

# DelFamDoc

The Official Peer-Reviewed Journal of the Delaware Academy of Family Physicians



**DAFP attends the 2018 Family  
Medicine Advocacy Summit**

**Testimony in Support  
of SB 199**

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## Thank You

Margot Savoy, MD, MPH, FAAFP, FABC, CPE, CMQ, FAAPL  
Editor, DelFamDoc

*"Be thankful for what you have; you'll end up having more. If you concentrate on what you don't have, you will never, ever have enough."*

— Oprah Winfrey

Thank you. It's only two words. Two words that when spoken with sincerity can bring a smile to the face of even the crankiest of people. It's so easy to get caught up putting out fires. Our lives are so complex. Juggling home, work, community service, health, and ourselves isn't a task for the faint hearted. Somedays we can get so caught up in our own whirlwind that we can forget that others are living through their own cyclone of stuff. Unlike money or time, gratitude is something you increase by giving it away. At a time when so many are suffering from burnout, depression, stress and anxiety simply knowing someone else sees them and their effort can mean a lot. I'm not naïve enough to believe if we all started running around saying thank you burnout would simply disappear and our suicide rate would decline. I do think that if we voiced the positive as quickly as we are willing to gripe about the negatives it would be a little harder to devalue our fellow human beings.

It calls to mind a moment I had the other day. I arrived at work early but my patients were all late (very late in some instances- like missed your appointment and the next one late). For an hour I sat around waiting for someone to show up and then suddenly there were 4 people arrived to be seen all at the same time. I was beyond frustrated. Then came the "I scheduled for a cold but really wanted to talk about (pulls out a stack of papers half of which are forms that need to be filled out today)." I could feel the anxiety about running behind creeping up on me like a wave or fire crawling up my neck. I was struggling with the EMR, overwhelmed with the medical student's curiosity about everything irrelevant to the task at hand. This is the part of the story when I am supposed to flip out on

someone and behave badly, but that isn't how the story goes. I have self-awareness and tools to use when I feel overwhelmed. (Thank you burnout, mindfulness and resiliency training!) I took a moment to go gather myself. I proceeded to breathe in the calm, patience and joy and exhale the frustration, stress and agitation. I reminded myself that I am only one me so I have to trust my team. I triaged the folks and we all got to work. Then it happened- a patient's daughter stopped me as they were leaving, looked me in the eye and said "Thank you Dr. Savoy for seeing us today. We were really late and knew you might say no, but you didn't rush us or make us feel badly. You just took care of my mom and she was so relieved." Then she gave me a hug. Later when debriefing about the morning and giving feedback, the student paused, looked me in the eye and said thank you for letting me keep seeing patients even when it got crazy. Sometimes people just stick you in the corner. Today I learned that I may have to get creative and juggle, but we can get it all done. Having been blessed with thanks I couldn't keep it to myself and realized I hadn't thanked the front desk and MAs for picking up the pace with me to get it all done. The collective exhale gave us all a positive frame to kick off the afternoon session. Gratitude makes life better.

This issue of DelFamDoc exists because of the hard work of a number of folks within DAFP and our publishing team at Publishing Concepts, Inc. THANK YOU to the authors, editors and staff who made sure we can bring you a consistently excellent publication. Enjoy the issue and thank YOU for being a loyal reader! ■



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## Paul Yerkes, MD uses experience as Family Emerging Leadership Scholar to tackle veteran mental health

Dr. Yerkes, a family medicine resident at Christiana Care Family Medicine Residency Program was selected as one of 30 scholars for the AAFP Foundation Family Medicine Emerging Leadership program. A military veteran himself, Dr. Yerkes was excited to develop a project that allowed him to address a critical concern- ensuring veterans having access to mental health services. His project, titled “Improving the Identification of Veterans and Their Access to Mental Health Services in the Community” assessed the needs of Delaware veterans obtaining care in community practices. While confirming that most veterans are receiving care outside of the VA, many community physicians do not ask about military service and are unsure where to start once identifying a veteran with PTSD. Many veterans are uncomfortable returning to the VA for mental health services and would welcome their community physician asking questions to start the conversation. Next steps for this project include development of a PTSD toolkit for community primary care physicians. For his outstanding work on this project Dr. Yerkes was honored as the 2018 Samuel Katims Scholar in Medical Humanism at the American College of Medical Quality and selected as the FML Emerging Leader Institute Best Leadership Project award winner.

## Past DAFP President Omar Khan, MD, MHS, FAAFP installed as president of the Delaware Academy of Medicine

Congratulations to Dr. Omar Khan, past president of the DAFP and now President of the Delaware Academy of Medicine and Delaware Public Health Association. Dr. Khan serves as President & CEO of the Delaware Health Sciences Alliance (DHSA), a consortium of Christiana Care Health System, Thomas Jefferson University, Nemours, and the University of Delaware. He is also the Physician Leader for Academic Programs & Partnerships at Christiana Care, and Associate Professor of Family & Community Medicine at Thomas Jefferson University. He serves as co-Director for Community Engagement & Outreach for ACCEL, the Delaware Clinical & Translational Research program. His full bio is available at [http://delamed.org/?page\\_id=571](http://delamed.org/?page_id=571).



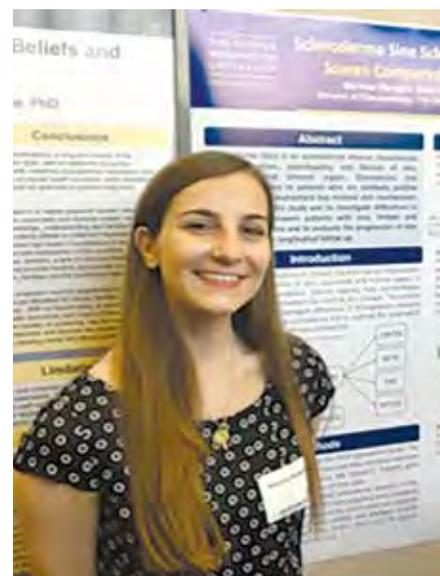


## DAFP Research & Education Foundation announces 2018 David & Ethel Platt Summer Fellowship winner Marissa Mangini

The David and Ethel Platt Family Physicians Summer Fellowship was established in the name of two exemplary family physicians to help create a way to excite first and second-year medical students about family medicine. Fellowships are offered each year for a four-week externship program where the chosen student will spend a week with various family physicians in Delaware.

