me Tell You.  

Sal Bernardo, MD

Although I have always been the type of person to be involved, it has always been my philosophy to not be in the forefront. I would rather work in the background and blend in. However, I felt compelled to write this article for Perspectives to let you, my colleagues, know that (not to be cliché) this is not your grandfather’s academy anymore—not this New Jersey Academy of Family Physicians.

I say this because of a major problem I had with Horizon Blue Cross in March of this year. As you all may know, the insurance system, and especially Horizon, is quite broken, and I was on the receiving end of that issue in March. It started when I did not receive my capitation check and list for the month of March. Like a good doctor, I waited two weeks and then contacted them. When I spoke to a representative at Horizon, they said that it was a “computer error.” I was listed as fee-for-service in one computer system and capitated in others. The person I spoke with said he would correct that issue.

Approximately five days later, I received my usual envelope in the mail (a Saturday, of course) to discover that not only was there no check, but they said I owed them over $21,000 and had set up an accounts receivable on me! (For those of you who don’t really know what that is, Horizon has the unique process of holding back any future monies you rightfully and legally earn when they think you owe them money. Other companies that have overpaid me in the past would usually contact me with the explanation, outside of any other claims for which they need to pay me.)

I immediately e-mailed Ray Saputelli, our executive vice president at NJAFP, on Saturday afternoon and within a very short time received a reply from him. The Academy mobilized; e-mails were sent to members of the executive committee, and by Sunday contact had been made with a medical director at Horizon. On Monday my office received a call from Horizon, and by Wednesday my capitation check arrived at my office.

Being a small solo practice, this is an issue that could have been financially devastating for me, especially considering the state of affairs with medicine, particularly in primary care. It is important for all of you who read this to understand the swiftness with which this situation was handled. It would not have been possible without the support from our colleagues and the wonderful staff at NJAFP headquarters. My take-home message to you is do not underestimate the power that our Academy and our combined efforts as a group can have. I urge you to get involved, stay involved, talk to your fellow family physicians, go to the many great educational programs offered by our Academy, join a committee, and lend your voice. As far as I am concerned, it is still a great feeling to be a family doc—I wouldn’t have it any other way.

Medicaid Prescription Pad Law Took Effect April 1

As of April 1, 2008, federal payments will be denied to states for Medicaid prescriptions that are not written on tamper-resistant prescription pads. The law that regulates this policy was instituted to save money and prevent patients from illegally obtaining prescription drugs.

There are exceptions to the new rule. Prescriptions that are faxed, e-mailed, or called into the pharmacy are not covered. Also, prescriptions that are filled on an emergency basis may be written on regular prescription pads, as are prescriptions that are paid for by managed care plans.

While the law was originally to take effect last October, strong concerns from physicians and pharmacists about not being able to comply in time pushed the start date to April 2008.
Help Us Protect the Family Physician’s Scope of Practice

If you are a former physician’s assistant, nurse practitioner, or pharmacist who is now a family physician, we would like to hear from you. If you could take a few moments to answer the questions below, we can use this to build testimony to assist us in protecting the scope of practice for family physicians here in New Jersey, and through collaboration with the AAFP, across the country. You will have the opportunity to review the testimony, and we will share with you when and where it is used.

Reply directly to Ray Saputelli, CAE, at ray@njafp.org or give him a call in the NJAFP office at 609-394-1711. Please feel free to share this request with your colleagues who meet the criteria.

1) What profession were you in before you became a family physician?
2) What were the limitations of your prior profession?
3) What compelled you to return to medical school?
4) What are the differences in the care you provide now compared to the care you provided then?
5) Based on your educational and practical experience, why can’t your former colleagues provide the same level of quality care that you currently provide as a family physician?

Thank you for your assistance with this very important effort.

Help Us Protect the Family Physician’s Scope of Practice

What has the NJAFP Done For You Lately?

On April 16, 2008, Claudine Leone, NJAFP Government Affairs Director, met with Senator Nia Gill, chair of the Senate Commerce Committee, to discuss several pieces of legislation currently pending review by the Senate Commerce Committee, including legislation allowing assignment of benefits. NJAFP also discussed retail health clinics and their growing presence in New Jersey and reviewed other states’ legislative efforts to study or regulate these clinics.

On April 29, Claudine Leone also met with Assemblyman Neil Cohen, chair of the Assembly Financial Institutions and Insurance Committee, to discuss similar legislation pending review by his committee. They also discussed retail health clinics and issues regarding managed care hassles that we have raised with the NJ Department of Banking and Insurance, including the voluminous number of preexisting condition questionnaires being received by our members.

On May 8, NJAFP met with top officials at the NJ Department of Banking and Insurance (NJDOBI) to discuss many of the managed care hassle factors we continue to work on for our members. Dr. Robert Eidus of Cranford, New Jersey, attended the meeting with Ray Saputelli, CAE, Executive Vice President of NJAFP, and Claudine Leone, Government Affairs Director. We urge members to reach out to NJAFP to discuss specific examples to support our efforts working with NJDOBI.

NJAFP participated in the New Jersey Business & Industry Association NEW JOBS South Jersey Legislative Reception held May 13. Claudine Leone was one of 100 guests and nine state lawmakers attending this event.

On May 15, Ray Saputelli, CAE, and Claudine Leone testified before the Senate Health Committee in support of legislation (S-1557) sponsored by Senator Joseph Vitale. The legislation would expand eligibility and outreach of the NJ Family Care Program and make various reforms in the individual and small employer insurance markets to ensure affordability and stabilize cost. NJAFP’s testimony stressed to the committee that this proposal represents a “first step” in the quest for universal health care in New Jersey. NJAFP focused its comments on the need for the state to make an investment in primary care, including a focus on Medicaid and family care payment rates for primary care services, raising awareness of the need for primary care work force development in the state, and the adoption of the patient-centered medical home model in public programs like Medicaid and Family Care.

On May 19, Claudine Leone provided similar testimony on S-1557, Senator Vitale’s Universal Health Coverage Proposal, before the Senate Budget and Appropriations Committee. This legislation is awaiting a vote by the entire Senate and consideration by the General Assembly.

On May 22, NJAFP testified in support of A-804, which permits a qualifying patient to use and possess marijuana for medical purposes. Claudine Leone provided testimony that there are times when patients with these types of illnesses do not respond to traditional therapeutic treatments and the medical use of marijuana—where such use is within a professional standard of care as determined with the guidance, medical judgment, and discretion of their personal physician—may be beneficial.

On June 5, NJAFP testified before the Assembly Financial Institutions and Insurance Committee in support of A-2091, which would prevent a managed care plan from identifying an electronically submitted claim as “unclean” simply because the plan’s postal address field is left blank or incorrect. Claudine Leone provided background to the committee on this bill, outlining the problems NJAFP members have had in tracking multiple mailing addresses for certain managed care plans. NJAFP further stated that NJAFP’s preference was to have a single address for all claim submissions. However, certain managed care plans expressed their unwillingness to accommodate this request.
are not altering the value that we deliver, then we are simply trying to change how we demonstrate that value. If, however, we disagree with the definition, and believe that we must alter the value that we provide, then it must be true that the need to “transform our practices” is equivalent to altering the value of those services.

Which side of that chasm you find yourself on likely depends on how you answer the question “who sets the value?” Is it the payers? The “providers?” Is it the statisticians and epidemiologists who measure health outcomes? Is it the patient who expects more and more that someone else is responsible for their health, even when they make choices that consistently put their own health at risk? Is it the politicians who too often use health care as a political tool? More and more I’ve come to believe that the answer is “all of the above,” and the scary truth is that it is entirely possible that the value that family physicians delivered in the past is not sufficient to keep Family Medicine viable in the future. It is rarely possible to fix a problem simply by “throwing more money at it.” Yet even though we are too well aware that the payment model is broken, I fear that it is also becoming far too easy to become locked in the seemingly endless “demonstration-loop.” We must move beyond continually attempting to demonstrate that we are “worth more,” and then begging for a percent or two here and there, to actually redefining how health care is delivered and then demanding that the payment model is adjusted for that new value.

It becomes all too clear that the challenge of “transformation” is not only the work that needs to be done to ensure that family physicians are prepared to deliver primary care as it is demanded by our high-tech 21st century world while maintaining the high-touch 20th century philosophy that made the family doc a trusted member of most families. Likewise, the challenge of “transformation” is not simply the effort that we will need to direct delivery of care and improvement in payment systems to ensure that family physicians are empowered to deliver that care. Further, it is not simply redefining the role that the American patient must play in his or her own health. It is in fact all of those things, and none of them. The real challenge of “transformation” may be in convincing ourselves that the changes required of everyone else are no greater than those required of ourselves. We must not be afraid to look inside and say that what we have been yesterday may not be enough tomorrow. Maybe this is where the story comes full-circle. Perhaps our definition of “transformation” needs to end with “altering the value we provide, but not the VALUES that we hold dear.” As “things” change, people and systems must “transform.” Those unwilling will not survive, and the strength of their lobby or the amount of money in their PAC will do nothing more than stall the inevitable. Until we agree on that, no discussion of “transformation” is going anywhere. If you don’t believe me, go ask your local blacksmith.

As always, that is just my opinion. I welcome yours.
January 2008, New Jersey Governor Jon Corzine signed legislation establishing a Prescription Monitoring Program in the Division of Consumer Affairs. This legislation was pending for many years and finally moved in 2007. Assemblyman Herb Conaway presented this proposal at the NJAFP’s House of Delegates’ luncheon when it was introduced. This new program is intended to assist the Division of Consumer Affairs (DCA) in the identification and tracking of prescription fraud. This program does not place any direct responsibility on the physician, but rather requires pharmacists in an outpatient setting to forward to DCA, via an electronic system, certain information regarding prescribed controlled dangerous substances to assist DCA in identifying diversion of prescription drugs.

The law does impact physicians by requiring changes to the New Jersey Prescription Blank Law. Effective October 2008, all prescription blanks are to be numbered consecutively and to have the physician’s National Provider Identification (NPI) number preprinted on the blank. A letter was sent out to all prescribers in March 2008 advising of these new requirements. This letter can be found at http://www.njconsumeraffairs.gov/drug/NJPBltr1.pdf.

The Division of Consumer Affairs provided an extension to comply with the prescription blank changes from the statutorily determined effective date of May 23, 2008, to October 1, 2008, recognizing that prescribers needed to use their existing supply of preprinted New Jersey prescription blanks and also allow for additional time for approved NJPB vendors to process requests for new blanks. The DCA has already advised all New Jersey prescription blank vendors to immediately begin printing serial numbers on each batch of prescription blanks manufactured and distributed to authorized prescribers. In the meantime, prescribers may continue to use their existing “non-serialized” blanks until the October 1 deadline.

All New Jersey prescription blanks also must be preprinted with the prescriber’s NPI number by October 1, 2008. Individual prescribers currently have the option of either having the NPI number preprinted onto blanks for current orders or writing or stamping the NPI number in a reserved space on the blank. Remember, though, that as of October 1, 2008, the NPI number must be preprinted on the prescription blank. For more information on NPI numbers please see the following link: http://www.cms.hhs.gov/NationalProvIdentStand/03_apply.asp#TopOfPage.

Do you need your DEA number preprinted on your blanks?

Over the years we have fielded many calls from members about the practice of pharmacists requiring a physician to disclose their Drug Enforcement Administration (DEA) number even on prescriptions for non-controlled substances. The pharmacists say that the health plan does not pay the pharmacist when the DEA number is not provided for all prescriptions (controlled and non-controlled substances). As a result, it seems that some New Jersey physicians believe they are required to preprint their DEA numbers on their prescription blanks or simply have provided the preprinted DEA number as a matter of convenience. The reality is that physicians and other prescribers with DEA numbers are not required to preprint their DEA number on their prescription blanks or provide pharmacists with the DEA number for the prescription of a non-controlled substance. The DEA has issued letters to individual NJAFP members stating that this is not a recommended practice. The DEA recognizes that physicians’ DEA numbers are being used to track physicians’ prescribing practices and does not recommend the over-publishing of your DEA number. Whether you agree or disagree with the prescription tracking occurring in the industry, your DEA number should remain protected. It is believed that the introduction of the NPI number may resolve some of the problems with the over-distribution and publishing of your DEA numbers.

If you have any questions, please contact Claudine Leone at 609-394-1711 or Claudine@njafp.org.

All New Jersey-approved vendors are aware of these changes and are advising prescribers to exhaust their existing blanks and only order what they expect to use prior to October 1, 2008. Talk to your vendors because they may be able to preprint the serial numbers and the NPI on your current orders in anticipation of the October 1 requirement. For a list of approved vendors follow the link: http://www.njconsumeraffairs.gov/njpb.pdf.
**Update on Cultural Competency Regulations**

**EFFECTIVE APRIL 2008,** New Jersey physicians must show that they have taken six credits in cultural competency CME for their next license renewal occurring after March 24, 2008. A detailed article concerning this new legislation can be found in the Clinical View, beginning on p. 10 which deals with the regulation as it applies to all physicians in New Jersey. However, family physicians should know that AAFP elective credit will not count toward the CME requirement. The New Jersey Board of Medical Examiners (NJBME) felt that because elective credit does not necessarily directly affect patient care, it would not fulfill requirements of the statute, the purpose of which was to directly and positively impact patient care.

The Board of Medical Examiners web site (http://www.state.nj.us/lps/ca/bme/press/cultural.htm) contains a comprehensive FAQ section. However, some of the FAQs are reproduced here for your information.

**Q.** Is this training required repeatedly for each license renewal?

**A.** No. Physicians licensed on or before June 29, 2007, and podiatrists licensed on or before October 30, 2007, are required to comply with the cultural competency training requirement by the next license renewal after March 24, 2008. Physicians licensed on or after June 30, 2007, and podiatrists licensed on or after October 31, 2007, are required to comply with the requirement by the end of the next complete renewal cycle after licensure.

**Q.** Does this training have to be formally accredited CME education?

**A.** Yes, all six hours must be approved for credit in one of the following categories:
- AMA Cat 1
- AOA Cat 1A, 1B, or 2A
- AAFP Prescribed hours
- COPME Contact hours

**Q.** Are there specific topics that must be covered in the accredited CME education on cultural competency to meet the board’s requirements?

**A.** Yes. There are six specific topics that must be covered in the accredited cultural competency CME to meet the board requirements. These six topics are listed below.
1. A context for the training; common definitions of cultural competence, race, ethnicity, and culture; and tools for self-assessment.
2. An appreciation for the traditions and beliefs of diverse patient populations at multiple levels—as individuals, in families, and as part of a larger community.
3. An understanding of the impact that stereotyping can have on medical decision making.
4. Strategies for recognizing patterns of healthcare disparities and eliminating factors influencing them.
5. Approaches to enhance cross-cultural skills, such as those relating to history-taking, problem solving, and promoting patient compliance.
6. Techniques to deal with language barriers and other communication needs, including working with interpreters.

**Q.** Would participation in accredited CME courses meeting the curriculum requirements prior to final adoption of the rules described here be acceptable for meeting the requirement?

**A.** Yes. Participation in courses that meet the requirements of the regulation taken before final rule adoption will be acceptable for demonstrating compliance.

**Q.** Does the requirement have to be met by attending a single course or can the requirement be met by attendance at various courses which, when taken together, meet the requirement?

