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Cover art by Preeti Lekhra, AAFP, AMA, former attending physician at Wyckoff Heights Medical Center, NY, NY. She comments, “My Mom and Me was made in 2004 during my pregnancy. It depicts the bond between a mother and a daughter. It also shows the care a mother can give to her child, emotional support being a great component of it.”
The volume of material regarding the topic of maternal and child health reflects the importance of children and child welfare in our society. The mix of clinical and policy articles in this issue illustrates the multifaceted nature of physician involvement in delivering quality health care to children and mothers. Perhaps no area of public policy reveals more clearly the philosophical differences between our two major political parties than health care, and no area of health care better frames that debate than maternal and child health.

The Affordable Care Act and state initiatives are replete with policies to protect mothers and children, requiring plans to cover certain benefits and further mandating that those benefits be affordable. It is no coincidence that these benefits are principally primary care services. Clearly, there is a cost for all of the services that are required by the Affordable Care Act and in the various mandates imposed upon insurance plans by the State. These costs will be paid for through a combination of taxes and premiums. The effect of these policies, therefore, is to establish a certain level of attention to the health care needs of women and children and to assess the cost thereof upon the general public.

Democrats seem to be comfortable with the idea that the health of women and children is a valid public concern and that the power of government is properly applied objectively make such decisions, especially people who cannot afford comprehensive health insurance.

The fact that political consensus is somehow formed around a public role in assuring that women and children have access to necessary health care as evidenced by enactment of the Affordable Care Act and state policy implies that we are somehow able to resolve enough of these philosophical differences to assure that women and children are not completely on their own in acquiring the health care they need.

I hope you enjoy this issue of Family Doctor.

Vito Grasso, MPA, CAE, is the Executive Vice President of the New York State Academy of Family Physicians.
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Your NYSAFP has had a cordial collaborative relationship with our New York State Department of Health (NYSDOH) over many years and through several challenges: the rollout of the NYS Immunization Information System (NYSIIS), the distribution of H1N1 flu vaccine in 2009, the development of regulations about the HIV law, discussions about the possibility of public purchase of vaccines. We were pleased but not surprised, therefore, to be invited to participate in a working group to develop vaccine policy for our state.

The NYS DOH organized a State Health Improvement Plan committee, and we were invited to send representatives to the Vaccine Preventable Diseases subgroup chaired by Debra Blog, MD, MPH, director of the Division of Epidemiology. Participants included members of DOH, academia, and organized medicine specialties – AAP, ACOG and NYSAFP. John Epling, MD, chair of family medicine at SUNY Upstate and member of our Public Health Commission, represented academic family medicine. John holds an AAFP fellowship to study vaccine science at the CDC.

I represented vaccine policy of NYSAFP. Our Congress of Delegates (COD) has endorsed single payer health care, universal purchase of flu vaccine, universal purchase of all vaccines. Our COD opposed pharmacist administration of flu vaccine. Our COD was evenly divided, and thus failed to pass a resolution advocating mandatory HPV vaccine for school attendance. All other policy discussions required me to conjure what a practicing family physician might find reasonable.

The committee distilled five goals in its draft documents (a final version is pending):
- improve childhood and adolescent immunization rates, ensure low exemption rates under school attendance law, decrease the disease burdens of pertussis, flu and HPV.

For each of these five goals discussion included whether expanding who gives vaccines would improve immunization rates. What follows are the positions I defended on behalf of NYSAFP:

Influenza immunization is unique in that it occurs annually, and there is little value in having a prior immunization record for adults. Most adults recall whether they had a flu shot this year, so the absence of a durable portable shot record is not an impediment to safe administration of flu vaccine outside the medical home. This is not true for pneumococcal polysaccharide vaccine, where adults are often unaware whether they had the vaccine, and doses given at venues outside the office often do not reach the medical home record, resulting in some patients getting three or more doses. Doses beyond a second are not recommended by CDC and may actually reduce immunity by desensitizing. The suggestion of Tdap given at a pharmacy troubled me. We have witnessed the effect of flu vaccine at the pharmacy causing a diversion of vaccine supply from the office. More insidiously, I cannot order flu vaccine for my office predictably, because the historic quantity needed in my practice is altered by my patients getting their shots elsewhere, (in our town the pharmacies had vaccine a few weeks before the doctors) causing me to waste both money and vaccine at the end of the season. The result then is less availability of flu vaccine in doctors’ offices as I order a smaller supply for next season. Tdap at the pharmacy would squander a limited resource (Pentacel and Daptacel are limited – can Adacel be far behind?), and make my order of such vaccine more precarious. Further, in the absence of a durable adult vaccine record, such access to vaccine outside the medical home would result in some repeat doses at short intervals – not known to be safe.

The other novel venue proposed was Tdap for parents in the office of pediatricians. There is no licensure issue preventing this, but the impediment, I learned, is MLMIC has opined they would not cover this exposure. We have no applicable NYSAFP policy, so I responded with personal opinion. We cannot oppose the administration of vaccine to protect the pediatrician’s newborn patient. So let us agree that I can immunize the pediatrician’s patient who accompanies a parent to my office, and the internist can immunize the teen in his office, and the obstetrician can immunize the husband.

Then we specialty societies can with MSSNY jointly lobby MLMIC for a vaccination policy that best serves the community.
None of this cross specialty immunization is safe or reasonable, however, until and unless we have an adult vaccine registry that is mandated and thus does not require permission of the adult patient. I observed that the burden for the mandated pediatric vaccine registry was not the daily upload of current doses, but the unfunded mandate of loading historic data. If an adult registry becomes law, I urged that loading historic data should not be mandated. Such adult data is often speculative. It is a waste however to squander the data available in our pediatric registry as kids currently in NYSIIS become adults. Meanwhile, Dr. Blog has assured me that NYSIIS has capacity to receive voluntary permitted adult vaccine data, with enthusiasm.

Standing orders were offered as a means to increase vaccination rates. LPNs cannot respond to non-patient-specific standing orders unless an RN has evaluated the patient. Those of you employing LPNs for vaccine administration must provide patient specific orders.¹

We should provide exemplary vaccination service for the good of our patients and for the reputation of our specialty. Give all indicated doses when the patient presents, and use only evidence based contraindications to skip or delay a dose. A great summary of vaccine allergy issues can be found in a recent article in the Journal of Allergy and Clinical Immunology².

You can join the vaccine policy conversation by becoming a delegate to the Congress of Delegates in Troy May 31-June 2, 2013. For questions about the delegate process, contact fp@nysafp.org. And I welcome your comments at vaccine@nysafp.org.

References
1 http://www.op.nysed.gov/prof/nurse/immunguide.htm

Philip Kaplan, MD, is the President of the New York State Academy of Family Physicians for 2012 – 2013.
The Patient Protection and Affordable Care Act (ACA) – passed by Congress and signed into law by President Obama on March 23, 2010 – helps make prevention and care for women and children more affordable and accessible. Effective August 1, 2012, health insurance plans are required to cover many recommended preventive services without charging a deductible, copayment or co-insurance (note, some plans are grandfathered in or were permitted to make benefits effective upon group renewal after August 1st). Below we have provided a summary of these covered services for women and children followed by an update on the implementation of the Health Insurance Exchange in New York State.