The 2018 Platt Fellow is Marissa Mangini. Marissa is currently studying at George Washington University in Washington, DC. Currently trying to choose between Internal Medicine and Family Medicine Marissa is looking forward to the opportunity to shadow a practicing family physician this summer. **Congratulations Marissa!**

The DAFP-REF is able to provide these opportunities through the generous donations of our members. Thank you to everyone who donated this past year. To make a donation, visit the website <http://delfamdoc.org/82-2/> or mail a check to the DAFP office. Thank you for your support!



## DAFP Members preparing to teach in the Big Easy for FMX 2018

DAFP faculty represent us well on the national stage and this year's Family Medicine Experience is no exception. Hosted in New Orleans, Louisiana from October 9-13<sup>th</sup>, FMX 18 looks to be a spectacular time for continuing medical education and fun. As usual we have DAFP members teaching workshops and sessions on the program! If you will be in LA, let us know so you can get an invite to the group meet up for dinner. Registration is open (and hotel rooms are filling fast!). <https://www.aafp.org/events/fmx.html>

### Upcoming Meetings

- The Annual Geriatric Medicine Symposium will be held on September 27, 2018 from 745am to 12 noon at the John H Ammon Medical Education Center at Christiana Hospital in Newark, Delaware.
- The next DAFP board meeting will be held in October, 2018 at St Francis Hospital in Wilmington, DE. More details to be available soon.
- The Annual Sports Medicine Symposium will be held on November 10, 2018 from 745am to 12 noon at the Medical Society of Delaware Conference Center in Newark, Delaware. ■

# Joseph Kim, DO, FAAFP



## **Tell us a little bit about your work and practice, what's your day to day like?**

I am a Full Time Family Physician in a small rural town named Laurel, Delaware employed by Nanticoke Health Services. I see patients of all ages. In addition to my outpatient practice, I continue to admit and round on my hospitalized patients. I also will occasionally perform a house call. My day is rather busy, unpredictable, and rewarding.

## **How long have you been practicing in Delaware and what do you love about working in Delaware?**

I grew up on the Eastern Shore of Maryland, graduated from PCOM in 2003, and completed my residency at St. Francis in Wilmington, Delaware in 2007. I returned back to the Eastern Shore and started practicing in Laurel, Delaware. I have been practicing for over ten years. I enjoy working in Southern Delaware because I can be part of a community and build personal relationships with patients, community leaders, and local politicians...providing me the opportunity to extend health care to more people.

## **Do you have a favorite patient story you would like to share?**

There are many, many stories. However, recently I had a hospitalized patient who was dying from metastatic cancer. I asked him what can I do for him and he responded by asking me to join him for an alcoholic drink. Interestingly, he had never tried alcohol. I then asked what he wanted to try. His family recommended to him Crown Royal, which is actually my drink of choice. Since our mission is to provide exceptional care, I brought (snuck in) a bottle of Crown Royal Reserve from my personal collection the following day. We all raised our glasses, acknowledged his

wonderful life, and shared a drink. After throwing back the shot, he exclaimed, "that burned!!!" His facial expression was priceless. Despite the sadness and the heaviness of his terminal condition, his reaction made us hysterically laugh! I left the bottle and told him the whiskey goes down better with Coke. I shook his hand and thanked him for being such a wonderful patient. He passed away at home with hospice one week later with

family surrounding him. I see his wife, adult kids, and his grandkids fairly often, since I am their family doc too, and we always smile about his reaction to the Crown. I believe as family physicians, we have the unique opportunity to be truly part of families and have long lasting relationships. Family physicians are not only doctors, we are teachers, mentors, counsellors, and friends.

## **What are you passionate about in medicine? And in life?**

I enjoy taking care of people and helping them through tough situations and conditions. I am also passionate about passing my knowledge and expertise to future generations of physicians and have been lobbying for a residency program in Sussex County for years. Besides trying to provide the best life for my wife and daughter, I am also passionate about our family's newly established charity, the Kim and Evans Family Foundation, Inc. Our mission is to better the lives of disadvantaged people and animals of Sussex County and beyond. Through our foundation, we have been able to help patients afford their prescriptions, help feed in-need people through the Nanticoke Healing Harvest Program, help supply school supplies to underprivileged children, and help provide blankets and provisions to homeless individuals and Veterans.



# THE HYPERTENSION & DIABETES EPIDEMICS ARE REAL

## It's Time to Take Action

The statistics are shocking. According to the Delaware Division of Public Health, more than one in ten Delaware adults reported having diabetes in 2016 and more than one in three Delaware adults reported having hypertension in 2015. Clinician practices like yours are on the front lines in the battle to derail this epidemic, but you are not alone. Quality Insights is here to help.

Join the other 100+ Delaware physician offices collaborating with Quality Insights in its initiative to improve the lives of patients with diabetes and hypertension through focused education and evidence-based strategies. Your participation in this work creates a foundation for your practice's quality improvement efforts, as well as prepares your practice for future value-based payment models. There is absolutely **NO COST** to participate.



### CONTACT US:

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### BENEFITS OF PARTICIPATION:

- Access to **Community Health Workers** to pilot specific hypertension and diabetes initiatives
- **Free letter campaign** referring your patients living with **DIABETES** to the state's Diabetes Self-Management Program (DSMP)
- **Free letter campaign** referring your patients living with **PREDIABETES** to the YMCA of Delaware's Diabetes Prevention Program (DPP)
- Monthly **electronic education modules** with downloadable tools for your practice and patients
- Access to a **free home blood pressure monitor loaner program**



## DAFP attends the 2018 Family Medicine Advocacy Summit

Immediate Past President Lindsay Ashkenase, MD attended the 2018 Family Medicine Advocacy Summit along with DAFP Executive Director Ray Saputelli and Candida . 224 family physicians from across the country gathered to meet with legislators and staff from their home states. AAFP is asking us to take action on several high priority policy priorities including:

- **Congressional Primary Care Caucus**
- **Improve Maternal Mortality**

The maternal mortality rate in the United States ranks among the highest in the developed world and is increasing, while maternal mortality rates in most other nations are falling. To address this worrying trend, 33 states have established maternal mortality review committees (MMRCs) to improve data collection and identify strategies to support women’s health care needs.