**A.** The board believes that ease of compliance and quality educational experience are better obtained by participating in one or two courses that are designed specifically around the NJBME requirements. A licensee may demonstrate compliance using any combination of accredited CME courses that can be shown to include all of the required topics.

**Q.** What documents will a licensee be required to provide to demonstrate compliance with the cultural competency training requirements?

**A.** Licensees should maintain certificates documenting CME attendance for a minimum of six years. Additionally, to demonstrate compliance with each of the topic areas required in the cultural competence regulation, you should keep evidence of the specific curriculum covered in the course(s) along with your certificates of completion (for example, brochures, course outlines, and materials distributed in the course).
Robert Like, MD, MS is a professor and Director for the Center for Healthy Families and Cultural Diversity in the Department of Family Medicine at UMDNJ-Robert Wood Johnson Medical School, New Brunswick, New Jersey.

Theresa J. Barrett, MS is the Deputy Executive Director of the New Jersey Academy of Family Physicians and the Managing Editor for Perspectives: A View of Family Medicine in New Jersey.

Jeffrey Moon is a medical student at UMDNJ-RWJ Medical School in Piscataway, New Jersey.

Introduction

New Jersey lawmakers enacted legislation in March 2005 requiring all physicians to complete cultural competency training as a condition of New Jersey relicensure and mandating the inclusion of relevant curricular content in the state’s medical schools. This mandate for continuing medical education (CME) credits in cultural competency arose in response to the state’s increasing cultural diversity, significant immigrant influx, and existing racial and ethnic disparities in health and health care.

The history and rationale for the development of this legislation in New Jersey has been well summarized by Salas-Lopez, Holmes, Mouzon, and Soto-Green. In the past three years, California, Washington, and New Mexico have also enacted legislation requiring cultural competency training; Maryland passed legislation “strongly recommending” training; and as of this writing, Arizona, Georgia, Kentucky, Ohio, and New York are considering legislation relating to cultural competency or the elimination of health disparities.

At the federal level, the Minority Health and Health Disparity Elimination Act of 2007 (S. 1576),5 the Minority Health Improvement and Health Disparity Elimination Act of 2007 (H.R. 3014)6 and the Health Equity and Accountability Act of 2007 (H.R. 3333)7 propose significant funding for cultural competency initiatives as an important strategy for improving the health and health care of racial and ethnic minority groups. The former act would require the Secretary of Health and Human Services to: (1) develop an Internet clearinghouse within the Office of Minority Health; (2) provide for programs of excellence in health professions education for underrepresented minorities; and (3) support demonstration projects designed to improve the health and health care of racial and ethnic minority groups through improved access to health care, patient navigators, primary prevention activities, health promotion and disease prevention activities, and health literacy education and services.5

What is cultural competency?

At the physician level, the US Department of Health and Human Services defines cultural competency as “the level of knowledge-based skills required to provide effective clinical care to patients from a particular ethnic or racial group.” At the organizational level, the Georgetown National Center for Cultural Competence (NCCC) calls for organizations to “have a defined set of values and principles, and demonstrate behaviors, attitudes, policies, and structures that enable them to work effectively cross-culturally.” They should also “have the capacity to (1) value diversity, (2) conduct self-assessment, (3) manage the dynamics of difference, (4) acquire and institutionalize cultural knowledge, and (5) adapt to diversity and the cultural contexts of the communities they serve.”

Why is culturally competent patient-centered care important and necessary?

The 2007 National Healthcare Disparities Report (NHDR) was recently published by the Agency for Healthcare Research and Quality. The NHDR describes the quality of and access to care for minority groups within the United States. The report is also a source of information for tracking the nation’s progress in meeting disparities. The report shows that, for the most part, disparities in quality and access to care for underserved and minority populations have either gotten significantly worse or have remained unchanged since the first NHDR. The number of measures for which quality and access is poor is higher than the number on which they have gotten significantly better for blacks, Hispanics, American Indians and Alaskan Natives, Asians, and poor populations.

The three key themes that emerge from the report are: (1) Overall, disparities in healthcare quality and access are not getting smaller; (2) Progress is being made, but many of the biggest gaps in quality and access have not been reduced; and (3) The problem of persistent uninsured is a major barrier to reducing disparities.

There is some good news. Improvement has been seen in the following areas:

• The disparity between black and white hemodialysis patients with inadequate dialysis was eliminated in 2005.
• The disparity between Asians and whites who had a usual primary care provider was eliminated in 2004.
• The disparity between Hispanics and non-Hispanic whites and between people living in poor communities and people living in high-income communities for hospital admissions for perforated appendix was eliminated in 2004.
• Significant improvements were observed in childhood vaccinations for most priority populations.
New Jersey's population is Hispanic, 14.5% is black, and 7.3% is Asian. According to the 2000 census information, 17.5% of persons living in New Jersey were foreign-born, and 25.5% spoke a language other than English in the home.\(^1\)

The number of immigrants coming to the state continues to rise. In 2000 the number of foreign-born people in New Jersey was estimated to be 1,662,857. By 2006 that number had risen to 1,754,253.\(^2\) These demographic and sociocultural changes have major implications for the delivery of primary and specialized medical care and highlight the need for New Jersey physicians to be more aware than ever of how an understanding of their patients' culture will impact the care they deliver.

New Jersey is no different from other states when it comes to health-related disparities. Selected statistics for New Jersey can be found at the University of Medicine and Dentistry of New Jersey's (UMDNJ) Institute for the Elimination of Health Disparities web site (http://www2.umdnj.edu/iehdweb/hdd/index.htm), which contains data on conditions including cancer, diabetes, obesity, asthma, lead poisoning, and healthcare quality and access.

**What are New Jersey's cultural competency CME requirements?**

The New Jersey State Board of Medical Examiners (NJBME) has finalized the regulation in the New Jersey Register (N.J.A.C. 13:35-6.25) that requires physicians and podiatrists to obtain “cultural competency training for CME… of at least six hours duration offered in the classroom, or through workshops, over the Internet or through other venues.”\(^3\) This is a requirement of NJ relicensure (not initial licensure), whether or not the physician practices in New Jersey or holds dual licenses in another state. In other words, if a physician holds a New Jersey license, no matter where that physician practices, he or she would have to comply with the new regulations to be relicensed in New Jersey.

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Cultural competency training will be offered by each of New Jersey's medical schools. The required CME content addresses and expands upon the important domains identified by the Association of American Medical Colleges in their Tool for Assessing Cultural Competency Training (TACCT).\(^5\) These domains focus on:

1. A context for the training; common definitions of cultural competence, race, ethnicity, and culture; and tools for self-assessment
2. An appreciation for the traditions and beliefs of diverse patient populations at multiple levels—as individuals, in families, and as part of a larger community
3. An understanding of the impact that stereotyping can have on medical decision making
4. Strategies for recognizing patterns of healthcare disparities and eliminating factors influencing them

**How diverse is New Jersey’s population?**

The US Census Bureau estimates that by the year 2050 approximately 52.3% of the United States population will be people of color, making the nation more diverse than it has ever been.\(^6\) New Jersey is already an increasingly diverse state. According to the US Census Bureau, there are an estimated 8,724,560 people living in New Jersey. Census Bureau data from 2005 shows that 15.2% of New Jersey's population is Hispanic, 14.5% is black, and 7.3% is white. However, gaps still persist:

- For blacks, large disparities remain in new AIDS cases, despite significant decreases. The proportion of new AIDS cases was 10 times higher for blacks than whites.
- The proportion of new AIDS cases was over three times higher for Hispanics than for non-Hispanic whites.
- Black children consistently have had the greatest proportion of children with asthma hospitalizations. The proportion of black children who were hospitalized due to asthma was almost four times higher than white children.
- Asians age 65 and over were more likely than whites to lack immunization against pneumonia.
- American Indian/Alaskan Native (AI/AN) women were twice as likely to lack prenatal care as white women. Also, AI/AN adults continued to be more likely than whites to report poor communication with their health providers.
- For the poor, disparities remain in communication with health providers. The proportion of children whose parents reported communication problems with their health providers was three times higher for poor children than for high-income children.
- Poor adults were twice as likely to not get timely care for an illness or injury.

The National Center for Cultural Competence lists the following as justification for increased cultural competency: \(^7\)

- Response to current and projected demographic changes
- Elimination of long-standing disparities in the health status in people of diverse racial, ethnic, and cultural backgrounds
- Fulfillment of legislative, regulatory, and accreditation mandates
- Improvement in the quality of services and primary care outcomes
- Gaining a competitive edge in the marketplace
- Decreasing the likelihood of liability and malpractice claims

In addition, the Institute of Medicine’s 2003 report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, described statistically significant variations in the rates of medical procedures by race, even when insurance status, income, age, and severity of conditions were comparable. The report made a series of recommendations, including:

- Increase healthcare providers’ awareness of disparities
- Integrate cross-cultural education into the training of all current and future health professionals.

More and more medical specialties, including family medicine, osteopathic medicine, internal medicine, pediatrics, psychiatry, obstetrics and gynecology, emergency medicine, and orthopedic surgery, are recognizing how important it is for their members to develop cultural competence. Each organization has published cultural competency guidelines or policies relating to the care of diverse populations.

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3. An understanding of the impact that stereotyping can have on medical decision making
4. Strategies for recognizing patterns of healthcare disparities and eliminating factors influencing them
5. Approaches to enhance cross-cultural clinical skills, such as those relating to history taking, problem solving, and promoting patient compliance
6. Techniques to deal with language barriers and other communication needs, including working with interpreters

Table 1 briefly summarizes when physicians (MDs or DOs), depending upon their licensure and relicensure dates, need to meet the cultural competency CME requirement and the number of hours required.

<table>
<thead>
<tr>
<th>Licensure Date</th>
<th>License Renewal Dates/CME Hours</th>
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<tbody>
<tr>
<td>Before March 24, 2005, and did not receive instruction in cultural competency training as part of the curriculum of a college of medicine</td>
<td>Licensees must, as a condition of the next license renewal after March 24, 2008, document 6 cultural competency CME hours or equivalent post-secondary education in cultural competency training by June 30, 2009. These hours are in addition to the 100 CME credits required by the NJBME.</td>
</tr>
<tr>
<td>March 24, 2005–June 29, 2007, and did not receive instruction in cultural competency training as part of the curriculum of a college of medicine</td>
<td>Licensees must, as a condition of the next license renewal after March 24, 2008, document 6 cultural competency CME hours or equivalent post-secondary training by June 30, 2009. These hours can be included in the 100 CME credits required by the NJBME.</td>
</tr>
<tr>
<td>On or after June 30, 2007, and did not receive instruction in cultural competency training as part of the curriculum of a college of medicine</td>
<td>Licensees must, as a condition of the next license renewal, document 6 cultural competency CME hours or equivalent post-secondary training by the end of the next complete renewal cycle in which he or she was licensed. These hours can be included in the 100 CME credits required by the NJBME.</td>
</tr>
</tbody>
</table>

Additional details about the NJBME cultural competency CME rule and requirements can be obtained in the New Jersey Register, Volume 40, Issue 7 (http://www.pdcbank.state.nj.us/ps/ca/adoption/0mmeado47.htm) and from the State Board of Medical Examiners website available at http://www.state.nj.us/oag/ca/bme/press/cultural.htm).

What else is New Jersey doing to eliminate health disparities?
Following a number of important summits devoted to health issues of African Americans (1999), Hispanics/Latinos (2000), and Asian Americans (2000), the New Jersey Department of Health and Senior Services launched an initiative to eliminate health disparities in the state. In March 2007 the NJDHSS published its “Strategic Plan to Eliminate Health Disparities in New Jersey.” This document is designed to provide a roadmap to guide a comprehensive effort to end minority health disparities. The result of this initiative has been the mobilization of a variety of public and private sector organizations, and several statewide initiatives are under way that are intended to meet the health promotion and disease prevention objectives outlined in documents such as Healthy New Jersey 2010: Update 2005.

Are New Jersey’s efforts consistent with national efforts?
The Institute of Medicine’s 2001 report, Crossing the Quality Chasm: A New Health System for the 21st Century, called for fundamental change in the healthcare system. The IOM’s action plan proposed a redesign of health care to include specific areas of improvement including medical care that is patient-centered (responsive to individual patient preferences, needs, and values, while assuring that patient values guide all clinical decisions) and equitable (providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, or socioeconomic status). These principles support the practice model known as the “patient-centered medical home,” which is supported by the American Academy of Family Physicians (AAFP) and a growing number of professional organizations. More information can be found at http://www.pcpcc.net.

The NJAFP strongly believes and is working toward ensuring that all New Jersey residents have a medical home. A white paper published by the NJAFP states that it is important to recognize that everyone needs a usual source of care—a medical home. The effects of insurance and having a usual source of care are additive. The medical home—in which patients receive fully integrated, whole-person care within the context of a sustained and supportive patient-physician relationship—is the focal point through which all individuals, regardless of age, sex, race, or socioeconomic status, can receive a basket of acute, chronic, and preventive care services. A medical home is defined as care that is family-centered, accessible, comprehensive, continuous, coordinated, compassionate, community-based, culturally competent, and is provided in an environment of trust and mutual responsibility.

How can physicians provide culturally competent, patient-centered care?
The first step is to realize that a person’s culture—those beliefs, values, and behaviors that are shared by a common group—has a profound influence on how health and illness are defined, care-seeking behavior, and what constitutes appropriate treatment. Physicians also need to understand how their own personal and professional experiences and biomedical culture influence and shape the clinical care process.

Physicians are not expected to learn about every sociocultural group; that would be impossible. Instead, each encounter with a patient should be viewed as a cross-cultural encounter. Every situation calls for mindful reflection and creativity. Cookbook approaches to care should be avoided. Juckett, in his article “Cross-Cultural Medicine,” says that when gathering information from patients of various cultural backgrounds, it is important to avoid ethnocentrism (conviction that one’s own culture is superior) and stereotyping (believing everyone from the same culture is alike). Clinical care should be patient-centered and tailored to each individual within
the context of his or her family and community.22

A study by Stewart et al. showed that patient-centered care improved the health status of patients and reduced the need for diagnostic tests and referrals. The study concluded that, “Medical education should go beyond skills training to encourage physicians’ responsiveness to the patients’ unique experience.”23 Culturally responsive patient-centered care depends on knowing each person as an individual and consistently acknowledging and respecting the beliefs, values, and behaviors of that person.

There are many clinical interviewing and communications mnemonics that may help physicians as they improve their skills in cross-cultural, patient-centered care. Some of these are LEARN,24 ETHNIC(S),25 ESFT,26 BATHE,27 and SPEAK28 (Table 2). Through the use of these mnemonics, physicians can elicit patients’ perspectives about health and illness, improve their understanding of the psychosocial context for visits, and address health literacy challenges during clinical encounters.