**Care for Women**

ACA requires the following to be covered for women without cost sharing:

- Annual well-woman visits, including pre-conception and pre-natal care (as detailed below)
- Counseling on sexually transmitted infections and testing for HPV
- FDA-approved contraceptive methods
- Annual screening and counseling for domestic violence

Under ACA, new health plans must also offer coverage without cost sharing for services that will prevent and control diseases, like:

- Screening for obesity, and counseling to promote sustained weight loss
- Blood pressure screening
- Counseling on the use of daily aspirin to reduce the risk of a stroke
- Tests to screen for high cholesterol and diabetes

Preventing breast cancer: Annual mammograms for women over 40. Other services to prevent breast cancer will also be covered, including a referral to genetic counseling and a discussion of chemoprevention for certain women at increased risk

- Preventing cervical cancer: Regular Pap smears to screen for cervical cancer and coverage for the HPV vaccine
- Preventing colon cancer: Screening tests for colon cancer for adults over 50
- Tobacco cessation interventions – like counseling or medication to help patients quit

**Care for Children**

ACA also ensures that a comprehensive set of preventive services are available in new health plans for children without cost sharing. This includes:

- Well-baby and well-child visits up to age 21 for:
  - Physical exam and measurements
  - Vision and hearing screening
  - Oral health risk assessments
  - Developmental assessments
  - Hemoglobin, lead, tuberculin and other screening tests
- Counseling and guidance on a child’s development
- Screenings and counseling to prevent, detect and treat common childhood problems like:
  - Obesity
  - Depression
  - Dental cavities and anemia
- Immunizations

**Pre-Natal Care**

ACA provides pregnant women with access to services without cost sharing to ensure a healthy pregnancy, such as:

- Screening for iron deficiency, hepatitis B, Rh incompatibility, bacteriuria and gestational diabetes
- Special, pregnancy-tailored counseling to help women quit smoking and avoid alcohol
- Counseling to support breast-feeding including rental of breast-feeding equipment
Additional information on covered preventive services can be found at: www.HealthCare.gov/center/regulations/prevention.html.

New York State Health Benefit Exchange
On April 12, 2012, Governor Cuomo created by Executive Order New York's Health Benefit Exchange. Since that time, the State has been working to establish the Exchange including appointing an Exchange Board, establishing Regional Advisory Committees, hiring staff, creating the online platform, identifying the State’s benchmark plan for essential health benefits and a number of other activities and functions (customer service, patient navigation, dispute resolution, etc.) to show that it has made significant progress in the establishment of its Exchange by January 1, 2013, as required by ACA. The State Exchange must be fully operational to enable those eligible to begin purchasing health insurance on January 1, 2014.

ACA includes ten required categories of services to be offered by all health insurance plans in the Exchanges. These categories are:

- Ambulatory Patient Services
- Emergency Room Services
- Hospitalizations
- Maternity and Newborn Care
- Laboratory Services
- Prescription Drugs
- Mental Health and Substance Abuse
- Rehabilitation and Habilitation Services and Devices
- Preventative and Wellness Services and Chronic Disease Management; and
- Pediatric Services including Oral and Vision Care.

Essential Health Benefits (EHBs); Benchmark Plan
On October 1, 2012, New York State formally submitted its selection of an Essential Health Benefits benchmark plan to the US Department of Health and Human Services (HHS). This plan defines the essential health benefits for the individual and small group health insurance markets under the State Health Benefit Exchange beginning in 2014. New York selected the State’s largest small group plan, Oxford EPO, as the benchmark plan.

Oxford EPO was selected from among 10 possible plans authorized under federal law: the three largest federal employee plans; the three largest state employee plans; the three largest commercial small group products; and the largest commercial group HMO offered in each state.

The State contracted with Milliman to provide a report (Essential Health Benefits for the New York Health Benefits Exchange) that outlines the covered benefits under Oxford EPO. The report can be accessed through the State’s Health Insurance Exchange website, http://www.healthcarereform.ny.gov/health_insurance_exchange/

We will continue to closely monitor the implementation of ACA and New York’s Health Benefit Exchange, which could change dramatically depending on the outcome of the November 6th elections. We will keep the Academy apprised as additional information is provided and as new developments arise.

Marcy Savage is the Government Relations Counsel for the NYSAFP from Weingarten, Reid & McNally, LLC in Albany, NY.
Two Views: Should FP Residencies Include Obstetrical Training?

Q. Should Family Medicine Residencies Continue to Include Obstetrical Training?

A. Yes, but ………

By William J. Bennett, MD

Specialization in medicine is based, at least in part, upon the assumption that more knowledgeable and clinically excellent physicians will render better patient care, and that being both knowledgeable and clinically excellent in all areas, as the body of medical knowledge increased exponentially over the past century, is likely not possible. Most specialties are defined by their members’ depth of knowledge and targeted clinical skills while family medicine is defined by its members’ breadth of knowledge, clinical skills and the ability to apply them successfully to the family unit while taking into consideration the dynamic interpersonal influences lying therein.

Like the practice of medicine, the scope of specialties has changed according to patient’s needs and preferences and scientific and technological advances. We need to look no further than to the scope of general surgery has been modified by advances in diagnostic radiology and endoscopy. What years ago would have been an exploratory laparotomy or bowel resection now has become a CT scan or colonoscopy. Aneurysms can now be treated by radiologic modalities. Physicians and their specialty organizations need to adapt to patient needs, financial realities, modern technology, and the changing quality-of-life demands of new generations of their colleagues, or become obsolete.

What are the facts about family physicians delivering babies? History has shown that well trained family physicians perform deliveries well and are chosen by many patients. Statistics tell us that in most rural areas of the United States family physicians are indispensable in obstetrical care, while in major metropolitan areas most patients choose obstetrical specialists. Of course in rural areas many patients have no choice in their decision because there are no obstetricians and in metropolitan areas most patients have no choice because few family physicians there practice obstetrics. Data collected by the AAFP in 2012 show that only 19.2% of family physicians deliver babies and 71.6% prefer not to. The remainder does not for a variety of reasons.

Why Family Physicians Should Receive Full Training in Obstetrics

By Manal Soliman, MD

Throughout my interactions with patients, friends, and colleagues, I am often posed the question as to why I wanted to do obstetrics. The simple answer is, I love the work and I’ve always had a passion for labor and delivery. While the decision to pursue this field was not made haphazardly, it was enhanced throughout my residency. I initially set out thinking family medicine would be my niche, as I enjoyed the vast spectrum that existed between newborns and geriatrics. It was only after I completed my residency that my passion for deliveries became so overwhelming. To satisfy my passion, I made a decision to stay on as a faculty member and teach obstetrics. The opportunity to teach in a metropolitan area, where there is tremendous competition with obstetrics for low risk prenatal care and delivery, was impossible to pass up. Here, I don’t have to do deliveries; I do them because I want to, and patients want me to. Now many years later, I still haven’t lost my passion or desire; in fact it’s even more exciting to know that the group of children I helped bring into this world are about to reach the parenting age. That is what’s great about being a true family doctor: I meet the patients as newborns, see them mature through life, see them get married, and eventually I’ll assist them with their own children. It is one of those continuing circles of life that make my job so rewarding.

When my first year residents start, I always go around the class and ask them one by one, “After graduation, where would you like to practice and what kind of family medicine practice would you like to join or have?” I can see the big question mark on most of their faces. Statistics tell us that in most rural areas of the United States family physicians are indispensable in obstetrical care, while in major metropolitan areas most patients choose obstetrical specialists. Of course in rural areas many patients have no choice in their decision because there are no obstetricians and in metropolitan areas most patients have no choice because few family physicians there practice obstetrics. Data collected by the AAFP in 2012 show that only 19.2% of family physicians deliver babies and 71.6% prefer not to. The remainder does not for a variety of reasons.