In further response to this health crisis, Congress introduced the Maternal Health Accountability Act (S 1112) and the Preventing Maternal Deaths Act (HR 1318) to authorize \$7 million to expand the number of state maternal mortality review committees, improve data collection, and address current health disparities that exist.

- **Rural Graduate Medical Education**

Rural areas continue to lag urban and suburban areas in their access to primary-care physicians, and geographic maldistribution of physician training programs contributes to this imbalance.

The Rural Physician Workforce Production Act would exempt participating hospitals that provide rural training from resident “caps” established under the Balanced Budget Act of 1997 and would establish a new mechanism to enhance payment to hospitals for such rural training positions. The legislation would also ensure that critical access hospitals are paid under GME using the same formula as urban hospitals to incentivize training in rural areas.

- **Standard Primary Care Benefit in High Deductible Health Plans**
- **Support Opioid Crisis Solutions & Chronic Pain**



### Managements and Opioid use Disorder

Treating chronic pain is one of the most complex health care issues facing America’s doctors. Limited options for pain management means more patients use prescription opioids, which can lead to accidental overdoses and increase risks for misuse. In 2016, 42,249 people died from overdosing on opioids, and the overall crisis is adversely affecting families and communities across the country.

To address this issue, the AAFP supports two key strategies: National Institutes of Health (NIH) research and improved prescription drug monitoring programs (PDMPs) through the ACE Research Act (HR 5002) and CONNECTIONs Act (HR 5812), respectively.

- **Insurance Market Stabilization**

In 2017, almost 22 million Americans were enrolled in high-deductible health plans (HDHPs). While the AAFP is supportive of HDHPs, they can sometimes



discourage appropriate use of primary health services, given the higher deductibles associated with these types of health plans.

- **The Primary Care Patient Protection Act (HR 5858)** would require HDHPs to offer access to their primary care physician, or their primary care team, independent of cost-sharing and the plan's deductible.
- **APC-APM Overview**



**Figure 1. Key Components of the APC-APM Payment Structure**

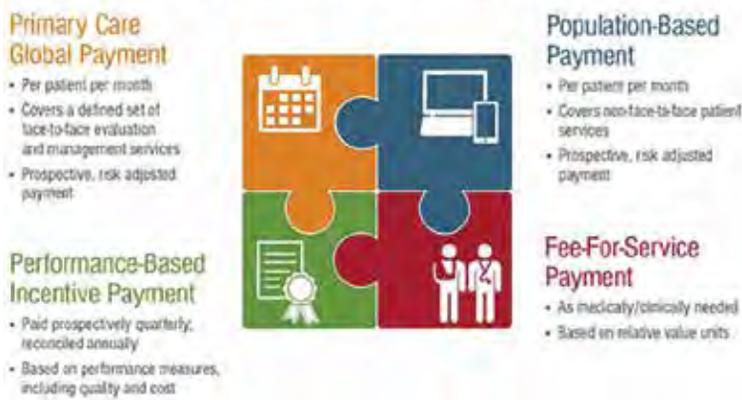


Figure 1 reference: <https://www.aafp.org/dam/AAFP/documents/events/fmas/BKG-APC-APMOverview.pdf>

These detailed documents you can use when meeting with our state and federal representatives available on the AAFP website at <https://www.aafp.org/events/fmas.html>.

How Can I Get Involved in Advocacy Efforts?	
<b>Speak Out</b>	Use the Speak Out tool to share your personal story with your legislators. Available on the website <a href="https://www.aafp.org/advocacy/involved/toolkit/advocacy-resources/speak-out.html">https://www.aafp.org/advocacy/involved/toolkit/advocacy-resources/speak-out.html</a> or in the AAFP mobile app  Need tips for how to frame your message effectively? They have a tip sheet for you too! <a href="https://www.aafp.org/advocacy/involved/toolkit/advocacy-resources/speak-out/using-speak-out.html">https://www.aafp.org/advocacy/involved/toolkit/advocacy-resources/speak-out/using-speak-out.html</a>
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<b>FMAS</b>	Mark your calendar now to attend the 2019 Family Medicine Advocacy Summit on May 20-21, 2019 at the Marriot Marquis in Washington, DC
<b>Family Medicine Advocacy Insider</b>	To keep abreast of news and key items for action, join the Family Medicine Advocacy network on the AAFP Connect Community page: <a href="http://connect.aafp.org/home">http://connect.aafp.org/home</a>
<b>DAFP Advocacy Committee</b>	We would welcome new members to join the committee! Contact Candida Taylor at <a href="mailto:candida@delfamdoc.org">candida@delfamdoc.org</a> for more information or to volunteer.

# Assessing Fall Risk

Margot Savoy, MD, MPH FAAFP, FABC, CPE, CMQ, FAAPL  
Department of Family & Community Medicine  
Lewis Katz School of Medicine at Temple University

An 81 year-old white man with a past medical history significant for well controlled hypertension, benign prostatic hyperplasia and osteoarthritis presents to your office for a routine follow-up. He denies any current complaints, but his wife appears concerned. She reveals that she is worried he will fall down again despite using the walker faithfully. You are surprised because he has never mentioned falling down at any past visit. Now you are concerned he is at risk for falling, but what should you do?