Table 2. Interviewing Mnemonics

<table>
<thead>
<tr>
<th>Mnemonic</th>
<th>Application</th>
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</thead>
<tbody>
<tr>
<td><strong>LEARN</strong></td>
<td>Integral to history taking and helps to elicit a patient’s perspective and explanation regarding the onset, etiology, duration, and treatment expectations for his or her illness or problem.</td>
</tr>
<tr>
<td><strong>ETHNIC(S)</strong></td>
<td>Framework to provide culturally appropriate geriatric care. Can be used to elicit and negotiate cultural issues during healthcare encounters with all patients and as an instructional strategy to be incorporated into ethnogeriatric curricula for healthcare disciplines.</td>
</tr>
<tr>
<td><strong>ESFT</strong></td>
<td>The ESFT Model for Communication and Compliance is an individual, patient-based communication tool that allows for screening for barriers to compliance and illustrates strategies for interventions that can improve outcomes for patients.</td>
</tr>
<tr>
<td><strong>BATHE</strong></td>
<td>Model for supplementing the biomedical clinical information gathered to assess the patient’s psychosocial status. Helps physicians to connect with and develop a therapeutic rapport with their patients.</td>
</tr>
<tr>
<td><strong>SPEAK</strong></td>
<td>Tool for addressing health literacy concerns in geriatric clinical encounters.</td>
</tr>
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Another resource for physicians in the delivery of culturally competent care is the Office of Minority Health’s (OMH) National Standards for Culturally and Linguistically Appropriate Services (CLAS) in health care. While primarily directed to healthcare organizations, individual physicians can use the CLAS standards to make their practices more culturally and linguistically accessible.

There are 14 standards, organized by themes, that are characterized as mandates (required by all recipients of federal funds), guidelines (activities recommended by OMH for adoption as mandates), or recommendations (suggested by the OMH for voluntary adoption). Table 3 provides a brief outline of the CLAS standards.

Table 3. Brief Outline of Culturally and Linguistically Appropriate Services in Health Care (CLAS)29

<table>
<thead>
<tr>
<th>Standard</th>
<th>CLAS standards</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Culturally Competent Care</strong></td>
<td></td>
</tr>
<tr>
<td>Standard 1 (G)</td>
<td>Patients should receive effective, understandable, and respectful care provided in a manner compatible with their cultural health beliefs, practices, and preferred language from all staff members.</td>
</tr>
<tr>
<td>Standard 2 (G)</td>
<td>Recruit, retain, and promote diverse staff and leadership that are representative of the demographic characteristics of the service area.</td>
</tr>
<tr>
<td>Standard 3 (G)</td>
<td>Staff at all levels and across all disciplines should receive ongoing education and training in culturally and linguistically appropriate service delivery.</td>
</tr>
<tr>
<td><strong>Language Access Services</strong></td>
<td></td>
</tr>
<tr>
<td>Standard 4 (M)</td>
<td>Offer and provide language assistance services at no cost to each patient with limited English proficiency.</td>
</tr>
<tr>
<td>Standard 5 (M)</td>
<td>Provide to patients in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.</td>
</tr>
<tr>
<td>Standard 6 (M)</td>
<td>Assure competence of language assistance provided to limited English-proficient patients. Family and friends should not be used as interpreters unless requested by the patient.</td>
</tr>
<tr>
<td>Standard 7 (M)</td>
<td>Make available easily understood patient-related materials, and post signage in the languages of groups commonly encountered.</td>
</tr>
</tbody>
</table>

Key: M, mandate; G, guideline; R, recommendation. |
Table 3. continued

<table>
<thead>
<tr>
<th>Standard</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Organizational Supports for Cultural Competence</strong></td>
<td></td>
</tr>
<tr>
<td>Standard 8 (G)</td>
<td>Develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.</td>
</tr>
<tr>
<td>Standard 9 (G)</td>
<td>Conduct initial and ongoing organizational self-assessments of CLAS-related activities, and integrate cultural and linguistic competence-related measures into internal audits, Performance Improvement (PI) programs, patient satisfaction assessments, and outcomes-based evaluations.</td>
</tr>
<tr>
<td>Standard 10 (G)</td>
<td>Collect information on the patient’s race, ethnicity, and spoken and written language in health records and periodically update it.</td>
</tr>
<tr>
<td>Standard 11 (G)</td>
<td>Maintain a current demographic, cultural, and epidemiological profile of the community.</td>
</tr>
<tr>
<td>Standard 12 (G)</td>
<td>Develop participatory, collaborative partnerships with communities, and facilitate community and patient involvement in designing and implementing CLAS-related activities.</td>
</tr>
<tr>
<td>Standard 13 (G)</td>
<td>Ensure conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints.</td>
</tr>
<tr>
<td>Standard 14 (R)</td>
<td>Regularly make available to the public information on progress and successful innovations in implementing the CLAS standards, and provide public notice in their communities about the availability of this information.</td>
</tr>
</tbody>
</table>

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These standards are increasingly being used by organizations such as The Joint Commission and the National Committee for Quality Assurance (NCQA) in their quality improvement and monitoring activities. More information about cultural competency and CLAS can be found at the Office of Minority Health Web site at <http://www.omhrc.gov/templates/browse.aspx?lvl=1&lvlID=3>.

Finally, The Joint Commission has published *One Size Does Not Fit All: Meeting the Health Care Needs of Diverse Populations*. This report is designed to provide a framework for hospitals to develop practices to meet the needs of diverse populations. However, many of the suggestions that they make can also be considered for implementation in an office setting:

1. Build a Foundation: Formal policies and procedures supporting cultural competence is a necessity if a practice hopes to meet the needs of a diverse population.
2. Collect and Use Data: Analysis of community and patient-level data can help inform a practice about the diverse populations that they serve.
3. Accommodating Specific Populations: As staff and patients change, procedures and processes should be tailored to meet those needs through continuous assessment.

4. Collaboration: Build relationships across the community to leverage the strengths that others may have in cultural competency.

**Which should we strive for: Cultural competence or cultural humility?**

Tervalon and Murray-Garcia in their article, “Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education,” postulate that mastery of cultural competence does not fit with the traditional definition of competence, which is mastery of a finite body of knowledge. They present the theory that training physicians and future physicians in cultural humility may be a more appropriate approach. Cultural humility follows a lifelong learning model where physicians commit to an ongoing process to continually engage in self-reflection and self-critique as reflective practitioners. The goal of cultural humility is to bring into balance the unequal power between physicians and patients using patient-centered care and patient-focused interviewing. Additionally, cultural humility is a process that builds a respectful partnership with patients, families, and communities.

**Are there guidelines for developing educational programs on cultural competency?**

The American Academy of Family Physicians (AAFP) has developed a list of issues to consider when developing programs on cultural competency. Among these are: socioeconomic issues, disparities in health care as they relate to special populations, barriers to health care, and cultural expectations or beliefs. The complete guidelines are available on the AAFP web site at http://www.aafp.org/online/en/home/clinical/publichealth/cultural-prof/cpguidelines.html.

The Society of Teachers of Family Medicine has published core curriculum guidelines for culturally sensitive and competent care and identified “cultural proficiency” as a critical component of residency training in the Future of Family Medicine Report. These activities are consistent with national efforts under way to prepare residents and medical students with the attitudes, skills, and knowledge needed to provide high-quality, cross-cultural care; address mistrust, subconscious bias, and stereotyping during clinical encounters; and reduce disparities in health and health care.

The University of Medicine and Dentistry of New Jersey and a growing number of New Jersey professional medical societies and organizations have also sponsored a variety of conferences, courses, workshops, seminars, and grand rounds devoted to these important subjects.

Selected resources on health disparities and cultural competency, monographs, practice tools, and continuing education/professional development programs can be found in Table 4.

**Conclusions, Caveats, and Opportunities**

Strong educational programs and physicians who are committed to a lifelong learning process are unlikely by themselves to sufficiently reduce disparities in health and health care. Interventions are also needed to address multiple socioeconomic, geographic, environmental,
legal, political, and public health factors.37,38 Fortunately discussions about healthcare policy, financing, and systems reforms are beginning to address cultural competency and patient-centered care perspectives. Developing partnerships and collaborations with communities, advocacy groups, and other key stakeholders is a critically important component of many national and state disparities reduction initiatives.

Physicians will continue to be on the front lines in caring for our nation’s and New Jersey’s increasingly diverse population. We should be champions and advocates for a patient-centered, family-focused, community-oriented model of care by providing a “personalized medical home” for our patients. By doing so, we will be contributing to broader societal efforts under way to help reduce and hopefully eliminate disparities in access to care, service utilization, quality, and health outcomes. We hope the list of resources provided with this article will provide direction and guidance, as physicians from all specialties and other health professionals work together to close the disparity gap in health care.

Table 4. Selected Resources on Health Disparities and Cultural Competency*

| University of Medicine and Dentistry of New Jersey’s (UMDNJ) Institute for the Elimination of Health Disparities | This integrated center is dedicated to the elimination of health disparities in New Jersey and the nation. The institute develops and supports collaborative networks and initiatives to promote research, evidence-based interventions, education, and advocacy to help eliminate health disparities across all populations in New Jersey, but especially those most at risk for disproportionate morbidity and mortality.  
• Available at http://www2.umdnj.edu/iehdweb/hdd/index.htm |
| US Department of Health and Human Services, Health Resources and Services Administration, Cultural Competence Resources for Health Care Providers | This site provides a list of assessment tools grouped according to language/culture, disease/condition specific, special populations, etc., put together by the US Department of Health and Human Services.  
• Available at http://www.hrsa.gov/culturalcompetence |
| US Department of Health and Human Services, Office of Minority Health | The Office of Minority Health was mandated by Congress to help healthcare professionals address cultural and linguistic barriers to healthcare delivery and increase access to health care for people with limited English proficiency. This site provides guides to help physicians achieve that goal.  
• Available at http://www.omhrc.gov/templates/browse.aspx?lvl=1&lvlID=3 |
| Centers for Disease Control, Office of Minority Health and Health Disparities | The Office of Minority Health and Health Disparities (OMHD) aims to accelerate the CDC’s health impact in the US population and to eliminate health disparities for vulnerable populations as defined by race/ethnicity, socioeconomic status, geography, gender, age, disability status, risk status related to sex and gender, and among other populations identified as at-risk for health disparities.  
• Available at http://www.cdc.gov/omhd/About/about.htm |
| National Network of Libraries of Medicine, Minority Health Concerns | Resources include links to government sites as well as brochures and health information.  
• Available at http://nnlm.gov/mcr/resources/community/minority.html |
| Administration on Aging, Cultural Competency | The AoA is a federal organization and advocate agency for older people and their concerns. This guidebook is designed for use by providers of services to racially and ethnically diverse older populations.  
• Available at http://www.aoa.gov/prof/adddiv/cultural/addiv_cult.asp |
| Georgetown University Center for Child and Human Development, National Center for Cultural Competence | The mission of the National Center for Cultural Competence is to increase the capacity of health and mental health programs to design, implement, and evaluate culturally and linguistically competent service-delivery systems.  
• Available at http://www11.georgetown.edu/research/gucchd/nccc |
| Maternal and Child Health Library—Knowledge Path: Racial and Ethnic Disparities in Health | This knowledge path, compiled by the Maternal and Child Health Library at Georgetown University, presents current, high-quality resources about identifying and eliminating racial and ethnic disparities in health. It is aimed at health professionals, program administrators, policy makers, researchers, and families and will be updated periodically.  
• Available at http://www.mchlibrary.info/KnowledgePaths/kp_race.html |

continued
| **Diversity Rx** | Diversity Rx promotes language and cultural competence to improve the quality of health care for minority, immigrant, and ethnically diverse communities. This site shows how language and culture affect the delivery of quality services to ethnically diverse populations.  
• Available at http://www.diversityrx.org |
| National Council on Interpreting in Health Care | The mission of this multidisciplinary organization based in the United States is to promote culturally competent professional healthcare interpreting as a means to support equal access to health care for individuals with limited English proficiency.  
• Available at http://www.ncihc.org |
| Hablamos Juntos, Language Policy and Practice in Health Care | Funded by the Robert Wood Johnson Foundation and administered by the UCSF Fresno Center for Medical Education & Research, this is a major educational and clinical branch of the UCSF School of Medicine. It develops affordable models for healthcare organizations to offer language services in regions with new and fast-growing Latino populations.  
• Available at http://www.hablamosjuntos.org |
| Cross Cultural Health Care Program | Established with a grant from the W. K. Kellogg Foundation, this program focuses on a systemic approach to cultural competency, looking at the relationships among language, tradition, history, economics, and other factors as they relate to health and human services.  
• Available at http://www.xculture.org |
| The Provider’s Guide to Quality & Culture | Produced by Management Sciences for Health along with several government agencies, this site is designed to assist healthcare organizations throughout the United States in providing high-quality, culturally competent services to multi-ethnic populations.  
• Available at http://erc.msh.org/mainpage.cfm?file=1.0.htm&module=provider&language=English |
| Curriculum in Ethnogeriatrics: Core Curriculum and Ethnic Specific Modules | This is the second edition of the five modules in the Core Curriculum in Ethnogeriatrics, supported by a bureau of the US Department of Health and Human Services. The modules serve as a basic curriculum in ethnogeriatrics.  
• Available at http://www.stanford.edu/group/ethnoger |
| EthnoMed | This site contains medical and cultural information on immigrant and refugee groups and is designed for use by healthcare providers. It is a project of the University of Washington Health Sciences Library and the Harborview Medical Center’s Community House Calls Program.  
• Available at http://ethnomed.org |
| Medical Economics: Cultural Competence | *Medical Economics* magazine was founded for physicians in 1923, and its web site makes its archived articles on cultural competency easily accessible.  
• Available at http://www.memag.com/culturalcompetence |
| Medscape’s Health Diversity Resource Center | The Health Diversity Resource Center features information on the way in which culture and other classifications (sex, sexual orientation, religion, age, economic class) affect health and the quality of health care.  
Sections include current news items, information from the recent literature, CME, and other relevant topics. The information comes from Medscape’s key clinical content, selected by the editors.  
• Available at http://www.medscape.com/resource/healthdiverse |
| MDNG Net Guide: Focus on Multicultural Healthcare (online/print publication) | This online and print publication disseminates relevant information to help physicians and other health professionals improve the quality, effectiveness, and safety of care to patients from diverse backgrounds. This includes evidence-based research findings, promising practices, new technologies, educational opportunities, and other resources relating to culturally competent patient-centered care.  
• Available at http://www.mdnglive.com/publications/3/1 |
Medicare Quality Improvement Community: Practice Cultural Quality—CLAS Standards Pre-Assessment Tool

This tool evaluates how well an organization meets national cultural competency guidelines and allows organizations to learn what actions are needed to become more culturally and linguistically competent. The MedQIC.org site has additional useful tools.

- Available at http://medqic.org/dcs/ContentServer?cid=1157485168058&pagename=Medqic%2FMQTools%2FToolTemplate&c=MQTools

American Academy of Family Physicians: Improving Patient Care—Cultural Competence

Site has an article on cultural competence and a self-assessment checklist for personnel providing primary health care services.

- Available at http://www.aafp.org/fpm/20001000/58cult.html


American Medical Association Foundation: Health Literacy

The American Medical Association helps doctors help patients by uniting physicians nationwide to work on the most important professional and public health issues, one of which is to create safer and shame-free healthcare environments for patients with limited health literacy, and by extension, for all patients.

- Available at http://www.ama-assn.org/ama/pub/category/8115.html

American College of Physicians Foundation: Health Literacy Resources

The ACP works to improve the health and welfare of patients and society through initiatives that provide patients with the information they need to understand and manage their health.

- Available at http://foundation.acponline.org/hl/hlresources.htm

American Academy of Family Physicians’ toolkit: Play It Safe … With Medicine!

This toolkit provides concrete tools and resources to enhance physician communication with patients regarding their medications, particularly with patients who are elderly or have limited English-language proficiency.