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CONTINUED ON PAGE 11
Having been involved in family medicine education for 34 years and a Program Director for 13 years in a suburb of New York City, I am acutely aware of the physical demands of delivering babies (although I personally gave up obstetrics upon graduation from residency) and the financial and logistical demands on a Family Medicine Residency Program that must teach obstetrics to a population of residents who are generally not interested in pursuing obstetrics after graduation. In years past four graduates of our program who remained local as attending physicians successfully practiced obstetrics at our hospital until its delivery rooms closed several years ago. These fine examples of the” historically complete” family physician were nonetheless the distinct minority of the many excellent family physicians trained. Currently on Long Island I am aware of only one family physician who continues an active obstetrical practice and only one hospital that grants privileges. An important consideration for residency programs is also the continued insistence by the ACGME that a family physician act as a role model for obstetrical care even though in many areas very few exist.

In my opinion family medicine is defined more by the caring, inclusive philosophy of its practitioners than by rigid adherence to a specific “basket of services”. If we exclude those in our specialty who do not practice obstetrics from the ranks of “the righteous” and diminish their worth as true family physicians then we have self destructed. If we continue to require the expenditure of major resources solely to adhere to traditional policies then we are denying the reality of both patient and physician preference.

Fortunately there is a middle road that serves both patients’ needs and family physicians’ preferences and allows for maintenance and possible expansion in the role that our specialty plays in obstetrical care. We can adapt to regional needs and the reality of the marketplace by instituting a “two tier” approach. We can avoid exhausting the resources of many programs in a vain attempt to universalize a tradition currently of questionable value. Why not teach obstetrical care to those who are interested, in programs that are capable, in areas where it is needed and welcomed, and expend our resources in a directed, rather than a “shotgun” approach? All programs would be required to provide a basic experience in obstetrics including prenatal, labor and delivery and postpartum care and assure that all graduates are competent in caring for the general medical needs of the pregnant patient. All graduates would be cognizant of the effect pregnancy has on the family unit without requiring that all residencies spend an inordinate amount of time and resources training residents in obstetrics who will not, by their own choice, deliver babies after graduation. Those programs that attract residents who wish to do obstetrics would provide a second tier that expands upon current requirements (that in reality many think are inadequate for independent practice) and produce graduates truly well trained in a much scrutinized skill.

I cannot see a real down side to this solution. The public is served, family physicians can continue, skilled in the practice of obstetrics, or not, and residency programs can expend their energies in training their residents for what they will really do in their particular locale. As much as all of us would at times like to return to earlier eras there is no viable alternative choice to adaptation.

William J. Bennett, MD has been a Program Director in Family Medicine for 13 years, a clinician and educator in Family Medicine since 1978.

Manal Soliman, MD is an Associate Professor of Family Medicine at Stony Brook University, Stony Brook, NY.
The U.S. Supreme Court, in reviewing appeals as to the constitutionality of the Affordable Care Act (ACA), with a 5 to 4 Decision and Chief Justice Roberts breaking with dissenters, has left the ACA intact, for now. The foundational requirement that most citizens buy health insurance or pay a fine was held to be a tax permitted by the Constitution, and not decided under the Commerce Clause. As all provisions hinging upon the mandate remain intact, the focus should now shift to — what will the ACA mean to physicians?

Some key surviving insurance provisions:

- Insurers cannot deny coverage based on pre-existing condition,
- Annual or lifetime coverage limits are barred,
- Dependent coverage is now mandated to age 26,
Preventive services must be provided without cost-sharing.

In addition, the ACA provides that insurers must also now meet medical loss ratio limits, maintain quality reporting requirements, coordinate with health insurance exchanges, meet employee enrollment/coverage requirements, include prescription drug benefit expansion, provide funds for recruitment/training/retaining of healthcare workforce, and empower Accountable Care Organizations and the Medicare Shared Savings Plan.

However, the ACA's Medicaid expansion provision was limited by the Supreme Court. Originally, the ACA would have forced states to expand Medicaid or face the loss of all of their Medicaid federal dollars. The ACA is now limited to acting on the potential loss of funds only for the newly eligible poor.

So, what does the ruling mean for physicians? While expanded insurance coverage should equate to additional patients, the "reimbursement" system remains profoundly broken. The ACA did not fix the reimbursement formula and the "hidden" provisions affecting physicians will continue, unless and until Congress acts to repeal.

Some of the ACA's provisions that the public and the average practicing physician doesn't hear about:

- Failure to comply could result in severe sanctions,
- Increased funding for health care fraud and abuse enforcement,
- Expansion of civil monetary penalties,
- Claims for services from an Anti-Kickback Statute violation now equate to false claims,
- Lower triggers for application of federal False Claims Act,
- Modified "knowing and willful" requirement under Anti-Kickback Statute,
- No need to prove actual knowledge of Anti-Kickback Statute, nor specific intent,
- CMS can suspend provider pending investigation of "credible allegation of fraud",
- Increased scrutiny of Medicare enrollment applications,
- CMS can exclude for knowing false statement or omission on the application,
- Overpayments must be refunded within 60 days or face False Claims Act liability.

The hard reality of the ACA ruling is that the regulatory burden on physicians will continue to accelerate, building an exponential growth curve of unprecedented scrutiny. To survive, physicians must actively and aggressively embrace a new concept – Prospective Compliance. It is no longer advisable, acceptable or survivable to focus exclusively on patient care. Physicians and medical practices must become multidimensional – caring for patients while also remaining compliant with law, regulation and contract.

Post ACA, Prospective Compliance means that physicians and practices must permit (if not dedicate) staff time and focus on issues beginning with proper credentialing, progressing through periodic snapshot audits and risk self-assessments, building toward a compliant medical practice. However, what the ACA foretells is that every physician, every practice must become Prospectively Complaint now, not after an investigation or action commences. Under the ACA, the risks and requirements lie not only with issues of fraud or abuse. The ability of any physician and/or practice to be compensated, compensated on a timely basis and rewarded under a “pay for performance” system will be dictated by the level of compliance held by the physician and the medical practice. While mandatory compliance plans presently exist only in the arena of Medicaid, they are certain to become an integral part of health care "reform”.

In conclusion, to survive the aftermath of the ACA ruling, physicians must view it as an awakening. While an awakening of the giant known also as government oversight, it must also be an awakening to every physician that the need for Prospective Compliance is no longer a political question, a legal dispute or an option.

Kern Augustine Conroy & Schoppmann, P.C.
Attorneys to Health Professionals. For more than 30 years the firm’s practice has been solely devoted to the representation of health care professionals. The authors may be contacted at 800.445.0954 or via email – info@DrLaw.com. For more information log on to DrLaw.com.

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BILLING FOR DISCHARGE SERVICES FROM MATERNAL AND NEWBORN NURSERY CARE

By Ronald J. Pope, DO

For maternity and newborn nursery care, assuming you are billing for the global fee for the delivery and maternity care, discharge billing is part of the global fee. However, the newborn does not fall under this same rule. You would bill the newborn discharge the same as an adult discharge, based upon time.

Discharge day billing encompasses all of the time spent on the calendar day of discharge: with the patient, on the floor reviewing records, preparing discharge instructions and discussing the case with the other consultants. It is actually very simple. If you spend less than thirty minutes on these components of the discharge, you will bill 99238. If you spend greater than thirty minutes you bill 99239. If you do not document how much time you spent, you must bill the lower level (99238).

What if you come in on Wednesday, your day off, see the patient and prepare the discharge for the next day in order to save time the next morning? That time counts toward your total time on Wednesday’s subsequent care visit but not toward Thursday’s discharge time. The same is true of discharge paperwork a week after discharge. Because there is no face to face time with the patient on that day, it is a non-billable service.

The other question frequently asked is “who bills the discharge if the patient is sent home by the cardiologist before I arrive that morning”. The discharge should be billed only on the day of physical discharge from the hospital and only by the provider (or covering provider) who is from the admitting group. A consultant who follows along during the hospital stay bills for the initial consult and then for subsequent care only for the remainder of the stay. On discharge day that consultant may write the discharge order, but should only bill subsequent care codes. In this case no one gets to bill for the discharge, because you didn’t get face to face time with the patient. The exception would be after transferring care to the specialist, when he/she does the discharge.