## Why do we worry about falls in the elderly?

### 1. They don't tell us.

Each year around 33% of community dwelling older adults and 60% of nursing home residents will fall. Yet only 28% of Medicare beneficiaries who fell had discussed their imbalance with their medical provider previously.<sup>1</sup>

### 2. They get hurt, lose quality of life and die.

Fall are the leading cause of fatal and non-fatal injuries in people over 65 years old. Fall injuries result in 2.8 million emergency department visits each year.<sup>2</sup> Once a patient has a history of falling the risk of a future fall jumps two to sixfold.<sup>1</sup> 25% of falls cause serious injuries including fractures and traumatic brain injuries. Hip fractures are particularly concerning because they are associated with significant morbidity, mortality, loss of independence and financial burden. The one year mortality following a hip fracture ranges from 14% to 58%!<sup>1</sup>

## Screening for Increased Risk of Falling

The initial screening for increased risk of falling can be accomplished in a few different ways. First, you can be aware of the common characteristics of people prone to falling. Table 1 lists the common non-modifiable and modifiable risk factors for falling. Using screening questions is another way to assess a patient's risk of falling. The Centers for Disease Control and Prevention's STEADI program provides a self-assessment tool

call "Stay Independent" which explores specific risk factors and helps the patient and clinician estimate the risk of falls. ([https://www.cdc.gov/steady/pdf/Stay\\_Independent\\_brochure-print.pdf](https://www.cdc.gov/steady/pdf/Stay_Independent_brochure-print.pdf)). If a patient cannot or isn't interested in completing a self-assessment tool, clinicians can use 3 screening questions identify at-risk older adults.

- Have you fallen in the past year?
- Do you feel unsteady when standing or walking?
- Do you worry about falling?

If the patient answers "Yes" to any of the screening questions they are considered at increased risk for falling and should undergo a multifactorial assessment.

**Table 1: Risk Factors for Falls in Older Adults**

Modifiable	Non-modifiable
<ul style="list-style-type: none"> <li>• Lower body weakness</li> <li>• Difficulties with gait and balance</li> <li>• Use of psychoactive medications</li> <li>• Postural dizziness</li> <li>• Poor vision</li> <li>• Problems with feet or footwear</li> <li>• Home hazards (rugs, tables etc.)</li> </ul>	<ul style="list-style-type: none"> <li>• Age (especially &gt;80 years)</li> <li>• Arthritis</li> <li>• Cognitive impairment</li> <li>• Female sex</li> <li>• History of fractures</li> <li>• History of TIA/CVA</li> <li>• History of past falls</li> <li>• Recent discharge from hospital (especially within first 30 days post discharge)</li> <li>• White race</li> </ul>

## Multifactorial Assessment

For older adults at increased risk of falling, the multifactorial assessment is an opportunity to identify modifiable risk factors that can be addressed. Table 2 lists the common elements in the

*continued on page 14*

# Talking to Parents about HPV Vaccine

Recommend HPV vaccination in the **same way** and on the **same day** as all adolescent vaccines. You can say, “*Now that your son is 11, he is due for vaccinations today to help protect him from meningitis, HPV cancers, and pertussis.*” Remind parents of the follow-up shots their child will need and ask them to make appointments before they leave.

**Why does my child need HPV vaccine?**

HPV vaccine is important because it prevents infections that can cause cancer. That’s why we need to start the shot series today.

**What diseases are caused by HPV?**

Some HPV infections can cause cancer—like cancer of the cervix or in the back of the throat—but we can protect your child from these cancers in the future by getting the first HPV shot today.

**Is my child really at risk for HPV?**

HPV is a very common infection in women and men that can cause cancer. Starting the vaccine series today will help protect your child from the cancers and diseases caused by HPV.

**How do you know the vaccine works?**

Studies continue to prove HPV vaccination works extremely well, decreasing the number of infections and HPV precancers in young people since it has been available.

**Why do they need HPV vaccine at such a young age?**

Like all vaccines, we want to give HPV vaccine earlier rather than later. If you wait, your child may need three shots instead of two.

**I’m worried my child will think that getting this vaccine makes it OK to have sex.**

Studies tell us that getting HPV vaccine doesn’t make kids more likely to start having sex. I recommend we give your child her first HPV shot today.

**I’m worried about the safety of HPV vaccine. Do you think it’s safe?**

Yes, HPV vaccination is very safe. Like any medication, vaccines can cause side effects, including pain, swelling, or redness where the shot was given. That’s normal for HPV vaccine too and should go away in a day or two.

Sometimes kids faint after they get shots and they could be injured if they fall from fainting. We’ll protect your child by having them stay seated after the shot.

**Can HPV vaccine cause infertility in my child?**

There is no known link between HPV vaccination and the inability to have children in the future. However, women who develop an HPV precancer or cancer could require treatment that would limit their ability to have children.

**Would you get HPV vaccine for your kids?**

Yes, I gave HPV vaccine to my child (or grandchild, etc.) when he was 11, because it’s important for preventing cancer.

**What vaccines are actually required?**

I strongly recommend each of these vaccines and so do experts at the CDC and major medical organizations. School entry requirements are developed for public health and safety, but don’t always reflect the most current medical recommendations for your child’s health.

**Why do boys need HPV vaccine?**

HPV vaccination can help prevent future infection that can lead to cancers of the penis, anus, and back of the throat in men.

Distributed by:



**U.S. Department of Health and Human Services**  
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**HPV VACCINE**  
IS CANCER PREVENTION



**DELAWARE HEALTH AND SOCIAL SERVICES**  
Division of Public Health  
Immunization Program

continued from page 12

assessment. Another way to recall the items to consider during an assessment is the mnemonic “IHATEFALLING.”<sup>3</sup>

- I: Inflammation of joints or joint deformity
- H: Hypotension (orthostatic blood pressure changes)
- A: Auditory and visual abnormalities
- T: Tremor (Parkinson’s disease or other cause)
- E: Equilibrium (balance) problem
- F: Foot problems
- A: Arrhythmia, heart block or valvular disease
- L: Leg length discrepancy
- L: Lack of conditioning (weakness)
- I: Illness
- N: Nutrition (poor; weight loss)
- G: Gait disturbance

### Functional Assessment

There are 4 tests commonly used during the assessment to examine the patient’s gait, strength and balance. Examples of these testing maneuvers can be found in videos online. The Timed Get Up and Go (TUG) assesses gait by having the patient rise from being seated in a chair, walk 10 feet away and back and sit down again in under 12 seconds. If the patient takes longer than 12 seconds the patient is at an increased risk of falling. (<https://www.cdc.gov/steady/pdf/STEADI-Assessment-TUG-508.pdf>) The 30 second chair stand test assesses leg strength and endurance by having the patients stand and sit as many times as possible within 30 seconds without using their arms. (<https://www.cdc.gov/steady/pdf/STEADI-Assessment-30Sec-508.pdf>) The 4 stage balance test assesses balance by observing the patient attempt to hold each of four increasingly challenging positions. Inability to hold each stage for 10 seconds indicates an increased risk of falling. (<https://www.cdc.gov/steady/pdf/STEADI-Assessment-4Stage-508.pdf>)