The Joint Commission: Public Policy on Health Literacy and Patient Safety

Download the commission’s white paper on health literacy titled, “What Did the Doctor Say?: Improving Health Literacy to Protect Patient Safety.”

- Available at http://www.jointcommission.org/PublicPolicy/health_literacy.htm


These reports recognize health plans that provide models for health care and add to the evidence base of effective methods for addressing culturally and linguistically appropriate services and disparities.

- Available at http://web.ncqa.org/Portals/0/HEDISQM/CLAS/CLAS_InnovativePrac06.pdf
  http://www.ncqa.org/tabid/676/Default.aspx

Table 5. Selected Practice Tools

<table>
<thead>
<tr>
<th>Medicare Quality Improvement Community: Practice Cultural Quality—CLAS Standards Pre-Assessment Tool</th>
<th>This tool evaluates how well an organization meets national cultural competency guidelines and allows organizations to learn what actions are needed to become more culturally and linguistically competent. The MedQIC.org site has additional useful tools.</th>
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</tr>
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</table>

Table 6. Selected Monographs on Cultural Competency

<table>
<thead>
<tr>
<th>National Initiative for Children’s Healthcare Quality (NICHQ), Expanding Perspectives: Improving Cultural Competency in Children’s Health Care</th>
<th>The NICHQ is dedicated to eliminating the gap between what is and what can be in health care for all children. The organization has developed a structured process to translate the abstract knowledge in the field of cultural competency into a package that can be used to drive change in clinical practice.</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Joint Commission and the California Endowment; Hospitals, Language, and Culture: A Snapshot of the Nation; Exploring Cultural and Linguistic Services in the Nation’s Hospitals: A Report of Findings</td>
<td>A qualitative cross-sectional study designed to provide a snapshot of how 60 hospitals across the country are providing health care to culturally and linguistically diverse populations.</td>
</tr>
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continued
### Table 6. continued

<table>
<thead>
<tr>
<th>Resource</th>
<th>Description</th>
<th>Availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Toolkit and Curriculum: Resources to Implement Cross-Cultural Clinical Practice Guidelines for Medicaid Practitioners</td>
<td>Prepared by the University of Massachusetts Medical School, Office of Community Programs, for the US Department of Health and Human Services, Office of Minority Health, this toolkit is designed to aid providers in application of the Cross-Cultural Clinical Practice Guidelines. It introduces the fundamentals of cross-cultural practice and offers steps and processes essential to delivering quality care to culturally diverse populations.</td>
<td><a href="http://www.omhrc.gov/assets/pdf/checked/toolkit.pdf">http://www.omhrc.gov/assets/pdf/checked/toolkit.pdf</a></td>
</tr>
<tr>
<td>An Ethical Force Program Consensus Report: Improving Communication—Improving Care: How health care organizations can ensure effective, patient-centered communication with people from diverse populations</td>
<td>From the American Medical Association, this report is to help healthcare organizations communicate better. The report describes why communication is important and how an organization can take steps to ensure good communication.</td>
<td><a href="http://www.ama-assn.org/ama1/pub/upload/mm/369/ef_imp_comm.pdf">http://www.ama-assn.org/ama1/pub/upload/mm/369/ef_imp_comm.pdf</a></td>
</tr>
<tr>
<td>A Patient-Centered Guide to Implementing Language Access Services in Healthcare Organizations</td>
<td>This guide from the Office of Minority Health is intended to help healthcare organizations implement effective language access services to meet the needs of their limited-English-proficient patients and increase their access to health care.</td>
<td><a href="http://www.omhrc.gov/templates/content.aspx?ID=4375&amp;lvl=2&amp;lvlID=107">http://www.omhrc.gov/templates/content.aspx?ID=4375&amp;lvl=2&amp;lvlID=107</a></td>
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### Table 7. Selected Continuing Education/Professional Development Programs**E-Learning

<table>
<thead>
<tr>
<th>Resource</th>
<th>Description</th>
<th>Availability</th>
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<tbody>
<tr>
<td>A Physician’s Practical Guide to Culturally Competent Care</td>
<td>From the US Department of Health and Human Service, Office of Minority Health, this e-learning site offers CME, CNE, and CEU credit and equips healthcare professionals with awareness, knowledge, and skills to better treat the increasingly diverse US population.</td>
<td><a href="http://cccm.thinkculturalhealth.org">http://cccm.thinkculturalhealth.org</a></td>
</tr>
<tr>
<td>Quality Interactions: A Patient-Based Approach to Cross-Cultural Care</td>
<td>Produced by the Manhattan Cross Cultural Group and Critical Measures, Quality Interactions is an e-learning program that provides case-based instruction on cross-cultural health care—an innovative CME-accredited cultural competency training program for physicians, nurses, and health care professionals.</td>
<td><a href="http://www.qualityinteractions.org">http://www.qualityinteractions.org</a></td>
</tr>
<tr>
<td>Cultural Competence for Health Professionals in Geriatric Care</td>
<td>Western Reserve Geriatric Education Center’s learning modules teach clinical skills to help physicians provide better care. In the long run, they’re meant to reduce the severe health disparities and healthcare disparities that persist among racial and ethnic groups in the United States, particularly in geriatric care.</td>
<td><a href="http://www.nethealthinc.com/cultural/">http://www.nethealthinc.com/cultural/</a></td>
</tr>
<tr>
<td>Culture and Health Care: An E-Learning Course (based on Cultural Sensitivity: A Guidebook for Physicians and HealthCare Professionals)</td>
<td>This course, from Doctors in Touch, covers nine major ethnic groups and helps participants understand their values and world views, family and gender issues, cradle-to-grave traditions, and health-related beliefs and practices. Each section contains interactive case scenarios highlighting each ethnic group’s beliefs and practices.</td>
<td><a href="http://www.doctorsintouch.com/courses_for_CME_credit.htm">http://www.doctorsintouch.com/courses_for_CME_credit.htm</a></td>
</tr>
</tbody>
</table>

*continued*
| Culturally Competent Care Package | From the American Academy of Orthopaedic Surgeons, this package includes the new *Culturally Competent Care Guidebook and Cultural Competency Challenge* CD-ROM. It offers tools that enhance your ability to effectively communicate with and treat an ethnically diverse patient population.  
• Available at www.aaos.org/challenge |
| Educating Physicians on Controversies and Challenges in Health: Health Care Disparities Among Racial-Ethnic Minority Patients | This American Medical Association program provides physicians with an overview of health disparities among racial-ethnic minority patients. It also provides physicians with strategies to enhance services for racial-ethnic minority patients, including building trust and addressing language barriers.  
• Available at http://www.ama-assn.org/ama/pub/category/18151.html |
| Unified Health Communication 101: Addressing Health Literacy, Cultural Competency, and Limited English Proficiency | Sponsored by the Health Resources and Services Administration, this program provides training to improve patient communication skills and increase awareness and knowledge of the three main factors that affect communication with patients: health literacy, cultural competency, and low English proficiency.  
• Available at http://www.hrsa.gov/healthliteracy/training.htm |
| Delivering Culturally Effective Care | Sponsored by Medical Directions, Inc., and the University of Arizona College of Medicine at the Arizona Health Sciences Center, this program emphasizes general concepts that will improve healthcare providers’ ability to treat patients from diverse cultures and deals with specific issues around the management of type 2 diabetes in Mexican Americans.  
• Available at http://www.vlh.com/shared/courses/course_info.cfm?courseno=1786 |
| Communicating Through Health Care Interpreters | From Medical Directions, Inc., the Virtual Lecture Hall, and Rush University Medical Center, this practical, case-based multimedia program teaches how to manage the language problems that often arise in today’s healthcare environment.  
• Available at http://www.vlh.com/shared/courses/course_info.cfm?courseno=155 |
| Cultural Competence in Health Care | Created by the University HealthSystem Consortium, this course is based on the book and workshop titled *Caring for Patients from Different Cultures* by Geri-Ann Galanti, PhD. The course modules address core cultural patterns of perceptions and behaviors that can lead to misunderstandings. The course is designed to improve patient communications and relationships.  
• Available at http://uhclearningexchange.uhc.edu/Presentations/pres-out67.html |
| Center for Healthy Families and Cultural Diversity | Programs available from the Department of Family Medicine, UMDNJ-Robert Wood Johnson Medical School, include grand rounds, workshops, and seminars on a variety of cultural competency-related subjects.  
• Available at http://www2.umdnj.edu/fmedweb/chfcd/ |
| Eliminating Health Disparities | The American Medical Association offers various programs and activities to help eliminate racial and ethnic health care disparities.  
• Available at www.ama-assn.org/go/healthdisparities |
| Delivering Culturally Effective Care | MDAdvantage offers programs on cultural competency, as well as risk management, and other topics. For more information, visit http://www.mdadvantageonline.com/index.aspx.  
• Available at http://www.mdadvantageonline.com/risk/cme.aspx |
| NetworkOmni Caring with CLAS: cultural competence in health care | Developed by NetworkOmni Multilingual Communications, this training program is designed to serve a full team of care providers, including nurses, physicians, social workers, administrative staff, and others. The full-day training is divided into two four-hour modules on language access and culturally competent care.  
• Available at http://www.networkomni.com/collateral/NetworkOmni_Caring_with_CLAS_Brochure.pdf |

* All links and programs were accurate at the time of printing  
**As of publication, it is not known whether these educational programs will meet the NJBME requirements for CME.
This list is selective and not exhaustive of all the programs currently available or under development. Their inclusion does not indicate an endorsement or recommendation by the authors or any organizations with which they are affiliated. Physicians and other health care providers are advised to contact the NJBME directly if they have any questions and should keep their certificates of attendance and any educational materials provided if they participate in any of these programs given the potential for future NJBME audits relating to meeting the cultural competency CME requirement. ▲

Disclosures:

Robert C. Like, MD, MS, has disclosed the following information relating to his Cultural Competency & Disparities in Health & Health Care activities: Consultant, Network Omni Multilingual Communications; Editor-in-Chief, MDNG: Focus on Multicultural Healthcare.

The Foundation of UMDNJ has also received gifts in support of the Center for Healthy Families and Cultural Diversity (CHFCD), Department of Family Medicine, at UMDNJ-Robert Wood Johnson Medical School in support of the CHFCD's cultural competency educational activities from Medscape, Inc., Network Omni Multilingual Communications, and Outcomes, Inc.

Theresa Barrett, MS and Jeffrey Moon have nothing to disclose in relationship to this article.

References

Caring for the Family Caregiver


I recently queried a group of family physicians about research on assessing and intervening with family caregivers in primary care and I wanted to share what I have learned in the hopes that family physicians will have a greater knowledge of what it means to care for the family caregiver.

Why did I engage in this research? I’m a clinical psychologist and family therapist who has worked for the past 13 years as a behavioral science faculty member in a community-based family medicine residency program in suburban Philadelphia, PA. In that time, I have taught dozens of budding physicians about the needs of family caregivers. But it wasn’t until the past 2 years, during which I presented to over 50 American family medicine residency programs and departments of family and geriatric medicine as a way of promoting my book on family caregiving, that I had the opportunity to take a sampling of literally thousands of primary care physicians’ attitudes about family caregivers. What I have found is that while there is substantial general interest in the health needs of family caregivers among these doctors, there is little knowledge of the research base on caregiver assessment or intervention. For example, none of the people I interviewed had heard of the federally funded, multi-site research studies on Alzheimer’s caregivers known as REACH, which have been ongoing since 1994, and they only had a vague awareness of local or national family caregiver support programs. More distressing, most family doctors don’t see an easy way of addressing family caregivers’ needs in their own practices because of concerns regarding their time constraints and the lack of remuneration for interacting with patients’ relatives. Even if they want to be helpful to caregivers, few doctors have any notion of how to proceed competently. If there’s anything that I’ve learned in my years in family medicine it’s that if family physicians don’t have the confidence to solve a problem, then they have a tendency to avoid it. In short, I concluded that primary care doctors, good, practical, hard-working people currently operating under great duress, need help in helping family caregivers.

Why do I think the question is so important? Because in the evolution of any healthcare or social service movement, be it to diagnose depression, identify battered women or prevent the spread of Lyme’s disease, leaders come to the realization that they will reach the greatest number of potential beneficiaries by doing screenings and providing education within the primary care setting. Primary care is the widest portal available for entry into any helping service. Specialty medicine or healthcare practices, for instance, neurology, cardiology, mental health, address a small portion of those who need care. Geriatric assessment programs reach even smaller numbers. Even Area Agencies on Aging don’t see nearly the number of needy people who family physicians and internists routinely do. Even if primary care physicians can’t provide the necessary interventions themselves to make a difference, their capacities to offer information and referrals matter greatly.

What did I learn? The last two times I did literature reviews on primary care and family caregiving, I came up with relatively little. While JAMA (Journal of the American Medical Association) has published many empirical studies on the healthcare needs of family caregivers, that research has not spurred the publication of overviews or practice guidelines in primary care journals such as the Journal of Family Practice or the Archives of General Internal Medicine. One exception is a Parks & Novielli article in American Family Physician from 2000; no other such article has been published, so far as I can discern, in the U.S. primary care journals since, despite the abundance of new research findings in the past 7 years. With the help of those who responded to my query, my literature review this time was more fruitful. I found more than I expected.

It appears that much of the best thinking about primary care and family caregiving is being conducted in other countries. There are a number of interesting articles in the Australian (e.g., get free access to Bruce, Paley, et al, 2002 on pubmed.gov), British (e.g., see Sewitch, Yaffe, et al, 2006 on pubmed), Canadian and French literature. They deal with primary care physicians’ attitudes toward caregivers (largely sympathetic) but point out that many doctors, like their American colleagues, feel constrained in their capacity to help because of the demands of their practices. One of the Australian articles notes difficulties for family physicians with identifying distressed caregivers because those caregivers are reluctant to ask for or accept help of any kind. Many of these articles focus on identifying those caregivers who most likely require assistance, whether or not the caregiver actually brings up his or her sense of burden to the physician. In one British article, a survey was mailed to all adults in one primary care practice to inquire about who was caregiving; among those who responded, 6% identified themselves as caregivers and, of these, 63% requested an information packet on caregiving resources (Jarvis, Worth, 2005). In the Sewitch, Yaffe article cited above, Montreal-based family physicians and epidemiologists concluded that primary care doctors should call or schedule an appointment with any elderly caregiving spouse whose ill spouse had a recent evaluation at an emergency room.

By the way, McGill University-affiliated, Canadian family physician Mark Yaffe, MD has done more research on family caregiving and primary care than any other doctor that I’ve encountered. He has published a number of illuminating studies over...
the past 30 years and should be considered a foremost expert in this sub-field. His work is worth perusing.

By my reading, the American medical journals appear to be preoccupied with other concerns, ones that truly do precede thoughts about helping family caregivers. JAMA has published articles suggesting that U.S. primary care doctors do an inadequate job of diagnosing patients with Alzheimer’s dementia. This has been echoed by two recent articles in the Journal of Family Practice (Christensen, Lin, 2002) and Journal of General Internal Medicine (Hinton, et al, 2007) which suggest that, unless there is more time and remuneration provided to evaluate potentially demented patients, American primary care doctors will make their diagnoses too late in the disease process for patients to take full advantage of the benefits of the current cholinesterase-inhibitors or future Alzheimer’s-altering drugs. It can be reasonably asked if American primary care doctors don’t even have the time to diagnose Alzheimer’s patients, how could they possibly devote resources toward helping Alzheimer’s caregivers?