Why not just bill every discharge as a 99238? I see this question often. The difference is approximately $25 and if you add that up over time it can be substantial. However, the most important reason is that following proper billing and coding guidelines keeps you out of trouble and is a better reflection of your level of work.

Ronald J. Pope, DO, is President of Coding Consultants of NY, LLC.
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Our defense never rests.
Several weeks ago on rounds we had a discussion about labor induction. Shortly thereafter I was asked to review an article entitled “Induction of labor and cerebral palsy: a population-based study in Norway”. At our monthly Ob department meeting we discussed whether physicians inducing labor are responsible for producing many of the CP cases. For term infants that are induced there is an odds ratio for CP of 4.4 to 1. (The odds ratio is the ratio of the odds of an event occurring in one group to the odds of it occurring in another group, in this case the group of induced patients versus non-induced patients.)

The article was used at our meeting as a means to drive home the point that physicians are responsible for CP because we are inducing patients.

The basic problem is one of causation versus correlation. Let’s take two example statements. Example one: “Adequate prenatal care significantly decreases the risk of low birth weight babies.” This statement shows causation between the two variables. If A is true then B necessarily follows. Example two: “Babies born prematurely were more likely to have low birth weights and to suffer from health problems than were babies not born prematurely.” (Premature birth is correlated with low birth weight and health problems.) This statement co-relates two variables, i.e., premature birth and low birth weight; it does not demonstrate cause.

The types of studies needed to demonstrate these two statements are different. For causation we need a prospective randomized study, which if done properly can be very powerful. For correlation all that is needed is a retrospective, observational study. Observational studies may be useful in situations where it may be unethical to perform a prospective study, for instance, in our case if we purposely induced patients at 37 weeks of gestation to observe the number of new CP cases. However, observational studies are by their very nature, laden with unseen biases and are therefore not always very reliable. Both the former and latter types of studies can be evaluated with the help of a contingency table. Notice that in a case control study (retrospective, observational study) the outcomes are known prior to the start of the study. In our case these are babies with known CP versus those who do not have CP. This is because relative risk (RR) is the risk of an event (or of developing a disease) relative to exposure or treatment prospectively. It is expressed as a ratio of the probability of the event occurring in the exposed group versus a non-exposed group. What we have in an observation study is retrospective data; the outcomes are chosen to compare specific events, for example known lung cancers patients who are smokers versus non-smokers.

The study in the article is a retrospective, case control study, therefore it cannot find causation, only associations. Furthermore its results will be an odds ratio, not relative risk. There are many associations that can be seen using the data from Table 1 of the study seen on next page. For instance, take the data for maternal disease and place them on the contingency table. Now we can compare the odds of having CP when the mother has a chronic disease to a mother who is healthy (Table B).
Contingency Tables:

For those unfamiliar with the use of contingency tables it is a technique whereby we evaluate outcomes in a group exposed to a risk factor, and to a group not exposed to the risk factor. Then we can calculate the odds and odds ratios. In this case the outcome is CP. Therefore the odds of CP if maternal disease is present are (cell A)/(cell B), Odds of CP if maternal disease is absent are (cell C)/(cell D), odds ratio is A/B divided by C/D.

<table>
<thead>
<tr>
<th>Table A</th>
<th>Outcome present</th>
<th>Outcome absent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exposed</td>
<td>A</td>
<td>B</td>
</tr>
<tr>
<td>Not Exposed</td>
<td>C</td>
<td>D</td>
</tr>
</tbody>
</table>

Table B

<table>
<thead>
<tr>
<th>CP present</th>
<th>CP absent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal disease present</td>
<td>104</td>
</tr>
<tr>
<td>Maternal disease absent</td>
<td>137</td>
</tr>
<tr>
<td>Total</td>
<td>241</td>
</tr>
</tbody>
</table>

Table 1: Occurrence (%) of risk factors for cerebral palsy (CP) in CP births and non-CP births, Norway 1996-1998.

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>CP (n=241) n (%)</th>
<th>Controls (n=176,350) n (%)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal disease</td>
<td>104 (43.2%)</td>
<td>38,837 (22.0%)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Nulliparity</td>
<td>105 (43.9%)</td>
<td>71,271 (40.5%)</td>
<td>0.29</td>
</tr>
<tr>
<td>Assisted fertilization</td>
<td>13 (5.4%)</td>
<td>2,011 (1.1%)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Multiple pregnancy</td>
<td>20 (8.3%)</td>
<td>2,747 (1.6%)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Boys</td>
<td>126 (52.3%)</td>
<td>90,920 (51.6%)</td>
<td>0.85</td>
</tr>
<tr>
<td>Congenital malformations</td>
<td>8 (3.3%)</td>
<td>5,183 (2.9%)</td>
<td>0.70</td>
</tr>
<tr>
<td>Pre-eclampsia</td>
<td>12 (5.0%)</td>
<td>5,640 (3.2%)</td>
<td>0.14</td>
</tr>
<tr>
<td>Pre-term birth</td>
<td>105 (48.8%)</td>
<td>11,349 (7.1%)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>SGA*</td>
<td>34 (14.1%)</td>
<td>12,075 (6.8%)</td>
<td>0.07</td>
</tr>
<tr>
<td>LGA</td>
<td>9 (4.7%)</td>
<td>6,282 (4.1%)</td>
<td>0.59</td>
</tr>
<tr>
<td>Breech</td>
<td>27 (11.2%)</td>
<td>6,249 (3.5%)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>PROM/PPROM</td>
<td>24 (10.0%)</td>
<td>2,860 (1.6%)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Labor induction</td>
<td>58 (24.1%)</td>
<td>23,543 (13.4%)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Placental abruption</td>
<td>21 (8.7%)</td>
<td>933 (0.5%)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Low Apgar score**</td>
<td>23 (12.8%)</td>
<td>818 (0.5%)</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

Note: *SGA: Small for gestational age, recorded only for pregnancies > 28 weeks.
**Low Apgar is defined as Apgar score of 3 or less at 5 minutes after birth compared with Apgar score of 7 or higher.
PROM, Prelabour rupture of membranes ≥ 24 hours before delivery.
PPROM, Preterm prelabour rupture of membranes ≥ 24 hours before delivery.

Odds of having a child with CP if maternal disease (CPWMD) is present are 104/38837. Odds of having a child with CP if there is no maternal disease (CPWNMD) are 137/137513. Odds ratio or Odds CPWMD/CPWNMD is 2.68. In other words CP was seen more often in mothers with chronic diseases. Does this really surprise anybody?
In Table C below CP was seen more often in children with low APGAR scores (odds ratio 22.6), PROM (odds ratio 6.7) and prematurity (odds ratio 11.22). What this demonstrates is that there are many events that are associated with CP, all intertwined, but none of them causal. Many questions therefore remain, such as: why were the patients in the study induced? Were they induced secondary to a maternal chronic disease, a poor biophysical profile or a hundred other things that caused the CP, and was the induction to improve an already bad situation?