### Medication Review

The goal of the medication review is to reduce or eliminate the medications that are unnecessary and linked to falls. Specific medications to wean or discontinue include psychotropic drugs (especially benzodiazepines), and medications with side effects such as blurred vision drowsiness, sedation or confusion including over the counter medications like diphenhydramine. Review each medication for it’s indication and ensure that the dosage is appropriate for the patient’s age, creatinine clearance and liver function. The Beer’s Criteria contains a list of medications best avoided in older patients (<http://www.americangeriatrics.org/files/documents/beers/BeersCriteriaPublicTranslation.pdf>) For additional strategies for de-prescribing medications, a recent article in Family Practice Management may be beneficial. (Deprescribing of medications: Endsley, S. *Fam Pract Manag.* 2018 May–June;25(3):28-32.)

### Interventions

Individualize intervention plans based on the patient’s risk level and specific areas needing improvement. In all patients educate about falls, fall risk and appropriate interventions for their situation. The STEADI website has a useful patient education site available at <https://www.cdc.gov/steady/patient.html>. Table 3 reviews the typical

Table 2: Multifactorial Assessment for Older Adults at Increased Risk of Falling	
Element	Key Highlights
Falls History	Ask about falls, near falls and slips Discuss circumstances Determine if there were injuries
Physical Exam	Complete physical exam including musculoskeletal and neurologic exam
Orthostatic Blood Pressure	
Medication Review	
Cognitive Screening	3 item recall is a useful initial screen. Tell patient 3 items to remember because you will ask them later. Ask them to repeat the three items back to you. Complete another task and then ask the patient to tell you the three items. If they are unable to recall the three items additional cognitive evaluation is recommended (eg. MMSE or MOCAa)
Mobility Aids	Inquire about use of aides like a cane or walker Was it being used at time of fall?
Visual Acuity	Asses with usual glasses and check both eyes individually and together Don't forget to assess peripheral vision
Feet Et Footwear	Examine for bunions, hammer toes and ingrown nails What footwear is worn in the home?

<sup>a</sup><https://www.parkinsons.va.gov/resources/MOCA-Test-English.pdf>

interventions. When considering community programs for older adults there are a number of well validated programs including Stepping On (reduced recurrent fall risk by 55%), Modified Tai Chi (reduced fall risk by 30%), Otago Exercise Program (decreased fall risk by 35%), and other community centers like the YMCA.

**Table 3: Interventions to Address Fall Risks Identified During the Assessment**

Finding	Intervention
Increased Fall Risk	Consider 800 IU of vitamin D by mouth daily. This is controversial. The 2014 AGS Consensus Statement recommends it (2014) but recent studies suggest no benefit. ( <a href="https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2478893?redirect=true">https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2478893?redirect=true</a> )
Strength & Balance	Low Risk: Community Exercise Program or Fall Prevention Program Moderate Risk: Fall Prevention Program or Physical Therapy High Risk: Physical Therapy
Mobility	Refer to Physical Therapy for walking aides, gait and balance assessment
Vision	Refer for eye exam if last was over a year ago or any changes in vision
Home Safety	Home safety evaluation to identify hazards (occupational, physical therapy)
Medication	Provide reconciled medications, remove old bottles from home
Feet & Footwear	Consider Podiatry or Orthopedics
Cognitive Support	Home Aides, caregivers

### Back to Our Patient

Because you realize he could be at risk for falling you conduct the 3 question initial screen which confirms your suspicion he needs additional evaluation today. You conduct a multifactorial assessment using the job aid available from the STEADI website (<https://www.cdc.gov/steady/pdf/>

*Because you realize he could be at risk for falling you conduct the 3 question initial screen which confirms your suspicion he needs additional evaluation today. You conduct a multifactorial assessment using the job aid available from the STEADI website (<https://www.cdc.gov/steady/pdf/STEADI-Algorithm-508.pdf>) and provide individualized counseling based on his specific risk factors.*

STEADI-Algorithm-508.pdf) and provide individualized counseling based on his specific risk factors. Because he is high risk you ask him and his wife to return to see you in a month so you can hear about how things are progressing.

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# Infantile Colic

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## Case

Recently my two-month old had excessive hiccups for what seemed to be hours on end. I tried burping and then repositioning him. As an Osteopathic physician, I tapped into my OMT skills by performing a gentle manipulative technique balanced ligamentous tension (BLT) to his diaphragm to help reset his phrenic nerve and possible fascial spasms. My mom had suggested placing a matchstick on his head and his hiccups will resolve. Initially I snickered, but since his symptoms were not resolving, I finally gave in and placed the matchstick on his head.

## Introduction

Family Physicians are commonly faced with parents concerned about their excessively crying infant. Fussing and crying are normal aspects of development in the first few months of a baby's life. It is estimated that infants cry an average of 42 minutes to 2.2 hours per day.(13) Peak crying period occurs around six weeks of life.(9) In a meta-analysis of 24 studies of parental crying diaries, mean duration of crying was 110-118 minutes per day during the first six weeks of life. The crying episodes decreased to 72 minutes per day by 10 to 12 weeks but varied from infant to infant(13).

Colic is commonly defined using Wessel Criteria or the "Rule of 3's" including: an infant who cries for more than 3 hours a day for more than 3 days per week for more than three weeks who is otherwise healthy. (1) This is similar to Rome IV definition which classifies colic as a "Functional Gastrointestinal Disorder(FGID)" from birth to five months. The infant must be less than 5 months, recurrent and prolonged periods of crying, and caregiver reports crying/fussing for more than 3 hours, and more than 3 days per week.(13) 10% to 26% of infants experience colic and other sources have listed even higher percentages up to 40%.(11)

A colicky episode has distinctive features compared to normal crying. Attacks often cluster in the evening with clear beginning

and ending times that appear unrelated to the infant's activity at the time on onset. The babies are also noted to have flushed faces, clenched fist and high-pitched screams.(9) The cry is louder, higher and more variable in pitch and episodes may include paroxysms, altered cry quality, hypertonia and difficulty consoling. Some parents report the baby seems to be in pain or distressed. Often infants are difficult to console despite intervention.