JAMA’s solution to this problem is to employ a care management model in which a primary care-based advanced practice nurse, working in close conjunction with the physicians, will help with Alzheimer’s diagnosis, treatment, education, and monitoring (see Callahan, et al, 2006 on pubmed for free access). The primary care-based care management model is one that has been recommended by numerous authors for caring for family caregivers, as well. Some suggest using health counselors or educators to identify and support family caregivers in primary care; others recommend social workers or nurses. For example, Johns Hopkins-based gerontologist and researcher Jennifer Wolff responded to my query by describing a study she is helping run in which primary care-embedded nurses, working with multi-morbid older adults, do caregiver assessments, offer caregiver coaching, refer to community resources, conduct caregiver training sessions and run monthly caregiver support groups. The common theme among all these care management approaches is to use the wide portal of primary care to identify as many vulnerable family caregivers as possible but to take responsibility for this clinical goal away from overly busy physicians. In my opinion, these approaches are very interesting and merit further study. Their applicability to most community-based primary care practices, however, will come down to cost. Who can afford to hire extra nurses, counselors or social workers when their practices are already financially strapped?

Many respondents wrote to me about yet another approach: making doctors more knowledgeable referrers. They suggested I look into “Making the Link: Connecting Caregivers with Services through Physicians,” a program launched in 2002 by the National Association of Area Agencies on Aging (n4a) to help primary care physicians make appropriate referrals to local AAAs. Such referrals would include connecting stressed family caregivers to local family caregiver support programs. Over 200 agencies nationally are now employing the program. Some of the respondents to my query were enthusiastic about the program’s results; others were not. In my opinion, giving primary care doctors greater expertise in making effective referrals can only be helpful to the caregivers and the docs themselves, who are only too glad to have some concrete means to make a positive difference.

Along the same lines, the Maine Primary Partners in Caring, a program of connecting rural family physicians and AAAs that was partly designed by University of Maine Center on Aging, director Len Kaye, Ph.D. and conducted from 2000-2004, gave family doctors training on how to briefly screen family caregivers and then taught them to refer those in need to appropriate AAA services. According to the journal articles published near the program’s conclusion (e.g., see Cotton, Downey, Butler, Geriatric Nursing, 25 (4), July/August 2004, 240-241), the intervention model had generally positive outcomes. To my knowledge, no attempt has yet been made to replicate it elsewhere.

So what are we to make of this data? I’d suggest that primary care physicians need more help to do a job many would actually like to do. The studies on how to help them do that have been too few and too preliminary thus far. Here are my own subjective recommendations for further studies/initiatives that might be productive:

1) One of the most important developments in medical education that has occurred in the past decade is that nearly every American medical school now requires its students to demonstrate competency in communicating with patients. This aspect of medical education is being conducted with what is known as standardized patient programs in which actors, playing patients, are interviewed by students in mock medical sessions. (Family medicine residency programs routinely teach communication skills through reviewing videotapes of sessions conducted with real patients.) In my opinion, requiring medical students to also demonstrate competence in communicating with patients’ family members (through the use of actors playing caregivers) would sensitize prospective primary care doctors to the needs of family caregivers, as well as giving them skills to assess and intervene with them. To add this requirement, caregiver organizations would need to lobby the medical education accrediting bodies and national organizations for family and internal medicine.

2) There is currently too little emphasis on teaching the skills of addressing the needs of family caregivers in the curricula of geriatric medicine fellowship programs and geriatric medicine requirements within the curricula of family and internal medicine programs. Again, making the evidence-based case, with all current research on caregiver assessment and intervention, might be effective in changing the educational standards of the accrediting bodies.

3) We need a brief (less than 10 item) screening instrument that primary care doctors can use to assess caregivers for burden. Current instruments (Zarit’s Caregiver Burden Scale, the American Medical Association’s Caregiver Self-Assessment Tool) are too lengthy to be of practical utility in the primary care setting. Whatever screening instrument is designed needs to be easily incorporated into electronic medical records (EMRs).

4) The implementation of EMRs has rapidly been changing primary care culture during the past 5 years. These computer-based...
Preoperative Patient Assessment for Non-Cardiac Surgery

Steve Nurkiewicz, MD, is a family physician in private practice in Hammonton, New Jersey.

Christina M. Johnson, RN, PA-C is head of the Department of Anesthesiology and Perioperative Medicine at the Atlanticare Regional Medical Center in Galloway, New Jersey.

Jeffrey Moon is a medical student at Robert Wood Johnson Medical School in Piscataway, New Jersey.

Overview

Family physicians are routinely called upon to perform preoperative evaluation and management for our patients. Proper coordination and relaying vital health information to the surgical and anesthesia team is crucial. This effort reduces risk to patients by identifying conditions or medications that may have adverse effects on surgery or recovery. If we, as family physicians, manage the medical home, then we can best serve our patients by reviewing their medical history, examining them for signs of stability of their chronic illness, or identifying a new condition that would affect surgery, and relaying the pertinent information to the appropriate medical personnel in a timely manner.

The goal of this article is to illustrate the key items in the evaluation of the surgical patient and show how to gauge low- to medium-risk procedures in cooperation with the patient. The scope of this article does not address emergency surgical evaluation or high-risk cardiac or vascular surgery evaluation. High-risk procedures, which carry more than 5% combined risk of cardiac death and nonfatal myocardial infarction (MI), generally include cardiac procedures, aortic and major vessel vascular procedures, or prolonged surgery (greater than two hours) associated with blood loss or large fluid shifts.1,2,3

The topics reviewed include the purpose of the preoperative evaluation, the elements of the history and physical, screening questionnaires, risk assessment for individual patients, appropriate screening tests and indicated testing, disease specific approaches, antibiotic prophylaxis, and medications that directly impact surgery or recovery.

Medical “Clearance”

The purpose of the preoperative evaluation is not to give medical clearance but to evaluate the patient’s current medical status and provide a clinical risk profile.4,5 This profile is used to make recommendations regarding the risk of cardiovascular problems over the entire perioperative period. This information is used by anesthesiology, surgery, and allied professionals in making treatment decisions.

Elective, low-risk procedures commonly evaluated by the family physician include cataract surgery, upper and lower endoscopy, hernia repairs, and breast surgery. Intermediate-risk surgery includes abdominal procedures, prostate surgery, carotid endarterectomy, and orthopedic surgery.1,4,6

History and Physical Examination

A basic history and physical are the key events in a preoperative assessment.1,4,5,6 The history and physical guide physicians in selecting the appropriate testing required for certain procedures, abnormal findings, chronic conditions, or age-related risks. Although the majority of patients having elective surgery need no testing if they are free of acute, unstable, or chronic illness, there are certain patients that need to be assessed to optimize their condition before surgery and help prevent certain surgical complications. There is also an aim to reduce unnecessary diagnostic tests performed without clinical indications.

During the evaluation, keep in mind three components: 1) The physician may discover a disease process that may not be known and may impact the procedure, recovery, or outcome; 2) If a patient presents with a history of an illness or condition, then verify the presence of that disease and, if present, assess its stability and see if the condition has worsened or

continued on next page
Preoperative Patient Assessment for Non-Cardiac Surgery continued

changed; 3) Record the history, physical, and laboratory data, and formulate recommendations for surgery, special monitoring, medication adjustments, or modification of the anesthesia approach.

To reach the goals of an effective preoperative evaluation, a history and physical or targeted physical needs to be performed.1 A review of the patient record should be done. Physicians should start with a review of their own patient file, and then review reports from other treating physicians. Pertinent details should be reflected in the consult or summary so that the anesthesia team and surgeon have the information before the procedure. There is debate as to the timing of the history and physical. A review by a member of the anesthesia team or physician performing the procedure the day of surgery has been proposed for low-risk procedures in relatively healthy patients. Some advocate for the history and physical to be performed 24 hours prior to surgery, or two weeks to a month before the procedure. Common medical sense should guide the family physician to prepare records and examine the patient in advance of a moderate- to high-risk surgery, or for patients with significant disease or complex history. In any scenario, the history, review of records, and physical examination are the cornerstone of the preoperative assessment.

The history of the patient and the review of records help the physician identify medical conditions that require a more focused examination. They may guide the choice of testing likely to affect outcomes. Documenting the conditions also aids in alerting the entire care team of the patient’s medical conditions that may need closer monitoring during the immediate pre- and post-procedure interval. New conditions need documentation to assess their potential for increased risk or poor outcome due to the procedure. For example, a patient with acute bronchitis with bronchospasm should be cleared of that infection before proceeding with elective surgical intervention.

Physical examination should always include a cardiopulmonary assessment.1 This organ system group has the most potential for complication and is greatly affected by the use of anesthesia and is at risk for potential blood loss or ability to recover successfully from the surgical procedure. Targeted examination is tailored to preexisting medical conditions and/or the patient’s past medical history or recent review of systems. Vital signs, including height, need to be documented in the preoperative assessment report. Drugs used for interoperative blood pressure management, oxygenation, specific types of anesthesia, and fluid volumes are based on these vitals. Documentation preoperatively gives the surgical team a baseline for the patient and helps in the management of unplanned complications. These vital signs should never be omitted.

Screening Questionnaires

Questionnaires are available to assist the physician in identifying undiscovered or forgotten medical conditions or medications the patient is taking. These are heavily utilized by the presurgical team and surgical centers. The major topics include existing or occult coronary artery disease, congestive heart failure (CHF), respiratory conditions such as infection or asthma, significant bleeding problems, anemia, preexisting blood loss, medications such as aspirin or those for arthritis, previous problems with anesthesia, or pregnancy.

The Institute for Clinical Systems Improvement (ICSI) has published its seventh edition of the Preoperative Questionnaire; however, many health care systems have expanded that 15-question screen with a more detailed form. Additional items often covered include: signs and symptoms of sleep apnea, including the use of CPAP/BiPAP at home; functional questions such as the ability to walk up a flight of stairs; the use of tobacco, alcohol, or illicit drugs; deep vein thrombosis (DVT); heart murmurs; diabetic status; neurological signs or symptoms, such as transient ischemic attack (TIA) or stroke; hepatitis; seizures; dental and neck disorders (to inform positioning or intubation during surgery); and careful review of nonprescription medications.1,4

Individualized approaches used for patients with significant issues on the screening questionnaire may include the use of CPAP in the recovery room, additional monitoring in the immediate postoperative period, or adjustment for the adequate delivery of anesthesia.

Screening and Indicated Testing

There are myriads of potential tests that can be performed to assess a patient’s condition before surgery. For example, there are screening tests that look for a medical condition not previously identified. These could include a coagulation profile, complete blood count (CBC), or 12-lead electrocardiogram (ECG) in an age-appropriate population. There are also tests performed to monitor a specific condition or to assess medical stability. These would include a 12-lead resting ECG in a patient with known coronary artery disease, hypertension, or stable angina, etc. Specific recommendations vary among the published literature, however, and there is a paucity of randomized clinical trials to guide physicians looking for evidence-based information. There is consensus that special testing for indicated conditions is usually appropriate if there is clinical concern for the patient or if there could be a significant modification in anesthesia type or surgical approach or postoperative monitoring.

Research on preoperative screening tests has categorized recommendations into three groups. These include 1) routine tests, 2) selective or indicated tests based on patient information, and 3) tests NOT recommended for all patients. Due to the wide range of abnormal results with testing and the wide range of subsequent changes in medical management, as well as a lack of well controlled studies to guide evidence-based decision making, there are no evidence-based routine screening tests required. Selective testing is a much better guide to optimize a patient’s condition or identify episodes of instability not otherwise noted by physical exam. It is important to document in the record the indication for the test. Selective tests can be performed on the basis of the previous medical record, the patient interview preoperatively, or on a finding during examination.

Specific Presurgical Tests

The following discussion of selected tests will illustrate the reasoning in choosing each test and its usefulness and impact on surgery. These tests include hemoglobin, prothrombin time/partial thromboplastin time (PT/PTT), metabolic profiles, urinalyses, and chest X-rays. A separate discussion will involve the role of cardiovascular testing.

The hemoglobin and hematocrit (H/H) test has long been customarily performed as an inexpensive test to monitor infection status with white blood cell counts or to identify new or occult anemia. Due to the fluctuations of fluid balance, blood pressure, and general cardiovascular stress during procedures requiring anesthesia, an anemic patient may do poorly, and oxygenation may be compromised in the face of significant anemia. Procedures that result in blood loss could exacerbate other conditions (such as cardiovascular or respiratory) when patients are already anemic. Studies show up to 28% of patients with anemia had a change in management based on lab results. Again, testing with an H/H or CBC for a known indication is generally helpful.

Coagulation profiles (PT/INR and PTT or bleeding times) are routinely performed, but evidence-based studies are lacking that would compel physicians to perform this test. In fact, some studies show no change in clinical management based on the result of a mildly abnormal coagulation

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profile. Indicated testing, such as in the face of a patient using aspirin, warfarin (Coumadin), or other blood-thinning agents, are helpful and guide the interoperative decisions of the surgeon. Some conditions require converting from a longer-lasting anticoagulant to a shorter one. For example, a patient controlled on warfarin for a prosthetic heart valve may be converted to heparin or low-molecular-weight heparin before surgery; the medication is discontinued for the procedure and restarted in the postoperative setting.

Metabolic profiles, often referred to as the SMA-12 or complete metabolic profiles, are not recommended solely for screening. Studies show that the most common change in medical and surgical management results from electrolyte abnormalities, specifically potassium. Change in surgical management occurred 1% to 12.8% for abnormal chemistry tests, but 1% to 29% in abnormal testing done for specific indications, such as diuretic therapy for hypertension or known renal insufficiency. Interestingly, studies show glucose levels did not result in management changes. Please refer to additional information in the disease segment under renal status.

Urinalysis is similar to hemograms in that it is very inexpensive and can result in changes in medical management. Between 2% and 30% of patients routinely screened for UAs in various studies had their preoperative management changed. Nearly 100% of patients with urinary tract infections in all studies were treated for infection before the procedure. Patients with UAs done for indicated reasons had between 4% and 42% likelihood of change in management.

Urinalysis for beta human chorionic gonadotropin (hCG) in childbearing women resulted in 100% change in medical management before the procedure.

Chest X-rays are not routinely used as screening tests. However, they play an important role when indicated for monitoring or assessing cardiovascular conditions. In identifying compensated heart failure, COPD, or hypertensive cardiomyopathy, a preoperative chest X-ray could be performed. Pulmonary function testing is helpful in patients with known COPD whose conditions may have asymptotically advanced, which would influence recovery from anesthesia or in the postoperative course.

Cardiovascular Testing (ECGs and Stress Testing)

Cardiovascular assessment has become complex, partly due to the number of interventions and medications used for bare-metal and drug-eluting stents and angioplasty. Advanced cardiac conditions themselves also increase morbidity and mortality. The scope of this article is not meant to be an exhaustive listing of each cardiac condition and its specific recommendations, but rather a general overview of handling the typical stable patient presenting to a family physician’s office for an elective procedure.