<table>
<thead>
<tr>
<th>Table C</th>
<th>Odds CP present</th>
<th>Odds CP absent</th>
<th>Odds ratio</th>
<th>Odds ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low APGAR</td>
<td>23/818</td>
<td>218/175532</td>
<td>0.028/0.00124</td>
<td>22.6</td>
</tr>
<tr>
<td>Maternal disease</td>
<td>104/38837</td>
<td>137/137513</td>
<td>0.00267/0.00099</td>
<td>2.68</td>
</tr>
<tr>
<td>Preterm</td>
<td>105/11349</td>
<td>136/165001</td>
<td>0.0093/0.00082</td>
<td>11.22</td>
</tr>
<tr>
<td>PROM/PPROM</td>
<td>24/2869</td>
<td>217/173490</td>
<td>0.0084/0.00125</td>
<td>6.7</td>
</tr>
</tbody>
</table>

It is worthwhile to note that the ratio is a tool used to amplify small changes or infrequent events. For instance, the odds of having a child with CP if maternal disease is present are 0.00267/1, fairly small. But when compared to the odds of having a child with CP if there is no maternal disease present, odds of 0.00099/1, there is an odds ratio of approximately 2.68, implying greater than twice as many bad outcomes. In other words although the odds ratio looks large the individual odds of an event are still very small.

Last, we need to ask the opposite question. What would the outcomes be if we didn’t induce the pregnancy? How many children’s lives have we impacted in a positive way because we did offer induction?

References
The Pharmacy Compounding Accreditation Board – PCAB – was formed to provide quality standards for compounding pharmacies through a voluntary accreditation program. The PCAB Seal of Accreditation demonstrates that our pharmacy adheres to the highest standards in pharmacy compounding.

**SPECIALIZED**

Benefit from the expertise of our compounding pharmacists, as we help you create medication solutions to meet your patient’s needs. Allergies to excipients, palpitability concerns and backordered medications are a few of the issues we can help resolve.

**DEDICATED**

Our pharmacists have over 100 years combined compounding experience and recognize the need for specialized compounding. Our goal is to provide quality, timely pharmaceutical preparations for you at a reasonable price.
Family physicians are uniquely positioned to help breastfeeding mothers choose a safe birth control method. When we see infants for their well child checks or illness, we can take the opportunity to ask mom if she needs contraception.

Most breastfeeding women want to prevent pregnancy. Fortunately, there are several safe and effective contraceptive methods available for nursing mothers, including breastfeeding itself!

Breastfeeding as Birth Control:
Breastfeeding greatly benefits both mothers and children. Exclusive breastfeeding serves as a natural contraceptive. Known as the Lactational Amenorrhea Method (LAM), breastfeeding as birth control is free, safe, and effective up to 6 months after delivery. Used correctly, LAM is 95-98% effective at preventing pregnancy. For the method to work, the woman must exclusively breastfeed (meaning no food, no formula!). She must nurse at least every 4 hours during the day and every 6 hours at night. If her period returns or the interval between feedings lengthens before the baby is 6 months old, the mother must begin to use another contraceptive method.

Although breastfeeding can be a great natural contraceptive method, LAM does not suit everyone. The requirements for breastfeeding frequency are especially challenging for working mothers. Most nursing women need to choose another method before they stop breastfeeding. Like breastfeeding itself, effective contraception helps to lengthen the interval between births, thus improving the health of mothers and of babies.

Helpful Resources:
- Medical Eligibility for Initiating Contraception
- Birth Control Choices Chart

References


This article was adapted from the CME program “Contraceptive Pearls” which can be subscribed to by writing to pearls@reproductiveaccess.org.

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Ruth Lesnewski, MD, is an attending physician at Beth Israel Residency Program in Urban Family Practice, medical director of East 13th Street Family Practice in Manhattan, and education coordinator of the Reproductive Health Access Project. In June, 2010, she became the clinical director of MyChart MyHealth, the patient portal for the Institute for Family Health.
Routine newborn screening is a fait accompli for most infants, hospitals and primary care practitioners. Newborn screening has been characterized as one of the most successful public health programs ever. Indeed, almost all infants born in the U.S.A. are routinely screened while still in the birthing facility. The general model of consent is that of parental “opt out” – that is the tests are done unless the parents specifically choose not to have their child screened. Biochemical screening is performed in or for the State Public Health Departments/Laboratories in most instances. The retention and utilization of residual dried blood specimens for laboratory quality assurance/improvement and for possible use in (clinical) research are governed by regulations of the individual states. Recently, tests performed in the birthing facility (Point of Care – POCT testing) have been added to the Recommended Newborn Screening Panel; currently these include hearing screening and pulse oximetry to screen for critical congenital heart disease.

History

New York State has played a key role in the development of newborn screening. In the 1930s George Jervis at Letchworth Village State School in Thiells, New York, identified 50 clients whose mental retardation was attributed to PKU. He pursued the study among programs in terms of conditions for which screening was performed and the method-

New York, Buffalo, devised a simple, inexpensive test which allowed screening for PKU to be done shortly after birth. In the early 1960s he coordinated a 29 state pilot study of 400,000 newborns which proved so successful in identifying infants affected with PKU that many states instituted screening programs immediately. New York State’s law for newborn screening, Public Health Law 2500a, went into effect in 1965 and mandated that every newborn be screened for PKU.

As technology advanced and treatments for rare genetic diseases were developed, additional conditions were added to the state panels. These included congenital hypothyroidism, sickle cell disease, galactosemia, maple syrup urine disease, as well as a few others. Development of programs over the next four decades progressed along state lines, with marked disparities among programs in terms of conditions for which screening was performed and the method-
CME ARTICLE, continued

SACHDNC Recommended Uniform Screening Panel
SECONDARY CONDITIONS (as of December 2011)

<table>
<thead>
<tr>
<th>ACMG Code</th>
<th>Secondary Condition</th>
<th>Metabolic Disorder</th>
<th>Hemoglobin Disorder</th>
<th>Other Disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Organic acid condition</td>
<td>Fatty acid oxidation disorders</td>
<td>Amino acid disorders</td>
</tr>
<tr>
<td>Chi C,D</td>
<td>Methylmalonic acidemia with homocystinuria</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MAL</td>
<td>Malonic acidemia</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IBG</td>
<td>Isobutyrylglycinuria</td>
<td>X</td>
<td></td>
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<tr>
<td>2MBG</td>
<td>2-Methylbutyric aciduria</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3MGA</td>
<td>3-Methylglutaconic aciduria</td>
<td>X</td>
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<tr>
<td>2M3HBA</td>
<td>2-Methyl-3-hydroxybutyric aciduria</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SCAD</td>
<td>Short-chain acyl-CoA dehydrogenase deficiency</td>
<td>X</td>
<td></td>
<td></td>
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<tr>
<td>M/SCHAD</td>
<td>Medium-chain L-3-hydroxyacyl-CoA dehydrogenase deficiency</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GA2</td>
<td>Glutaric acidemia type II</td>
<td>X</td>
<td></td>
<td></td>
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<tr>
<td>MCAH</td>
<td>Medium-chain ketocarboxyl-CoA thiolase deficiency</td>
<td>X</td>
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<td></td>
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<tr>
<td>DE RED</td>
<td>2,4 Diene-lysyl-CoA reductase deficiency</td>
<td>X</td>
<td></td>
<td></td>
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<tr>
<td>CPT IA</td>
<td>Carnitine palmitoyltransferase type I deficiency</td>
<td>X</td>
<td></td>
<td></td>
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<tr>
<td>CPT II</td>
<td>Carnitine palmitoyltransferase type II deficiency</td>
<td>X</td>
<td></td>
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<tr>
<td>CACT</td>
<td>Carnitine acylcarnitine translocase deficiency</td>
<td>X</td>
<td></td>
<td></td>
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<tr>
<td>ARG</td>
<td>Arginemia</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CIT II</td>
<td>Citrullinemia, type II</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MET</td>
<td>Hypermethioninemia</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>H-PHE</td>
<td>Benign hyperphenylalaninemia</td>
<td>X</td>
<td></td>
<td></td>
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<tr>
<td>BIDOPT (BS)</td>
<td>Biotinoperoxide</td>
<td>X</td>
<td></td>
<td></td>
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<tr>
<td>BIDOPT (REG)</td>
<td>Biotinoperoxide</td>
<td>X</td>
<td></td>
<td></td>
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<td>TYR II</td>
<td>Tyrosinemia, type II</td>
<td>X</td>
<td></td>
<td></td>
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<tr>
<td>TYR III</td>
<td>Tyrosinemia, type III</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Var Hb</td>
<td>Various other hemoglobinopathies</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GALE</td>
<td>Galactose intolerance</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GALK</td>
<td>Galactokinase deficiency</td>
<td>X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. Selection of conditions based upon “Newborn Screening: Towards a Uniform Screening Panel and System.” Genetic Med. 2006; 8(5) Suppl: S12-S232” as authored by the American College of Medical Genetics (ACMG) and commissioned by the Health Resources and Services Administration (HRSA).
2. Disorders that can be detected in the differential diagnosis of a core disorder.