## Etiologies of Colic

Several theories have been proposed, but a definite etiology of colic has not yet been identified. These theories include gastrointestinal, psychosocial and neurodevelopmental disorders (1,9,11). Luckily, less than 5% of cases of excessive infant crying are related to an illness or true organic cause. (11) Table 1 lists some organic causes of infantile distress to be considered in the differential diagnosis of colic.

Table 1: Organic Causes of Infantile Distress	
System	Causes
Central Nervous System	Infantile migraine, Subdural hematoma, Chiari type I malformation, Congenital cerebral malformations
Gastrointestinal	Hunger (Failure to thrive), Constipation, Obstruction, Pyloric stenosis, GERD, Rectal fissure, Lactose/Cow Milk Intolerance
Trauma	Abuse, Neonatal Abstinence Syndrome, Corneal abrasion/foreign body in the eye, Hair tourniquet syndrome, Fractured bone
Infection	Meningitis, Otitis Media/Externa, Urinary Tract Infection, Diaper Rash, Viral URI
Congenital	Cardiomegaly, Heart Failure, Neuromuscular disease, Metabolic Disorders



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### **Gastrointestinal:**

Increased gas production from colon function can result in excessive distention and hyper-peristalsis (13) and the hormone motilin is thought to cause excessive peristalsis.(9) Anticholinergic agents such as dicyclomine appear to decrease colic symptoms further supporting the motilin theory.

Many babies do not have symptom improvement after transitioning from cow milk to soy leading some to question the milk allergy/intolerance theory. A systemic review of randomized controlled trials did show that breastfeeding mothers who eliminated milk products, eggs, wheat and nuts from their diet reported decreased crying episodes in their infants.(11)

### **Psychosocial:**

There is less evidence to support psychosocial causes of Colic. Some studies hypothesized that Colic is an early manifestation of a difficult temperament.(1) Temperament refers to inherent behavioral patterns that appear in early life.(12) Colic by definition resolves by 5 months of age, and there is not sufficient evidence to suggest it is related to a difficult temperament later in life.(4)

More research is needed to further investigate the correlation between communication in families and colicky infants. It is not uncommon for parents with history of anxiety and/or depression to worry they have poor parenting skills. (4, 13) Many families with colicky infants tend to have problems with communication and family function.

### **Neurodevelopmental:**

Some studies have suggested that babies with Colic simply lie at the upper end of the normal distribution range

of normal crying pattern in an infant. (11) The known patterns of crying in colicky infants are not drastically different from “normal” infants.(9) A neuro-developmental etiology is further supported by the fact that infants outgrow colicky crying episodes by five months of age.

### **Workup**

A careful history and physical exam is essential to evaluate for other etiologies of excessive crying.

Specific questions that can aid in diagnosis:

When does the crying occur? - Colic typically occurs during the evening.

How long does the crying last? - Duration helps differentiate normal infant crying from Colic episodes.

What do you do when the baby cries? - evaluate if soothing techniques are helpful, not helpful or harmful (i.e. Shaking baby).

How do you feed your baby? - Identifies underfeeding/ overfeeding and inappropriate feeding techniques.

Why do you think the baby cries and How has the Colic affected your family? - This provides insight into stressors and ways to identify resources for the family.

Physical Exam:

The physician can begin the exam by observing the interaction between the infant and caretaker. The infant should be examined without clothes to inspect for signs of trauma which may indicate abuse. Vitals signs and the growth chart should be evaluated. If possible the visit should be scheduled around the time when Colic episodes occur. This will enable physicians to assess first hand the infant’s behavior and caregiver’s response. There is little evidence to support obtaining laboratory testing or imaging if the infant meets all developmental milestones, and thorough history and examination are unremarkable. (11)

## **Management Options**

### **Medication:**

Simethicone, an over the counter drug, is a commonly used to decrease intraluminal gas in an attempt to ease colic. However, randomized control studies have shown limited difference between the medication and placebo.(11) Anticholinergic agents, such as dicyclomine, have been associated with apnea and are now contraindicated for infants under six months.(11) Gripe water and herbal teas have also been used to reduce crying episodes. However, there is no standardized dosage or strength per FDA. Parents are cautioned to review over the counter medications with a healthcare provider first.

### **Behavior Interventions/Devices:**

Infantile colic is an issue that has occurred throughout history, around the world. Various methods of infant soothing have been employed. Many behavioral interventions have been proposed to decrease crying episodes with varying results ranging from car-ride simulators to crib vibrators to carrying devices. The popular “Happiest Baby” or “Five S’s” method has anecdotally worked well. The “five S’s” include (#1) Swaddle, (#2) Side or Stomach Position, (#3) Shush or White Noise, (#4) Swing, (#5) Suck.(2) An example can be seen through the link ([https://www.youtube.com/watch?v=ftKua\\_qL2rk](https://www.youtube.com/watch?v=ftKua_qL2rk)) (2)

For example, through historical accounts we know swaddling was used by ancient Jews, Greeks, and Romans. (14). England employed rocking nurses who rocked cradles in the late 1800’s. Prams were first introduced during the same time period as a convenient way to transport babies, and the smooth motion may have helped with soothing.(14) The Manta and Awayo are wraparound slings used in Peru and Bolivia. Varying styles of wraparound

slings are also used in many parts of Asia. (14) In Africa, a rectangular piece of material (called Kanga in Kenya, Ntoma in Ghana, and Capulana in Mozambique) is used for carrying infants. The cloth is tied around the back rather than over the shoulder. An example can be seen through the link: <https://www.youtube.com/watch?v=Gaz6rfjW8co>.(6)

In the 1960's, former Peace Corps nurse Ann Moore was stationed in Togo in West Africa.