Cardiovascular testing, such as ECGs, treadmill exercise stress testing, stress echocardiography, or testing for left ventricular function (LVF), have an appropriate place in the preoperative assessment for indicated conditions. Observational studies have shown that a preoperative 12-lead resting ECG has value in assessing patients beyond the age of 50. There is insufficient data to draw absolute conclusions for or against screening ECGs. Consultants disagree on the age at which screening ECGs should be performed. Some argue that screening should be performed on patients starting as low as 45 or as high as 60 years of age. One consensus guideline noted by the Institute for Clinical Systems Improvement (ICSI) was to set the screening age at 55. Most hospitals and procedure centers have agreed to a screening age of 50. It is recommended that you follow the policy set by the organizational body where the procedure is being performed. Unfortunately, due to the widespread occurrence of ECG abnormalities which increase with the age of the patient, there is no consensus as to what testing should be done to follow up on an abnormal test. There was insufficient data found to guide physicians on the preoperative requirements for echocardiograms, stress testing, or angiography in all conditions.

According to ICSI, consider performing a 12-lead ECG if one is not available within one year, regardless of age, for patients with diabetes, hypertension, chest pain, congestive heart failure, smoking, peripheral vascular disease, inability to exercise, or morbid obesity.

Resting 12-lead ECGs are frequently performed on older patients preoperatively. The literature supports a Level B Evidence for the use of preoperative 12-lead resting ECGs in persons without clinical risk factors who are undergoing vascular surgical procedures. The same level of evidence (B) holds for the use of 12-lead resting ECG for patients with at least one clinical risk factor who are undergoing intermediate-risk operative procedures such as joint replacement. Clinical risk factors are presented in Table 1.

Table 1. Clinical Predictors of Increased Perioperative Risk

<table>
<thead>
<tr>
<th>Level of Risk</th>
<th>Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major</td>
<td>Unstable coronary syndromes (acute or recent MI, unstable angina)</td>
</tr>
<tr>
<td></td>
<td>Decompensated CHF</td>
</tr>
<tr>
<td></td>
<td>Significant arrhythmias (high grade AV block, symptomatic ventricular arrhythmias with underlying heart disease, SVT with uncontrolled rate)</td>
</tr>
<tr>
<td></td>
<td>Severe valvular disease</td>
</tr>
<tr>
<td></td>
<td>Severe hypertension (diastolic over 110, systolic over 180)</td>
</tr>
<tr>
<td>Major Non-cardiovascular</td>
<td>Pulmonary disease, severe or symptomatic (COPD requiring oxygen, dyspnea at rest)</td>
</tr>
<tr>
<td></td>
<td>Symptomatic poorly controlled diabetes mellitus (DM)</td>
</tr>
<tr>
<td></td>
<td>Symptomatic anemia</td>
</tr>
<tr>
<td>Intermediate</td>
<td>Mild angina pectoris</td>
</tr>
<tr>
<td></td>
<td>Previous MI by history or Q waves</td>
</tr>
<tr>
<td></td>
<td>Compensated heart failure</td>
</tr>
<tr>
<td></td>
<td>Diabetes (especially insulin dependent)</td>
</tr>
<tr>
<td></td>
<td>Renal insufficiency</td>
</tr>
<tr>
<td>Minor</td>
<td>Age over 75</td>
</tr>
<tr>
<td></td>
<td>Abnormal ECG (LVH, LBBB, ST-T abnormalities)</td>
</tr>
<tr>
<td></td>
<td>Rhythm other than sinus</td>
</tr>
<tr>
<td></td>
<td>Low functional capacity (less than 4 METS)</td>
</tr>
<tr>
<td></td>
<td>History of stroke</td>
</tr>
<tr>
<td></td>
<td>Uncontrolled systemic hypertension</td>
</tr>
</tbody>
</table>

Cardiovascular Risk

Level C Evidence supports the finding that noninvasive stress testing is not useful for patients without risk factors undergoing intermediate-risk surgery. There was insufficient evidence to routinely recommend the 12-lead resting ECG or noninvasive cardiovascular testing for asymptomatic persons undergoing low-risk surgical procedures. Patients with poor functional capacity (four METS or less), who also have one to two risk factors, may benefit from noninvasive stress testing before intermediate-risk noncardiac surgery.

Left ventricle assessment is important for appropriate management of patients with significant cardiovascular history (such as CHF, MI, valvular heart disease) or findings on physical. An echocardiogram and Doppler assessing overall ejection fraction, contractility, and condition of the
values is valuable in preoperative assessment of the patient with cardiac conditions. Certain recommendations on the use of left ventricular (LV) function can be obtained from the literature. With a level of evidence B rating, routine perioperative evaluation of LV function is not recommended. However, with a level of evidence C, the LV function assessment should be performed within 12 months on patients with dyspnea of unknown origin, prior heart failure, or other changes in clinical status.

There are agreements on the need to assess good functional capacity. Highly functional asymptomatic patients rarely have a change in management based on additional cardiovascular testing. To clinically assess functional capacity in patients who have not recently or ever had cardiovascular testing such as stress tests, activity of daily living provides a reasonable estimate of such function. For example, functional capacity has been classified as excellent (greater than 10 METS), good (7-10 METS), moderate (4-7 METS), and poor (less than 4 METS). The Duke Activity Status Index contains questions that can be used to estimate functional capacity. A patient’s risk factors and functional capacity assessment will determine the need for additional cardiovascular testing or consultation. (See Table 2.)

Table 2. Estimated Energy Requirements for Various Activities

<table>
<thead>
<tr>
<th>MET</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 MET</td>
<td>Take care of yourself, eat, dress, use toilet, walk indoors around the house, walk a block or two on level ground at 2-3 mph</td>
</tr>
<tr>
<td>4 METS</td>
<td>Do light work around the house like dusting or washing clothes, climb a flight of stairs or walk up a hill, run a short distance, mow grass, ride a bike, do heavy work around the house: scrub floors, lift furniture, moderate recreational activities: golf, bowling, dance, doubles tennis, baseball</td>
</tr>
<tr>
<td>&gt; 10 METS</td>
<td>Strenuous sports: football, singles tennis, swimming, skiing</td>
</tr>
</tbody>
</table>

The Lee’s Revised Cardiac Risk Index can stratify the risk of cardiac complications for patients with multiple diagnoses. Since some patients arrive at the office without recent medical treatments and have unknown clinical status for a period of time, the Lee’s Index can be used clinically to assess overall risk in broad terms. A point scale is given for each of several clinical conditions resulting in a score that places the patient in a risk class of very low, low, moderate, or high. (See Table 3a and 3b.)

<table>
<thead>
<tr>
<th>Clinical variable</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>High-risk surgery</td>
<td>1</td>
</tr>
<tr>
<td>Coronary artery disease</td>
<td>1</td>
</tr>
<tr>
<td>Congestive heart failure</td>
<td>1</td>
</tr>
<tr>
<td>History of cerebrovascular disease</td>
<td>1</td>
</tr>
<tr>
<td>Insulin treatment for DM</td>
<td>1</td>
</tr>
<tr>
<td>Preoperative creatinine over 2.0 mg/dL</td>
<td>1</td>
</tr>
</tbody>
</table>

TOTAL

There are many complex evidence-based formulas used to assess risk in patients with previous cardiac procedures, such as angioplasty or coronary artery stenting, severe valvular disorders, or previous open heart surgery. Family physicians can identify those cardiovascular patients at particularly higher risk, thereby avoiding unplanned complications, or can alert the surgical and anesthesia team as to the patient’s history and baseline exam. The systematic stepwise approach put forth by the American Heart Association states that once a patient is identified as having a cardiac condition, look for evidence of an unstable condition (see Table 2 for definition of unstable conditions). For example, the highest risk patients have unstable angina, decompensated heart failure, severe valvulopathy, or severe arrhythmia. These conditions warrant delay or cancellation of elective noncardiac surgery.

Intermediate risk factors include previous MI by history or Q waves, compensated heart failure, insulin dependent diabetes, renal insufficiency, or mild angina pectoris. Minor predictors of increased risk were grouped into age over 75, abnormal ECG such as LBBB, LVH, or ST-T wave abnormalities (except of atrial fibrillation, which falls under greater risk), or history of stroke or uncontrolled systolic hypertension and low functional capacity.

Hypertensive patients with blood pressure higher than 180/110 may experience potential benefits in delaying procedures and utilizing anti-hypertensive regimens to control blood pressure. However, few randomized control trials have been done. Controversy among authors is noted with regard to discontinuing angiotensin converting enzyme (ACE) inhibitors and angiotensin II receptor blockers (ARB) drugs on the morning of surgery due to the risk of perioperative renal dysfunction. This is unlike the use of beta-blocker therapy, which is discussed later in this article. For an in-depth guide to current evidenced-based recommendations for cardiac conditions for testing and risk, please refer to the ACC/AHA 2007 Guidelines on Perioperative Cardiovascular evaluation and care for Noncardiac Surgery.

Pacemaker patients should be clearly identified due to the types of electrical grounding of the patient and the use of electrocautery. Patients with automatic defibrillating devices may need them turned off during certain procedures. Interestingly, controlled studies on surgical patients who are classified as moderate risks show no significant outcome differences whether they underwent revascularization procedures before vascular surgery.

Table 3a. Lee’s Revised Cardiac Risk Index

<table>
<thead>
<tr>
<th>Risk</th>
<th>Points</th>
<th>Risk of complications (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very low</td>
<td>0</td>
<td>0.4</td>
</tr>
<tr>
<td>Low</td>
<td>1</td>
<td>0.9</td>
</tr>
<tr>
<td>Moderate</td>
<td>2</td>
<td>6.6</td>
</tr>
<tr>
<td>High</td>
<td>3+</td>
<td>11.0</td>
</tr>
</tbody>
</table>

Conditions

There are several diagnostic conditions that deserve special mention due to their influence on the types of anesthesia or other medication used in the perioperative setting. These conditions are smoking, obstructive...
sleep apnea syndrome (OSAS), joint replacement, antibiotic prophylaxis, chronic liver disease, cardiovascular conditions or interventions, and renal insufficiency.

**Smoking**

Smokers should be encouraged to quit at least six weeks before a planned procedure. Although there is little published evidence that smoking cessation prior to surgery improves outcomes or reduces complications, preparing for the procedure may be a valuable motivator to the patient who is willing to quit. In addition, the evidence supports improved wound healing, especially in head and neck surgeries.

**Obstructive Sleep Apnea Syndrome**

In the special report by the American Society of Anesthesiologists Task Force on patients with OSAS, recommendations were developed to assist the clinician in reducing the risk of adverse surgical outcomes. Because sedation, analgesia, and anesthesia have direct effects on ventilation, and patients with sleep apnea syndromes may already be compromised, a symptom scale and scoring system is available. Again, it is common to be asked to evaluate patients who potentially have OSAS but have never had a sleep study. Others are on treatment at home with CPAP and BiPAP. These home settings are valuable to the operative team and may be used during procedure to secure the airway.

A presumptive diagnosis of OSAS may be made based on several factors, such as significantly elevated body mass index (BMI), increased neck circumference, snoring, daytime hypersomnolence, inability to visualize the soft palate on exam, and tonsillar hypertrophy. Consultants agree that identifying potential or actual OSAS improves perioperative outcomes. These patients are also affected by the invasiveness of the procedure and the severity of their sleep apnea. Should there be a high clinical suspicion for advanced OSAS, elective procedures should be postponed until adequate evaluation is performed. If a patient had a formal sleep study, it should be reviewed. CPAP and NIPPVC or oral appliances may be used during surgical procedures. Spinal or epidural anesthesia is generally recommended over major conduction anesthesia for patients with significant OSAS. General anesthesia is preferable to moderate or deep sedation for patients with OSAS undergoing procedures such as upper endoscopy or bronchoscopy.

**Prophylactic Antibiotics**

Prophylactic antibiotics for subacute bacterial endocarditis (SBE) recommendations changed radically in 2007, altering years of previous recommendations based on the type of surgery and the presence of valvular heart conditions. The American Heart Association recently updated endocarditis prophylaxis information, and the 2007 guidelines replace the 1997 guidelines. Mitral valve prolapse is no longer considered a condition requiring antimicrobial SBE prophylaxis. Their endocarditis committee reviewed the current literature and determined there is no conclusive evidence that links dental, genitourinary (GU) tract, or gastrointestinal procedures with the development of bacterial endocarditis (BE). Therefore the current practice of treating patients with antibiotics is no longer recommended except for very select individuals. These are patients with a prosthetic cardiac valve, previous endocarditis, cardiac transplants with valvular disease, and certain congenital heart diseases such as: 1) unrepaired cyanotic congenital heart disease; 2) completely repaired congenital heart disease (CHD) with prosthetic material or device during the first six months post procedure; and 3) repaired CHD with residual defects adjacent to the prosthetic patch or device. Procedures of the respiratory tract or infected skin or musculoskeletal tissue do not require BE prophylaxis unless patients have the underlying cardiac conditions previously mentioned.

**Joint Replacement**

Joint replacement patients often receive antibiotics before a procedure based on recommendations by the American Academy of Orthopedic Surgeons and the American Dental Association. Before joint replacement, candidates should receive a thorough dental evaluation and correction of asymptomatic dental abscesses or deep caries or periodontal gum disease. This is due to the higher risk of bacteremia in patients with ongoing dental inflammation. Since the initiation of perioperative antibiotic prophylaxis to avoid prosthetic infection by seeding, deep infection in the immediate postoperative period from interoperative contamination has been greatly reduced.

After joint replacement, or orthopedic corrections using grafting or metal, antibiotic prophylaxis is not indicated for patients with pins, slates, or screws, nor is it routinely indicated for those with joint replacements. A literature review does point to a potential benefit of antibiotic prophylaxis within the first two years of a total joint replacement to avoid prosthetic infection. It may be helpful to premedicate patients with high-risk comorbidities, such as compromised immune systems or HIV, or those with previous prosthetic joint infections, insulin-dependent diabetes mellitus (IDDM), ongoing malignancy, malnourishment, or bleeding disorders.

**Chronic Liver Disease**

Liver disease can affect drug metabolism, be associated with renal insufficiency, coagulopathy, increased bleeding times, and a variety of other endocrine and metabolic conditions. A history and physical exam is usually sufficient to identify patients with advanced hepatic dysfunction such as jaundice, ascites, coagulopathy, and edema. Another key to finding patients with significant liver disease is finding a family history of jaundice, anemia, or liver disorders. Routine laboratory assessment is not recommended unless clinical signs or symptoms are present. Routine use of liver function tests (LFT) has low predictive value, and it is very rare to cancel surgery in asymptomatic patients with mild elevations in aspartate transaminase (AST) and alanine transaminase (ALT). Patients with LFTs three times the upper limit of normal, however, need evaluation before surgery since nearly one-third of these patients may have undiagnosed cirrhosis. Patients with known chronic liver disease, such as hepatitis, who are asymptomatic and have no known cirrhosis and have normal laboratory enzymes do well operatively.

**Beta Blockers**

Beta blockers have been more extensively studied due to their numerous indications and widespread use. Although increasing the risk

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*continued on next page*
of bradycardia and hypotension, beta-blocker use has been demonstrated to reduce risk of death when continued for patients at high risk, but not low risk.

If a patient is under beta-blocker therapy prior to surgery or is a high-risk patient planning vascular surgery, then their use is recommended (level of evidence B). In regard to intermediate-risk surgery for patients with coronary artery disease or at least one clinical risk factor, then beta blockers are probably recommended (level of evidence B).