Screening versus Confirmatory Testing

Although newborn screening provides an early opportunity to detect disorders before symptoms appear, these tests are not diagnostic. Every abnormal screen requires further confirmatory testing to confirm or exclude the presence of the condition(s) indicated as likely present on the basis of the abnormal test.

In New York, abnormal findings (indicative of a possible disorder) are phoned to the designated physician at the hospital-of-birth, the physician of record and to a NYS-certified specialty care center. The results are also faxed to the specialty care center. The family physician or general pediatrician and the specialist need to work together to notify the parent of the possibility of a disorder and to get the confirmatory testing done as soon as possible.

Following the report “Newborn Screening: Toward a Uniform Panel and System” in 2006, the American College of Medical Genetics (ACMG) developed ACTion Sheets (ACT sheets) as decision support tools for primary care practitioners. A concise outline of immediate management actions to be considered was paired with an algorithm of confirmatory laboratory studies for each disorder in the newborn screening (NBS) panel. The ACT Sheets, for NBS disorders and with recent additions addressing topics such as carrier screening and transition from pediatric/adolescent to adult medical care, are available at no charge and without registration on the ACMG website (www.acmg.net) by clicking on the ACT Sheet Button.

Regardless of screening results, physicians are continuously reminded that they should immediately evaluate any infant who exhibits findings consistent with the targeted disorders. The screens are not 100% sensitive.

The Process in New York

Newborn Screening is a public health mandate in New York State’s law for newborn screening. Public Health Law 2500a, which went into effect in 1965 and mandated that every newborn be screened
for PKU. The law, as well as appropriate regulations, has been amended repeatedly to add more conditions. As of now there are 45 conditions in the NYS NBS Panel. The birthing facility is responsible for collecting a satisfactory specimen for each baby born at their facility. The American Academy of Pediatrics recommends that the specimen be collected after the newborn is at least 24 hours old. Optimally the specimen should be collected after 48 hours of life.

The responsible physician’s duties are delineated in the Compilation of the Rules and Regulations of the State of New York (NYCRR) 69-1.5. The key elements are:

1. Fully inform the parent of the purpose and need for newborn screening, and interpret all test results;
2. Promptly collect and submit repeat specimens requested by the testing laboratory. All repeat specimens shall be clearly marked REPEAT;
3. Include in the infant’s health record the test results received from the chief executive officer or from the testing laboratory;
4. In the case of confirmed abnormal test results, arrange for diagnostic evaluation and case management with an approved specialized care center;
5. Provide case information, specimens and other information for tracking and follow-up reviews requested by the testing laboratory.

Results (New York)

1. As noted above, abnormal findings (indicative of a possible disorder) are phoned to the designated physician at the hospital-of-birth, the physician of record and to a NYS-certified specialty care center. The results are also faxed to the specialty care center.
2. Borderline results – not highly abnormal but also not within acceptable limits – are phoned to the hospital of birth and the pediatrician of record. Both are asked to obtain and submit a second dried bloodspot as soon as possible.
3. Screening tests that identify carriers of a screened disorder (i.e., hemoglobinopathy trait) are mailed to the hospital of birth and the physician of record
4. If all the results are within acceptable limits, a report is mailed to the hospital-of-birth, to be placed in the newborn’s medical record. Per the New York State Codes, Rules and Regulations (NYCRR) 69-1.3 (j), the hospital remains responsible for forwarding a copy of screen negative results to the physician of record.

Newborn Screening ACT Sheet

Congenital Hearing Loss

[Congenital Hearing Loss >30dB]

Differential Diagnosis: Extensive. Includes 40% environmental (mostly bacterial/viral) and 60% genetic (30% syndromal and 70% non-syndromal representing over 100 genes).

Condition Description: Defined as hearing loss that is permanent, bilateral or unilateral, sensorineural or conductive, and averaging loss of 30 decibels or more in the frequency range important for speech recognition.

You should take the following actions:

- Notify family to inform them of the newborn screening result.
- Ensure coordinated and comprehensive multidisciplinary hearing loss evaluation and care.
- Initiate timely diagnostic evaluation by a multidisciplinary hearing loss team, including evaluation by a genetic specialist.
- Report findings to state Early Hearing Detection and Intervention (EHDI) program.

Diagnosis Evaluation: Hearing loss is confirmed and followed up by a comprehensive hearing loss team evaluation and testing for an etiologic diagnosis. Testing algorithms are prioritized around family history and likelihood of a syndromal condition. If familial and/or non-syndromal, GJB2 (Genetic Testing http://www.ncbi.nlm.nih.gov) and GJB3 (Genetic Testing http://www.ncbi.nlm.nih.gov) gene testing is done. Cytomegalovirus (CMV) and mitochondrial etiologies are also possible. Confirmatory work should be completed by age 3 months and early intervention services initiated before 6 months of age.

Clinical Considerations: Hearing loss may indicate a genetic syndrome with involvement of other organ systems. Untreated hearing loss can result in lifelong deficits in speech and language development, so it is critical that all infants who fail newborn screening have follow-up testing.

Additional Information:

- Gene Tests/Gene Clinics
- National Center for Hearing Assessment and Management
- Genetics Home Reference
- Center for Disease Control and Prevention
- State Committees on Infant Hearing
- American Academy of Medical Genetics
- American Academy of Pediatrics
- Referral: local, state, regional and national

How to Get Screening Results

Preliminary screening results for all tests are generally available the day following receipt. Preliminary results can be obtained by calling (518) 473-7552. Confirmation of results depends on the specific verification test, with the longest procedures taking three business days. Complete results can be obtained by calling (518) 473-7552. Providers registered with the screening program can obtain faxed screening results via the Voice Response System, a computerized answering system, by calling (800) 535-3079. Providers can contact the Newborn Screening Program at (518) 473-7552 about requirements and registering for access to the Secure Remote Viewer, a web based system for accessing results, available at the Department of Health’s Health Commerce System.

Resources:

1. ACT sheets and Confirmatory Algorithms: (http://www.acmg.net/AM/Template.cfm?Section=ACT_Sheets_and_Confirmatory_Algorithms&Template=/CM/HTMLDisplay.cfm&ContentID=5661)
2. State Health Department (New York State specific information): www.wadsworth.org/newborn
3. Other:
   a. Baby's First Test www.babysfirsttest.org
   b. Regional Collaboratives – NYMAC www.wadsworth.org/newborn/nymac
CME POST-TEST

Instructions:
Health care professionals seeking AAFP credits will receive 1 credit for the year in which the quiz is taken upon the completion of this quiz online at www.nysafp.org under the Education and Events tab. Health care professionals seeking Category 1 AMA credits are eligible to receive 1 credit in Category 1 of the Physician’s Recognition Award of the AMA. NYSAFP staff will notify those who take the quiz of their scores.