After studying how the Togolese women carried their babies she created a line of products in the United States modeled after the African style called "Snuggli", which included soft baby carriers and other kinds of specialized carrying devices.(8) The concept was further popularized by William and Martha Sears in the 1980's when they patented the word "Babywearing".(15)

### **OMT (Osteopathic Manipulative Treatment):**

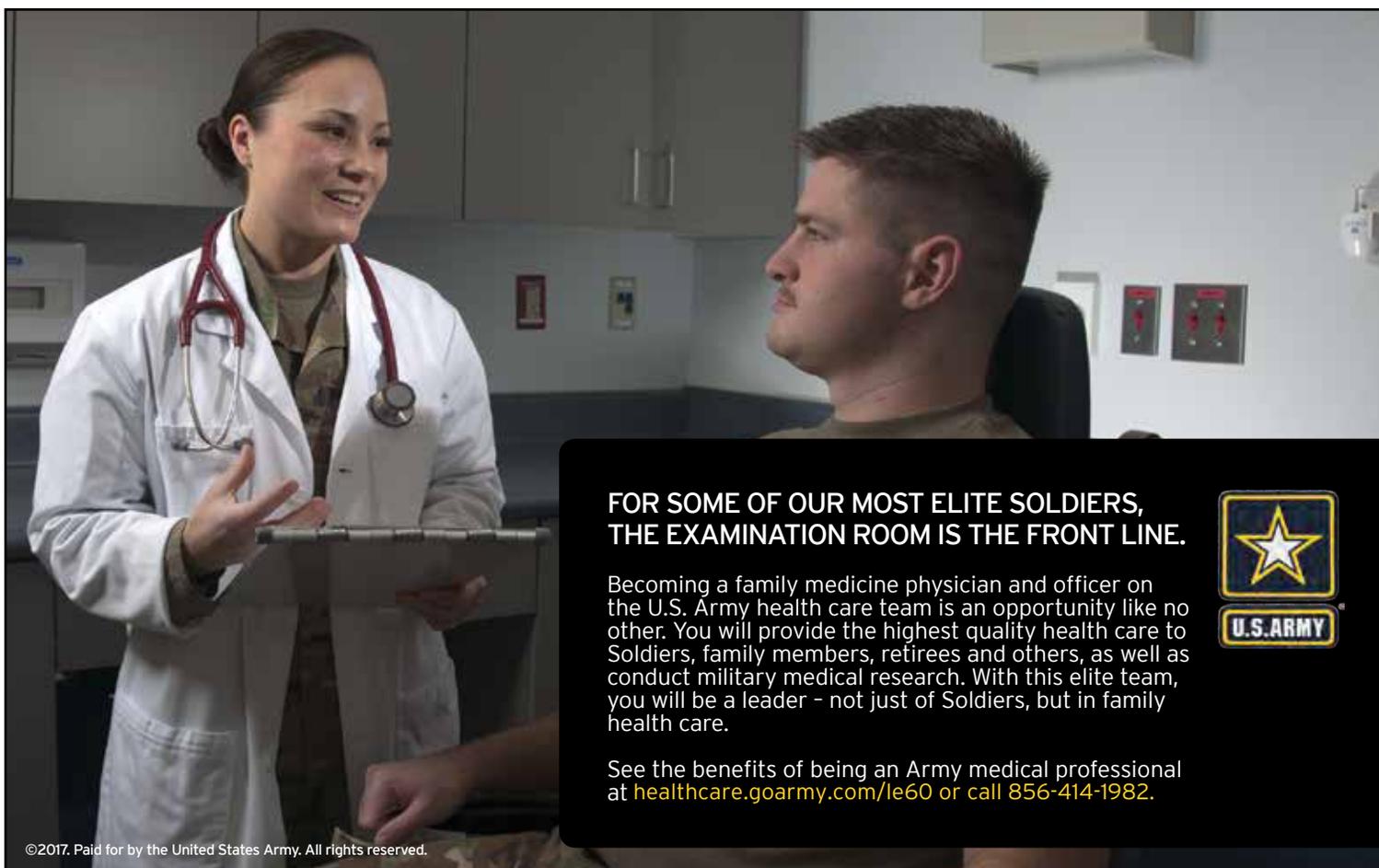
Osteopathic tenets from the pediatric perspective are based on the standpoint that structure and function are interrelated, and infants/children are dynamic and require continuous assessment and reassessment to create balance. Common treatment sites include the head and neck, the gut, diaphragm and rib cage(10).

Cranial osteopathic manipulation involves gentle application of force to somatic dysfunctions on the head and impact on the body. The vagus nerve which supplies the gut and the nerves to the diaphragm are supplied by the neck. Osteopathy utilizes gentle manipulation to release restrictions in the posterior neck by balancing parasympathetic innervation from the hypoglossal and vagus nerves. This in turn promotes the baby to suckle more easily and decreases excessive gas. (10) The diaphragm and rib cage can often

get distorted during delivery, causing a torsion in the diaphragm resulting in the valve at the entrance to the stomach not closing properly so that acid comes up into the esophagus. Osteopathic techniques can balance the rib cage and release tensions through the diaphragm.

A controlled prospective study by Dr Hayden included 28 infants with Colic who were treated with cranial osteopathic manipulation in a four week period.(3) Eight infants with colic were randomized to either cranial osteopathic manipulation or no treatment; all were seen once weekly for four weeks. Treatment was selected according to individual findings, and administered by only one osteopath. Parents recorded time spent crying, sleeping and being held/rocked on a 24-hour diary. Overall decline in crying was 63% and 23%, for treated and control

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groups respectively.<sup>(3)</sup> Treated infants also required less parental attention as compared to the untreated group per parent's report and sleep diary review.

The research is limited due to the size of the study. A larger study group could provide stronger supporting evidence.

### Long-term Family & Infant Outcomes

At a one year follow up, a group of Colicky infants compared with Non-Colicky infants showed no differences in behavior in nine assessments using the "Toddler Temperament scale".<sup>(11,12,13)</sup>

There is currently no research to support an association between infantile colic and later development of illness such as asthma or allergic diseases <sup>(11)</sup>. This is a reassuring conversation to be had with the caregiver to promote sound mind and decrease worrying. This is especially important because there is research that shows once Colic resolves there is lasting effect on levels of maternal anxiety and/or depression.<sup>(11)</sup> Physicians must closely monitor for signs of family distress and or postpartum depression. It is important to assess the family's coping mechanism and resources including Behavioral Healthcare or support groups. The mainstay of colic management is an acknowledgement by the physician of the difficulties the parents are facing.<sup>(13)</sup> Self-care for the mother/caregiver is just as important as caring for the infant. This should include information that Colic is a self-limiting condition and is likely not due to a disease process. Parents should be assured that a Colicky infant is not a reflection of poor parenting. Parents should be advised to check for hunger cues, change soiled diapers, and to establish regular patterns during the day. Parents should also be advised not to exhaust themselves. More research is needed on dietary changes to reduce Colic. Mothers are advised to

continue breastfeeding. OMT has been shown to have effectiveness on common infant issues such as constipation, improving latching, and reducing crying attacks. Anticholinergic agents have known side effects including apnea and parents are cautioned against using such products. More research is needed prior to recommending over the counter herbal products. Common soothing mechanisms such as the "5S's" are strategies that parents can perform on a day to day basis.