Continuing beta blockers for hypertensive patients currently being treated with them, stable angina, or symptomatic arrhythmias is supported by C level of evidence. This includes the use of beta blockers up to and including the day of surgery. Stopping beta-blocker therapy places patients at increased risk of postoperative complications. There is uncertain usefulness of beta blockers in patients with a single risk factor undergoing intermediate-risk surgery. Perioperative beta blockade has not been studied in low-risk individuals not on beta blockers contemplating elective surgery.

Anticoagulants

Evaluation for traditional anticoagulants such as warfarin, aspirin, or NSAIDS is critical due to the increased risks of bleeding complication in the surgical patient.

Vitamins, Herbs, and Supplements

There are additional risks for hemostasis from several nontraditional sources, such as vitamins, herbal treatments, and supplements. Since nearly half of all patients take some form of nonprescription supplement, and nearly three-quarters fail to disclose herbal medicines during routine preoperative assessment, the patient should carefully be asked about over-the-counter medications. Vitamin E and ginkgo biloba are just a few of the blood-thinning supplements that should be stopped before surgery. Ginkgo may alter vasoregulation as well as inhibit platelets. Garlic may inhibit platelet aggregation, depending on the dose. Ginseng may promote hypoglycemia in fasting patients, and prolong PT and PTT. Kava may inhibit sodium and calcium channels; interacts with anesthetics and lorazepam; and potentiates GABA. Other GABA mediators include valerian, and medications that work at that receptor site like anesthetic and adjuvants (for example, midazolam) are potentiated. Other salicylate containing medications, such as Pepto-Bismol, should be stopped as well.

Glucocorticoids

Wound healing is profoundly inhibited in several ways in patients treated with steroids. Fibroblast proliferation is decreased, and granulation tissue reduced. Protein and collagen production is decreased, and host defenses are reduced. Vitamin A has been shown to reverse many of the effects of corticosteroids. Doses of glucocorticoids equivalent to 10 mg per day of prednisolone are thought to be lower risk.

Statins

Retrospective observational studies seem to point to a protective benefit of statins, especially in combination with beta blockers. By the mechanisms that produce plaque stability and antiproliferative effects, there are reduced incidences of perioperative mortality and nonfatal MI. There is preliminary support for the use or continuation of statins preoperatively, especially with higher risk patients.

Summary

The family physician plays an important role in evaluating patients who are contemplating invasive medical procedures. We are most frequently called upon to assess patients ready to undergo testing for low- to intermediate-risk noncardiac surgery. Although evidence is still incomplete regarding recommendations in every scenario, several points worth noting were summarized in this article. The history, indication for the procedure or testing, and a review of records is the first critical step in a sound preoperative evaluation. The physical exam, including attention to vital signs and cardiopulmonary assessment, along with targeted examination of organ systems affected by a chronic condition, needs proper documentation. Routine or screening testing is rarely required in the generally healthy individual. Preoperative testing for monitoring existing disease stability or assessing medication effects is indicated. Timely relay to the surgical and anesthesia team of the information and results gathered concludes the assessment. This strategy leads to better patient care and reduction of complications and provides certain baselines to help guide the treatment of unexpected complications. Because additional studies are under way, and consensus guidelines and clinical recommendations change, periodic review will be necessary to provide the most up-to-date evaluations for our patients.

Disclosure: The authors have indicated that they have nothing to disclose in relationship to this article.

References

Overview of the Ninth Scope of Work

Joseph A. Lieberman, III, MD, MPH

Joseph A. Lieberman, III, MD, MPH, is a former president of the New Jersey Academy of Family Physicians and a member of the Board of Trustees at Healthcare Quality Strategies, Inc., (HQSI), which is the federally designated Quality Improvement Organization (QIO) for New Jersey. HQSI is an independent, non-profit company committed to accelerating improvement in healthcare quality through a collaborative and interactive process with the healthcare community.

IN AUGUST 2008, the Ninth Scope of Work (9th SOW), which is a three-year national healthcare quality improvement initiative developed by the Centers for Medicare & Medicaid Services (CMS), begins. It is designed to assist healthcare providers with:

- Preventing illness in Medicare beneficiaries
- Decreasing harm to beneficiaries
- Reducing waste in health care

The 9th SOW activities are conducted in the 50 states, the District of Columbia, and several US territories, including the Virgin Islands and Puerto Rico, by federally designated Quality Improvement Organizations (QIOs). Healthcare Quality Strategies, Inc., (HQSI) is the QIO for New Jersey.

The 9th SOW has two primary components: national themes and subnational projects. While the national themes will be conducted in every designated QIO area, the subnational requirements will be awarded on a state-by-state basis, depending on CMS’s assessment of the state’s need and the QIO’s approach to improvement. This article presents CMS-generated summaries of the national themes (Table 1).

Table 1

<table>
<thead>
<tr>
<th>Theme: Prevention</th>
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<tbody>
<tr>
<td><strong>Overview</strong></td>
</tr>
<tr>
<td><strong>Opportunity for QI</strong></td>
</tr>
</tbody>
</table>
The primary activities involved in the theme will focus on nine tasks:
• Recruiting participating practices
• Identifying the pool of nonparticipating practices
• Promoting care management processes for preventive services using EHRs
• Completing assessments of care processes
• Assisting with data submission
• Monitoring statewide rates (mammograms, CRC screens, influenza and pneumococcal immunizations)
• Administering an assessment of care practices
• Producing an annual report of statewide trends, showing baselines and rates
• Submitting plans to optimize performance

Theme: Patient Safety

Overview
QIO activities under this theme will focus on six primary topics:
• Reducing rates of healthcare-associated methicillin-resistant *Staphylococcus aureus* (MRSA) infections
• Reducing rates of pressure ulcers in nursing homes and hospitals
• Reducing rates of use of physical restraints in nursing homes
• Improving inpatient surgical safety and heart failure treatment in hospitals
• Improving drug safety
• Providing quality improvement technical assistance to nursing homes in need

Opportunity for QI
The requirements of the theme, also known as the CMS National Patient Safety Initiative (NPSI), are designed to address areas of patient harm for which there is evidence of how to improve safety by improving healthcare processes and systems. The theme brings forward several components from the 8th SOW (surgical care; heart failure; pressure ulcers and restraints in nursing homes; and drug safety), allowing QIOs to build on the progress they have made with providers over the past three years.

With the 9th SOW, however, the safety focus also pushes into new areas (MRSA, pressure ulcer prevention in hospitals, and QIO technical assistance for nursing homes in need), giving providers and QIOs the chance to broaden the scope of their patient safety-related improvement activities.

QIO Activities
QIO activities under the NPSI will support the development of an “all-teach, all-learn” community in action to meet the goals within each component of the initiative. To this end, CMS is requesting that QIOs identify two to three individuals from each QIO to serve as national QI leaders. These individuals will serve as liaisons between QIO senior leadership and the work that is occurring at the patient care level in each state/jurisdiction. They will also be liaisons with healthcare executives in their respective states/jurisdictions to highlight the work occurring at the national level in their provider groups.

QIOs will have a wealth of tools available to them to assist in reaching goals for specific quality measures. These include survey instruments geared toward leadership and/or patient safety processes in hospitals and nursing homes. Additionally, QIOs can draw upon successful tools that were utilized in the 8th SOW. It is expected that as successful tools and practices develop, the QIOs will share these with one another for implementation in other QIO communities.

QIOs may expand their local quality improvement communities by reaching out to potential patient safety partners and encouraging their participation to expand upon the momentum that will be created by the CMS NPSI.

Theme: Beneficiary Protection

Overview
QIOs will continue to carry out statutorily mandated review activities, such as:
• Reviewing the quality of care provided to beneficiaries
• Reviewing beneficiary appeals of certain provider notices
• Reviewing potential antidumping cases
• Implementing quality improvement activities as a result of case review activities

continued
Opportunity for QI

Individual patient complaints and provider medical record reviews are important starting points for analysis of quality improvement needs among providers. QIOs will be increasing their efforts to link case review activities to improvements in the quality of care, specifically by developing quality improvement activities focused on system-wide changes. QIOs will utilize all data related to case review activities to identify problems associated with the quality of care and design QI activities (QIAs) aimed at helping providers correct these problems. The QIOs will be responsible for collaborating with all pertinent CMS contractors to ensure that all available data are considered and to maximize opportunities for quality improvement.

QIO Activities

The activities involved in this theme will focus on nine tasks:
- Case reviews
- QIAs
- Alternative dispute resolution, including mediation
- Sanction activities
- Physician acknowledgement monitoring
- Collaboration with other CMS contractors
- Promoting transparency through reporting
- Quality data reporting
- Communication (education and information)


More information about the 9th SOW can be obtained by visiting the CMS Web site at www.cms.gov/QualityImprovementOrgs.

Summary

CMS under statutory authority has identified the following requirements for the QIO program:

- Improve quality of care for beneficiaries
- Protect the integrity of the Medicare Trust Fund by ensuring that Medicare pays only for services and goods that are reasonable and medically necessary and that are provided in the most appropriate setting
- Protect beneficiaries by expeditiously addressing individual complaints, notices, and appeals, such as beneficiary complaints; provider-issued notices of noncoverage (Hospital-Issued Notice of Noncoverage [HINN], Notice of Discharge and Medicare Appeal Rights [NODMAR], and Medicare Advantage appeal); Emergency Medical Treatment and Labor Act (EMTALA) violations; and other related statutory QIO responsibilities

The 9th SOW supports these requirements by using measurable criteria to evaluate QIOs’ performance. In addition, CMS will closely monitor QIOs in their efforts to promote value-driven health care, support the adoption and use of health information technology, and work to reduce health disparities.

References


This material was prepared by Healthcare Quality Strategies, Inc., (HQSI), the Medicare Quality Improvement Organization for New Jersey, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the US Department of Health and Human Services. 8SOW-NJ-GEN-08-
Jeff Levine, MD who was awarded the 2008 Professional Osteoporosis Recognition Award by the New Jersey Interagency Council on Osteoporosis (ICO).

Gregory Herman, MD (Underwood-Memorial Hospital) and David Zalut, MD (Virtua Health). Both have been chosen by SJ Magazine (June 2008) as “Top Docs for Kids.” These physicians were chosen by their peers with one simple question: If a child in your family was ill, what doctor would you refer him (or her) to?

Lauren Carruth-Mehnert, MD on the birth of her son Michael Vincent on May 30th. Michael was 6 lbs 15 oz and 20.5 inches and according to Mom, very cute.

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The NJAFP extends its deepest sympathies to Jeff Levine, MD on the passing of his father, Fred Levine, in April 2008.

The NJAFP collection of audio podcasts is becoming more robust. We have recently added four new programs: Update on the Treatment of Depression, Vaccine Guidelines for Adults, Pay for Performance, and excerpts from the 2007 Town Hall Meeting with Donald J. Parker, President, CEO of AtlantiCare Behavioral Health.

You can access NJAFP podcasts from the NJAFP website at www.njafp.org/podcasts.
A Goal Worth Reaching For

Robert “Butch” Pallay, MD, a Past President of the NJAFP and current Director of the AAFP has been put forward as a candidate by the New Jersey Academy of Family Physicians for President Elect for the American Academy of Family Physicians. Dr. Pallay has been Residency Director at Savannah Family Medicine Residency since September 2007.

I recently spent three days at the Program Directors Workshop in Overland Park, Kansas with over 300 other family medicine residency directors from all over the United States. The program is run by the Academy of Family Medicine Residency Directors (AFMRD), one of the groups within the family of the family medicine organizations. AFMRD is responsible for the residency programs across the country. To say being at this event has been an eye-opening experience would be to put it mildly. A friend of mine on the AAFP Board has said that the most difficult job in family medicine today is being a residency director and after the last few days, I would have to agree.

Among the many interesting subjects we covered at the business meeting of the AFMRD, the one that stood out to me most was the topic of maternity care in family medicine training. At issue is whether we should continue with the curriculum that was established when the specialty began some thirty years ago. There are many parts to the maternity discussion, one of which centers on the regional difference in maternity care. For example, in the northwest, the 17 residencies that comprise that region responded that over 80% of their residents would be doing OB care after they finished their residency training! That is a far cry from the northeast, where only a small percentage of family physicians still do OB. Many northeast physicians either choose not to or even if they want to they often cannot get the hospital privileges to practice obstetrical care. In Georgia, where I am now, there are pockets of family physicians who practice OB and pockets of those who do not, but precious few of the residents trained in my or any other of the Georgia residencies actually add obstetrical care as a part of their basket of services once they leave their residency. Our family medicine residents are having trouble even qualifying for the Residency Review Commission’s (RRC) recommended 40 deliveries – a number many of the residency directors think is woefully low to demonstrate competency. Based on the many comments heard, I believe the possible recommendation from the AFMRD board will be to continue to maintain OB training as it is currently required now for all residents as a minimum level of competency, with the possibility of adding an increase in the number of deliveries required for those who will actually be doing OB care after graduation.

Why do I bring up this particular topic out of all the topics discussed at the workshop? It is because I had a revelation for what we need to do in family medicine in the matter of obstetrics. When I trained in my residency, in New Jersey some 30+ years ago, I did many deliveries -- many more than the presently required 40 -- and chose to continue to deliver obstetrical care when I went out into my own practice. It was a different time and different environment, and not many primary care physicians were doing OB. But for the 12-15 years I delivered babies, it was the most special and precious part of my practice. It allowed me to really care for the WHOLE family and all the issues that came with that. It also guaranteed me an ongoing and vibrant pediatric practice. Though it was often difficult for my practice when I had to leave to care for a woman in labor, it was very special. Right up until I stopped doing OB, delivering a baby gave me a jolt unlike anything else I did. What’s more, I know that I, as a family doctor, practiced OB in a very different manner than my OB-Gyn associates. It’s not that they were not doing the best they could for their patients, they could just never match the totality of the care we give as family doctors doing OB. And I think many of them knew it, and still know it today. In fact, there are areas of the country where the obstetricians ask us to NOT give up doing OB as they know it is good for the communities in which they live.

And so, as we struggle to find the right answer to the question of where OB training should fit into the curriculum, let me offer a differing point of view. I believe the problem we face offers us a tremendous opportunity, even, and maybe especially, in the northeast. As more and more OB/Gyn’s opt to give up or never even start obstetrical care, a void is being created and a tremendous need for women across the country is growing. Rather than moving away from OB, as the health care system moves to the patient-centered medical home, I think obstetrical care should be added to our basket of services. As we move to a team delivery model of health care it is natural for us to be the leaders of the OB teams throughout the country. We need to sit down with our obstetrical colleagues, reach out to the nurse midwives, and work together to set up a system of family medicine-centered obstetrical care in all regions of the United States. This will give the people of this country the most satisfying system of child delivery which fits in the patient-centered medical home, the best system of care for the future. We can and should do this, and if we can, we will naturally adjust our residency training to accomplish this goal. It may be a reach, especially in some areas, but it is a goal worth reaching for.

Robert “Butch” Pallay, MD
Adding Mid-level Providers to Your Practice

Susan B. Orr, Esq.

If patients have to schedule appointments with your practice weeks or months in advance or if your practice is unable to accommodate same-day appointments, this might be the time to consider bringing a mid-level provider such as an advanced practice nurse (APN) or a physician assistant (PA) into your practice. Many practices have found that hiring mid-level providers is an effective means of boosting practice revenue, while freeing up the physician’s schedule and increasing patient satisfaction.