Physicians are responsible for reporting their own CME credits to their respective organizations.

Choose the One Best Answer:

1. When notified of an abnormal Newborn Screening result, the Family Physician should
   A. Inform the parents of the diagnosis and arrange referral for treatment
   B. Ascertain from the Health Department, Specialty Consultant and or ACMG “ACT sheet” the urgency and nature of confirmatory testing.
   C. Send in a repeat blood spot to confirm the diagnosis
   D. Do nothing. The Department of Health will coordinate care

2. In New York, borderline Newborn Screening results are usually addressed by
   A. Proceeding to confirmatory testing, so as not to miss a diagnosis
   B. Follow up only as indicated clinically
   C. Notification of the parents to bring the infant to the Regional Department of Health Lab for repeat screening
   D. A request to the birth hospital and primary care physician of record for a repeat specimen

3. Which of the following is a “Point of Care” screen?
   A. PKU screen
   B. Sickle cell screen
   C. Pulse oximetry screen for critical congenital heart disease
   D. Congenital hypothyroidism screen

Choose all that apply:

4. Types of conditions included in the Recommended Universal Newborn Screening Panel include:
   1. Hemoglobinopathies (Hemoglobin Disorders)
   2. Inborn errors of metabolism
   3. Endocrine conditions
   4. Chromosomal disorders like Down Syndrome and Turner Syndrome

5. ACT sheets
   A. Provide a concise outline of management actions and confirmatory algorithms for infants with abnormal screens
   B. Are available free of charge at www.acmg.net
   C. Only provide information about inborn errors of metabolism
   D. Also provide information on Transitions from adolescent to adult care for patients with heritable and congenital conditions

References


Kemper, AR, Kus, CA, Ostrander, RJ et al., A framework for key considerations regarding point-of-care screening of newborns, Genetics in Medicine (Online August 2012).

Barry H. Thompson, MD, MS, FAAP, FACMG, is the Medical Director of the American College of Medical Genetics and Genomics.

Katharine B. Harris, MBA, is the New York-Mid-Atlantic Consortium for Genetics and Newborn Screening Services (NYMAC) Project Manager and New York State Genetic Service Program Director at Wadsworth Center, New York State Department of Health.

Deborah Rodriguez RN, MPH, CPH, is with the Newborn Screening Program at Wadsworth Center, New York State Department of Health.

Robert J. Ostrander, MD, FAAP, is an Assistant Professor in the Department of Family Medicine at SUNY Upstate Medical University in Syracuse. He is a 1983 graduate of Upstate Medical College in Syracuse and the founding partner of Valley View Family Practice in the rural Finger Lakes. He serves on the Medical Home Workgroup and the Follow Up and Treatment Subcommittee for the Secretary of Health and Human Services Advisory Committee on Heritable Diseases of Newborns and Children.
As the NYSAFP 2012-2013 resident representative I would like to update other residents and Academy members on some of the upcoming changes that will affect family medicine residents both now and in the future. Admission into medical school and then into residency was not an easy task and felt like it took forever. With the proposed requirement changes by the ACGME Review Committee for Family Medicine (RC-FM), graduating from a family medicine residency may become longer and more challenging.

Over the past one to two years, the ACGME RC-FM has been working on implementing revisions to family medicine residency program requirements. One of the proposed major changes is to increase family medicine residency program training from three years to four years. Some of you may cringe at the thought of this and wonder why they want to prolong our seeing the light at the end of the tunnel (a.k.a. graduating from residency and receiving a nice salary to start paying off our many loans, etc.)? The thought behind this proposal is that there’s so much to learn to be an adequately trained family physician that three years may not be enough.

The ACGME plans a pilot project to test four-year family medicine residency training. The pilot starts July 2013 and ends June 2019. It will include 20 to 25 residency programs that will be selected by the ACGME RC-FM to participate; an equal number of programs will serve as the control group. Residents in each of the selected programs will be expected to meet an additional set of competencies that include:

• practice-based learning and improvement that, among other things, apply principles of patient safety to the care of individual patients.

• management of the health of populations, including the ability to identify disparities across populations, as well as factors that place populations at risk for disease or injury.

• systems-based practice, such as the use of electronic health records and the elements necessary for coordinated care of patients with complex and chronic diseases.

This pilot project will be funded by the American Board of Family Medicine Foundation, which has committed as much as $2 million.

Other revisions being considered for family medicine residency program graduation requirements include having documentation of all the patients that each resident has managed as inpatient, outpatient, pediatric cases (especially in patient and ER), and OB.
patients. In addition to these revisions, the ACGME RC-FM is considering making pediatric emergency medicine (peds ER) a mandatory rotation. The thought behind this is that family medicine residents are not managing enough of peds ER cases, which is important as the number of family physicians doing urgent care is steadily increasing.

Another proposed change is the development of a two track system within family medicine residency programs. The two tracks are an OB-focused track and non-OB focused track. The OB-focused track will be geared towards family medicine residents who plan to do OB after residency. This track will require that residents to complete about two to three times more deliveries than currently required in general for family medicine residents. However, this will not take the place of an OB/GYN fellowship after completing a family medicine residency program.

It is very important for family medicine residents to be aware of these possible changes and to share information with our colleagues. My advice would be to take the initiative to keep record of all your inpatients (both adult and pediatrics), peds ER, and OB cases. This will serve not only to cover yourself just in case these revisions take place sooner than we expect and also so that you can keep track for yourself of the types of cases you are being exposed to before you graduate. When it’s all said and done, all of these changes serve to make us into well-trained and great family physicians.

References
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Neka Anyaogu, DO, is a second year family medicine resident at Ellis Medicine Family Medicine Residency Program in Schenectady, NY. She is the 2012-2013 resident delegate on the New York State AFP Board of Directors, responsible for representing the interests of residents statewide, and also the delegate of the Ellis Medicine NYSAFP Chapter. Dr. Anyaogu earned a medical degree from New York College of Osteopathic Medicine (NYCOM).
The Erie County Chapter of the New York State Academy of Family Physicians hosted their 44th Annual Awards dinner on Saturday, November 3rd, where they presented the Chapter’s Golden Stethoscope Award, recognizing outstanding accomplishments in family medicine within Erie County, and the Max Cheplove Medal, given to acknowledge exceptional contributions to the ideals and discipline of family medicine.

The Chapter’s Golden Stethoscope Awardee: Timothy F. Harrington, MD, MS, FAAFP.
Dr. Harrington attended medical school at the State University of New York at Buffalo and completed family medicine training at the Deaconess Hospital in Buffalo concurrently with a Master’s degree in Epidemiology from SUNY at Buffalo. During two years in the US Navy Medical Corps he developed and secured certification for a Family Medicine Residency Training Program and coordinated the Physician Assistance Program at the Pensacola Naval Hospital.

Since returning to Western New York in 1974, Dr. Harrington has maintained a private medical office, initially in Buffalo and currently in Cheektowaga. A member of the medical staff at Sisters of Charity and St. Joseph’s Hospitals, now both part of the Catholic Health System, Dr. Harrington also participated as volunteer faculty in the UB Family Medicine Residency Program and has served as a preceptor for many UB medical students. He is Life Member of the American Academy of Family Physicians and the NYSAFP, and a member of the Medical Society of the State of New York and the Erie County Medical Society. Dr. Harrington and his wife Diane reside in Williamsville.

The Max Cheplove Awardee: James C. Puffer, MD.
Dr. Puffer has served as President and CEO of the American Board of Family Medicine (ABFM) since 1994, where he has directed the implementation of the maintenance of certification program for board certification. He is also Professor of Family Medicine at the University of Kentucky College of Medicine.

Dr. Puffer completed medical school and residency training at the University of California at Los Angeles; he subsequently completed a certificate of added qualification in sports medicine. Prior to relocating to Kentucky several years ago, he held a variety of leadership positions in the Department of Family Medicine at the UCLA School of Medicine. Dr. Puffer has served as Team Physician for multiple national and international sports teams at prestigious sporting events including the Summer Olympics in 1984 & 1988, the Winter Olympics in 1988 and the World University Winter Games in 1983 & 1985.

He has served in a variety of governance positions within the ABFM, the Association of Departments of Family Medicine, the American Medical Society for Sports Medicine and the American College of Sports Medicine. Currently Executive Editor of the Journal of the American Board of Family Medicine, Dr. Puffer is a current or former editorial board member for several sports medicine journals. He is well published on a variety of sports medicine topics through peer-reviewed articles and dozens of book chapters.

This award honors Max Cheplove, MD, (1902-1983) who through his leadership and accomplishments, is considered to be the Father of Family Medicine in the Western New York.

“We are honored to recognize Drs. Harrington and Puffer for their accomplishments. They are true leaders who serve to inspire their family medicine colleagues,” said Martin Mahoney, MD, PhD, president of the Erie County Chapter of the New York State Academy of Family Physicians. “Within the fragmented health care system where many medical specialties limit their practice to a particular organ, disease, age or sex, family physicians are dedicated to treating the whole person across the full spectrum of ages, through an ongoing, personal patient-physician relationship focused on providing integrated, high quality care.”
Southside Hospital’s Family Medicine Residency celebrated its 40th year of operation at a gathering in Bay Shore, New York, on September 15th. The residency was one of the first FM residencies in the downstate area, initiated as a collaboration between the community hospital at Southside, the newly opened School of Medicine at SUNY Stony Brook, and the Suffolk County Department of Health. The goal was to provide family physicians for Suffolk County and to provide care to an indigent population served by Southside Hospital. Since that time Southside has graduated over 320 FM residents, many of whom practice on Long Island, but also work throughout the U.S.

The celebration honored several of the program founders. The late Dr. Melville Rosen was the founding Program Director and went on to become Chairman of the Department of Family Medicine at Stony Brook. Dr. Rosen was the first recipient of the New York State AFP Educator of the Year Award. Three of the original attending faculty members; Dr. Daniel Friedman, Dr. Clive Caplan, and Dr. Robert Bobrow, were also recognized. Three members of the first PGY 1 Residency class in 1974, who are all still practicing in the Southside community were honored for their 35 year commitment to family medicine and the community: Dr. Stanley Blyskal, Dr. Kenneth Levites, and Dr. Robert Ruggiero. Also present were NYSAFP President-elect Dr. Raymond Ebarb and Past Presidents of the NYSAFP, Dr. Scott Kirsch, Dr. Richard Bonanno (Southside Program Director 1979-2009) and Dr. George Dunn. The celebration was hosted by Dr. Tochi Iroku-Malize, Southside’s Program Director and Chairman of the Department of Family Medicine at Hofstra University/North Shore/LIJ School of Medicine, the sponsoring Medical School for the Southside Residency.

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Pencil us in!
NYSAFP Members recognized by "Go! Diabetes Program"

Drs. Samuel Sandowski of Oceanside and Coveney Fitzsimmons of Schenectady were recognized by the Go! Diabetes Program, which provides tools for family physicians, faculty, residents, and clinicians to achieve higher standards of diabetes and patient care through practice improvements and system changes. Thanks to an unrestricted educational grant from Sanofi, the GO! Diabetes program just completed its fourth year educating program leaders, or “Change Agents,” in diabetes management and team care. The goal: help them identify, initiate, and implement sustainable clinical, practice and system-based quality improvements.

To highlight events, activities, and stories collected from Change Agents representing residency programs and private practices nationwide, the GO! Diabetes team produced an electronic “Fieldbook 2012.” The e-book, featuring New York Academy members, is accessible from the www.godiabetes.org homepage or directly via the URL www.godiabetes.org/fieldbook.

This year, the program’s 12-month duration allowed for more comprehensive measures from GO! Diabetes' online quality improvement tool METRIC, approved and provided by the American Academy of Family Physicians. In addition, the GO! Diabetes team and lead faculty supported its participating residency programs and private practices through ongoing education, access to improvement tools, incentives, research assistance, and stipends for residency program participation.

Writers Wanted for this journal. We are especially interested in articles suitable for CME accreditation and articles or opinion pieces on policy issues or other subjects of interest to Academy members.

Contact journaleditor@nysafp.org for more information or to submit your ideas. The deadline for suggestions for content for the Spring issue is February 1st.
AHRQ Launches Regional Partnership Development Initiative to Promote Comparative Effectiveness Research

The Federal Agency for Healthcare Research and Quality (AHRQ) recently launched efforts to promote comparative effectiveness research (CER), a type of patient-centered outcomes research, in patient and professional communities in all 50 states, Washington, D.C., and the U.S. territories. AHRQ has established five Regional Partnership Development Offices that are cultivating sustainable partnerships with hospitals and health systems, patient advocacy organizations, businesses, and other groups that serve clinicians, consumers, and policymakers. You’re invited to learn more about CER and to partner with AHRQ by using and encouraging others to use free CER reports and materials, which support efforts to improve the quality of health care in communities.

What is comparative effectiveness research?

Comparative effectiveness research provides information that helps clinicians and patients work together to treat an illness or condition. CER compares drugs, medical devices, tests, surgeries, or ways to deliver health care. The research findings don’t tell clinicians how to practice medicine or which treatment is best, but they provide evidence-based information on the effectiveness and risks of different treatments. Clinicians and patients can use this information to support their treatment decisions based on each individual’s circumstances.

AHRQ’s Effective Health Care Program works with researchers, research centers, and academic organizations to conduct the research and focuses on 14 priority health conditions, including: cardiovascular and related diseases, diabetes, arthritis, mental health disorders, and pregnancy. The full research reports are made available, and findings are translated into practical patient and clinician materials, that include:

- Patient treatment comparison summaries (English and Spanish)
- Clinician research summaries
- Executive Summaries
- Faculty Slide Sets
- Continuing education (CME/CE) Modules
- Podcasts

Partners can participate in a range of scalable activities such as distributing guides at meetings and in medical offices, placing articles in newsletters, and hosting Web conferences that highlight CER findings. Organizations that are using these materials or the CER findings include Mayo Clinic, the American Academy of Nurse Practitioners, and AARP, among many others.

Findings from comparative effectiveness research can be helpful to everyone participating in health care decisionmaking:

Patients are often faced with complicated decisions, such as which test is best, which medicine will help most with the least side effects, or whether surgery is the best option. Every patient is different, and each should make informed choices based on individual needs. By providing Effective Health Care Program products that summarize evidence-based, comparative effectiveness research findings, you can help patients work with their health care professionals to make a more informed decision among many treatment options.

Health care professionals can use CER to keep current on comparisons of medications and treatments. The products developed by the Effective Health Care Program help distill the information so health care professionals and consumers can review treatment options together. When research is not available to answer clinical questions, AHRQ publications highlight research gaps.

Policymakers, business leaders, and others want to make health care policy decisions based on reliable, objective information about effectiveness. Comparative effectiveness research helps decisionmakers plan evidence-based public health programs.

To learn more about comparative effectiveness research, order free materials, access our free continuing education modules or to become part of this growing partnership network, please contact Tara Schuh in AHRQ’s New York Regional Partnership Development Office at 212-880-5209 or tara.schuh@ahrq.hhs.gov. You can also learn more about CER by visiting www.effectivehealthcare.ahrq.gov.
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Introducing Empire BlueCross BlueShield’s Patient-Centered Primary Care program.

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