These mid-level providers compliment the services of physicians: they do history and physicals, diagnose and treat illnesses, order and interpret tests, prescribe medications, provide preventive care, perform patient education and counseling services, and are available to treat patients in hospital or nursing home settings. Many practices use them to accommodate same-day and urgent-care appointments, freeing up the physicians for more chronic patients. Since these providers tend to be less busy than physicians, they have more time to spend with patients.

Before bringing a mid-level provider into your practice, you should be familiar with New Jersey’s supervisory requirements. New Jersey requires that a PA work under the direct supervision of a physician. This doesn’t mean that the physician has to be present in the office, but simply that he or she is available by telephone for either consultation or for recall back to the office. The supervising physician must personally review all charts and patient records and countersign within seven days of the entry in the patient’s chart. In the case of medications prescribed or administered, a physician must review and countersign the order within 24 hours. Keep in mind that one physician can supervise up to four PAs.

The APN statute and regulations, on the other hand, call for the APN to “collaborate with” a physician and require that they develop and enter into a written joint protocol to document the services provided, accepted standards of practice, the method of communication between them, and an outline of the circumstances and conditions under which the APN may prescribe medication. Unlike the PA, there are no supervision requirements other than making sure the physician is immediately available to the APN either in person or by telephone and that the physician periodically review the records of patients treated by the APN. Furthermore, unlike the PA, the APN may prescribe controlled substances, subject only to any restrictions imposed by the collaborating physician.

The key question is how do you get reimbursed for their services? Under Medicare, you can bill either under the mid-level provider’s number, or you can bill their services “incident to” your care. If you bill “incident to,” payment is made at 100% of the physician’s fee schedule, but if you bill under the mid-level provider’s number, reimbursement is reduced to 85% of the physician’s fee schedule. Even though billing “incident to” is more attractive to your bottom line, you need to ensure that all requirements are met: (a) you must first see the patient on a previous visit and develop a plan of care; (b) any time a new problem arises, the patient will need to see you first; (c) services must be furnished under your direct supervision or that of another physician in your group; and (d) the supervising physician must be in the office suite (but not in the same room) and be immediately available.

“Incident to” billing is limited to office visits only.

Services provided by mid-level providers in nursing homes or hospitals must be billed under the PA’s or APN’s provider number. However, in a hospital setting you can take advantage of billing a split E&M service where both you and the mid-level provider see the patient on the same day, but not at the same time and correlate the two visits into a single E&M code based on both of your notes.

Many commercial third-party payers have yet to credential mid-level providers, but that doesn’t mean that these providers can’t see their members. Check with your payers to see how to bill for the services of your APN or PA. Occasionally, they will have their own “incident to” requirements, but if they don’t, you are safe if you follow Medicare’s “incident to” requirements.

It may take some time for patients to understand who this new APN or PA is and the role he or she will play in your practice. It is important to train your staff about your mid-level provider so that they can educate patients when they call to schedule appointments or have questions. Always make sure that patients are informed when they schedule their appointments with your practice that they will be seeing an APN or a PA and not a physician.

For questions about this article, contact Susan B. Orr, Esquire, at Tsoules, Sweeney, Martin & Orr, LLC, at 610-423-4200 or sorr@tshealthlaw.com.

Ms. Orr is a partner in the law firm of Tsoules, Sweeney, Martin & Orr, LLC, in Exton, PA. Prior to joining the firm, Ms. Orr served as practice administrator for her husband’s family practice. Ms. Orr regularly counsels physicians and group practices on practice management issues including reimbursement and payment issues, Medicare and Medicaid compliance, managed care, employment issues, professional practice formation, healthcare affiliations, joint ventures, and contractual arrangements. She is licensed to practice in Pennsylvania and New Jersey.
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Sushanth Bhaskarabhatla is a senior at Passaic Valley High School in Little Falls, NJ.

This spring I presented Tar Wars to over 200 at-risk fourth- and fifth-graders in Passaic, NJ. Of course, dealing with them all was a bit daunting, but I quickly got a hold of it, and we began to mutually enjoy the process. Tar Wars hands-on philosophy allowed me to maximize my interaction with the students and thus maximize the impact of my message. By the end of the presentation, the students were a little disappointed that their fun had ended, but most importantly, they were left with a strong, lasting message about the dangers of tobacco use.

I am glad that I have done my part to spread the anti-tobacco message, and I look forward to presenting Tar Wars again in the future. I urge you, too, to present Tar Wars to young students in your area. Though Tar Wars requires a little preparation beforehand, it is effective and very rewarding. With an investment of just a few hours, you can help to spread a crucial message to young minds. Remember, if you can deter just one child from using tobacco through your presentation, it would all be worth it.

Get Involved in Tar Wars!

Tar Wars is a strong program, but we need your involvement to keep it that way. There is still time to get involved and bring this program to a fourth- or fifth-grade class at a school near you. Getting involved is easy. Visit www.tarwars.org and click on “Volunteer to be a Presenter” (http://www.tarwars.org/x2105.xml). Fill in the form and email it to us. Send it to candida@njafp.org or call us at 609-394-1711 and we’ll get you started. Tell us the school you are interested in, and we will make the initial contact for you. Or if you prefer, you may make your own arrangements.

The Tar Wars curriculum can be downloaded from the Tar Wars web site (http://www.tarwars.org/x1886.xml) and is full of helpful hints to make presenting easy. If you enjoy connecting with young students, sharing thoughts and having open discussion, this program is for you. Tar Wars is an ideal opportunity for residency students to fulfill their community service requirements. Join thousands of family physicians who have influenced a child to make a healthy decision in his or her life. Tar Wars makes heroes every day.
Congratulations to the 2007-2008 Tar Wars Poster Contest Winners

First Place
Alexa McCarthy
Grade 5
Round Valley School
Lebanon, NJ

Alexa’s poster was the New Jersey entry in the Tar Wars 2008 National Poster Contest, held July 21 and 22, 2008, in Washington, DC.

Second Place Paige McCann
Grade 4 - Franklin Elementary School, Westfield, NJ

Third Place Alaa Assaf
Grade 4 - Jefferson School #1, Passaic, NJ

Ask and Act is a smoking cessation program designed to encourage family physicians to ASK their patients about tobacco use, then ACT to help them quit.

More information is available at:
Another Successful Medfest

*The NJAFP and SONJ extend their sincere thanks to all who participated on April 18, 2008.*
Thank You 2007 Foundation Donors

The editors would like to extend deepest apologies for leaving two donor names off of the Thank You list published in the last issue of Perspectives: A View of Family Medicine in New Jersey.

The New Jersey Academy of Family Physicians Foundation would like to gratefully recognize the following donors for their contributions to the Foundation in 2007:

Silver Sponsor
George Leipsner, MD

Donor
Jeffery Zlotnick, MD

Foundation Recognition Levels for 2008

The mission of the NJAFP Foundation is to serve as a source of substantial and unique support for the advancement of family medicine in the areas of research, education, student interest, and academic achievement. The NJAFP Foundation achieves its mission through the promotion of excellence in the standards and practice of family medicine to benefit the citizens of New Jersey.

Specifically the NJAFP Foundation works to:

• Increase interest in family medicine among medical students and college students through its scholarship and grant programs;
• Assist men and women in entering the practice of family medicine through preceptor programs and resident repayment programs;
• Enhance the specialty through encouragement and support of research by medical students and family physicians; and
• Assist the New Jersey Academy of Family Physicians in its efforts to provide quality education to its members.

To fulfill its mission, the NJAFP Foundation needs your support. To make a donation, mail the form included in this edition to the Foundation office at 224 West State Street, Trenton, NJ 08608. You may also go to www.njafp.org and click on the “Make a Donation” link.

The donation levels for 2008 are:

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Century Club/Gold – $500 to $999
Century Club/Platinum – $1,000 and up

I would like to support the NJAFP Foundation. Enclosed is my donation for:

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☐ Check enclosed or please charge my credit card: $ __________ Visa ____ MasterCard ____ American Express ____

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Signature: ___________________________________________________________________________________

Joseph P. Wiedemer, MD, is on staff at Phillips-Barber Family Health Center, Lambertville, New Jersey, and is a faculty member in the Hunterdon Medical Center Family Medicine Residency Program. In addition to developing a large patient following at Phillips-Barber, he also serves on the Asthma Task Force at Hunterdon Medical Center. He has been an Academy member since 1995 and lives in Ringoes, New Jersey.

When I want to be motivated and inspired, I read about Dr. Martin Luther King.

He graduated from high school at age 15 and college at age 19. He earned his PhD from Boston University at age 26 and later that year he lead a bus boycott, was arrested, had his home bombed, and was personally abused. Between 1957 and 1968 he traveled over 6 million miles and spoke over 2,500 times, wrote 5 books, and lead the massive protest in Birmingham, Alabama, where he wrote his "Letter from a Birmingham Jail." At age 35 he became the youngest man to have received the Nobel Peace Prize. And, as you know, he was murdered in Memphis, Tennessee at age 39. I am now 39 years old and feel as though I have achieved nothing in comparison to Dr. King.

There are times when I am an "overachiever" in the sense that I take on too many of my patients' responsibilities when they are "under-achieving," if you will. A patient of mine reminded me of this recently. He misses about every other visit, and when he does come, he is inevitably late. When he missed his last visit, I had a moment to remember a conversation I had with a second-year resident and our behavioral scientist about five years ago. The resident had a patient with diabetes, hyperlipidemia, hypertension, chronic obstructive pulmonary disease (COPD), coronary artery disease (CAD) with percutaneous transluminal coronary angioplasty (PTCA) and stenting, and a marriage to a woman with alcoholism and depression. He missed two out of three visits and usually arrived 20 to 30 minutes late for the appointments he did keep. He would say to the resident, "Doc, you gotta keep me healthy. I have a business to run, and I can't run it if I'm not healthy." In between visits, he would stop one or several of his medicines and add a supplement or two.

My resident became very frustrated after his patient missed an appointment and sat down with the behaviorist and me. The resident said, "I get really upset. I don't know how to fix his problems, and I try to keep his meds straight, and he has so many problems, and I don't know how to sort them out for him and help him."

The behaviorist picked up a Physician’s Desk Reference (PDR) and handed it to the resident and said, "What are you going to do with it?" The resident looked a little uncomfortable and said "I . . . I . . . " "What are you going to do with it?" the behaviorist asked again. The resident responded, "This is really heavy," and she reached to give the PDR to me. The behaviorist asked, "What are you going to do with it? Are you going to hand it to Dr. Wiedemer?" The resident looked blankly at the behaviorist and said slowly, "I'm . . . I'm going to hand it back," as a look of clarity migrated across her face.

The behaviorist said, "Exactly. He is handing you all of his medical problems just as I handed you the PDR, and he says, 'fix this.' You are going to hand it back. You can tell him, 'When you missed your last appointment, it gave me time to think. I'm working much harder at your health care than you are. That does not work for me, and it does not work your health.'"

Some patients have no contingencies regarding their health or life, and sometimes we have to help them learn their responsibility in the healthcare equation. I believe most, if not all, of us practice medicine because we want to help take care of people and help them to take care of themselves. The frustration comes when the patient does not uphold their end of the bargain.

Fortunately, most of my patients do take care of themselves and are responsible. One example is a 55-year-old woman I saw about six months ago for a complete physical. We have preprinted questionnaires that patients complete before the appointment. She checked "Yes" to the question, "Have you ever been physically or sexually abused?" I asked her if she could tell me more about this. She told a horrific story of how she was beaten by her mother and repeatedly sexually assaulted by her father more than 40 years ago. I was the first person she had ever told. We talked for almost an hour, and I gave her the names of a few good therapists and helped her get an appointment. She returned after having worked very hard with her therapist, and she said, "I feel a little better, and I realize I am not alone. Other people went through worse." Most importantly, I could see the tension melted from her face and her voice lost its tremor. She spoke more confidently even after six months of therapy, and she will continue with her therapist for the foreseeable future.

She is a patient who is working very hard on her health care and is invested in herself. As for my patient who missed his appointment, I think we will talk about his life, his goals, what role he sees me playing in his health care, and what role he has in his health care. Hopefully, he will become more invested in his health.

I will continue to work as hard as I can for my patients, but I feel strongly that patients have to work, too. They first have to find a medical home, then learn about their preventive and chronic health care, and ultimately work as hard as they can to stay healthy.

We also need to enlist our patients’ help in improving our healthcare system. You must advocate for your patients to be active partners in healthcare reform. Help your patients understand the problems we face, what the political candidates’ views are about fixing our system, and encourage patients to contact their political representatives or candidates and tell them what their views are.

I believe Dr. King faced more perils than we do, yet he was able to change the world by the time he reached my age. I don’t think I can change the world, but I believe together, we as physicians working with our patients can.

As always, I look forward to your comments. You can reach me at editor@njafp.org.
Name: ___________________________________________________________________________________________________________________

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Educating Physicians to Provide Culturally Competent, Patient-Centered Care

1. Overall, disparities in healthcare quality and access are not getting smaller. T or F
2. No change has been observed in childhood vaccinations for most priority populations. T or F
3. Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care, described statistically significant variations in the rates of medical procedures by race, even when variables were comparable. T or F
4. The US Census Bureau estimates that by the year 2050 over 50% of the United States population will be people of color. T or F
5. If a physician holds a New Jersey license, but does not practice in the state he/she is exempt from the NJBME cultural competency CME requirements. T or F
6. Licensees who received their license prior to March 24, 2005 and whose next renewal date occurs after March 24, 2008, must document 6 cultural competency CME hours by June 30, 2009, in addition to the 100 CME credits required by the NJBME. T or F

Caring for the Family Caregiver

7. Most physicians feel constrained in their capacity to help family caregivers because of the demands of their practices. T or F
8. Sewitch and Yaffe concluded that primary care doctors should call or schedule an appointment with any elderly caregiving spouse whose ill spouse had a recent evaluation at an emergency room. T or F

9. Research has shown the primary care physician does an adequate job diagnosing Alzheimer’s disease early in the disease process. T or F

Preoperative Patient Assessment for Non-Cardiac Surgery

10. The purpose of the preoperative evaluation is to give medical clearance. T or F
11. A basic history and physical are the key events in a preoperative assessment. T or F
12. It is not necessary to include a cardiopulmonary assessment in a physical examination. T or F
13. Coagulation profiles are routinely performed in preoperative assessment, but evidence-based studies are lacking that compel this test. T or F
14. Studies show that the most common change in medical and surgical management results from electrolyte abnormalities. T or F
15. Routine or screening testing is required even in the generally healthy individual. T or F
The simplest advice is often the best advice – that’s why it’s still the best advice for your patients two years and older to eat more fruits, vegetables, whole grains, and low-fat and fat-free milk and milk products to get the nutrients that are often lacking in their diets.

So forget the here-today, gone-tomorrow trends that only seem to complicate and confuse matters – give your patients time-tested advice. Follow the steps outlined in the 2005 Dietary Guidelines for Americans and emphasize increased consumption of the four "Food Groups to Encourage." You’ll help your patients get the key nutrients they need for a lifetime of good health.

Together with suggesting regular physical activity, that’s a prescription for success.

For more information on the USDA 2005 Dietary Guidelines and the health benefits of dairy foods, visit www.nationaldairycouncil.org.