### Case Conclusion

The hiccups resolved a few minutes afterwards. Perhaps it was the OMT or when I repositioned him on my lap or the burping, but my mom insists it was the matchstick. ■

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# The Limited English Proficient Patient

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From September to December of 2017 I had the privilege of participating in the Achieving Competency Today (ACT) course taught through the iLEAD Institute for Learning, Leadership and Development at Christiana Hospital. This is a 12-week course designed to bring people together from many facets of the healthcare system and examine issues in health care quality, cost, systems and safety. A large part of this course is the development of a Quality Improvement project designed to study areas within our healthcare system that need further examination or improvement. My team chose to look at the utilization and documentation of qualified interpreter services during encounters with Limited English Proficient (LEP) patients at Christiana Hospital. Through working on this project, I learned an incredible amount about the needs of LEP patients, the correct and incorrect ways to communicate with them and the importance of utilizing qualified interpreter services during an LEP encounter. As a Family Physician, I began to think of the ways that this project could translate into my outpatient clinical practice and how the knowledge I gained would help me to take better care of my patients.

## Definitions

Limited English Proficient (LEP) is a term used to describe people who do not speak English as their primary language and/or a person who has a limited ability to read, speak, write, or understand English.

## Demographics

According to information published by the Migration Policy Institute, in 2013 approximately 61.6 million individuals in the United States spoke a language other than English in their home. About 41 percent (25.1 million) of these 61.6 million people were considered Limited English Proficient (LEP). Nearly 19 percent (4.7 million) of LEP individuals

*According to the U.S. Census Bureau, in the state of Delaware, approximately 18% of the total population either does not speak English at all or does not speak English proficiently and roughly 13% of the population speaks a language other than English in the home.*

were born in the United States. Overall, 8 percent of the total U.S. population ages 5 and older was considered LEP.

According to the U.S. Census Bureau, in the state of Delaware, approximately 18% of the total population either does not speak English at all or does not speak English proficiently and roughly 13% of the population speaks a language other than English in the home.

## What the Evidence Shows Us

Communication issues due to language barriers can result in poorer quality of care, adverse outcomes and decreased patient satisfaction. One study from Canada examined the effect that English language proficiency would have on hospital length of stay (LOS). They found that LEP patients stayed in the hospital approximately 0.5 days longer than English proficient (EP) patients for 7 out of 23 conditions including chest pain, CABG, CVA, Diabetes, craniotomy procedures, elective hip replacements and intestinal procedures. When we consider that the average hospital stay in Delaware costs about \$2,700/

day, the financial burden of an increased LOS by even half a day is significant.

Another study out of Massachusetts also examined hospital length of stay. They found that LEP patients who did not have qualified interpreter services on admission or both admission and discharge had an increase in their length of stay of between 0.75 and 1.47 days as compared to patients who had qualified interpreter services on both admission and discharge. They also found that these patients were less likely than patients not receiving qualified interpreter services to be readmitted within 30 days.

Looking directly at adverse events, one study examined varying characteristics of adverse events between EP patients and LEP patients. They found that about 49.1% of LEP patient adverse events involved some physical harm and 46.8% of these patients who experienced physical harm had a level of harm ranging from moderate temporary harm to death. Only 29.5% of adverse events for EP patients resulted in physical harm to the patient. Not surprisingly, the adverse events that occurred to LEP patients were also more likely to be the result of direct communication errors as compared to EP patients.

### Barriers to Proper Use

One of the leading barriers to the utilization of qualified interpreter services for LEP patients is identification of the patient as LEP. Many LEP patients speak and understand English and may even decline interpreter services if asked. This can often make the task of safe and thorough communication by the healthcare provider even more difficult. The job of requesting interpreter services and coordinating them for a patient visit can be very challenging as well. Many providers don't know how to request in person interpreters or may not have identified the patient as LEP prior to their encounter. Resources for many outpatient offices may be another barrier for LEP patients, with many offices having little to no access to in person interpreters.

### Room for Improvement

The consistent and proper use of these approved services is happening everyday throughout our healthcare system, however there is still significant room for improvement. Baseline data collected during our ACT project showed that less than 10% of LEP patient encounters we examined were being documented appropriately with the language used, the type of service provided and the interpreter ID. In addition, the use of ad hoc interpreters amongst healthcare professionals is very prominent. A study released by the Joint Commission in 2007 showed that up to 50% of providers were using family

and/or friends, not trained in medical interpreters, as in person interpreters. Discharge instructions are another major barrier, and at many hospitals written discharge instructions are only available to patients in English. This forces many patients to try and either remember their discharge instructions or write them down prior to being discharged. ■

### Conclusion

While many healthcare providers may not want to admit it, LEP patient encounters can at times feel burdensome. They take a significant amount of time and it can be frustrating to have to rely on outside sources such as interpreter services to complete a patient visit. Although there may be challenges when it comes to LEP visits, providing these patients with quality healthcare in their preferred language is not only their right as patients, it is our responsibility as providers. By utilizing proper interpreter services and documenting these encounters judiciously, we can decrease adverse events, increase patient satisfaction and ultimately better care for our patients. ♦

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# Accentuating the Positive: Creating a Culture of Gratitude

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When was the last time someone took the time to pause, look you in the eye and say “Thank you” in a meaningful way? And can you remember the last time you gave a truly heartfelt thanks to someone else? If you found yourself having to search for an answer to either question this article is for you!

With the growing eye on burnout, depression and physician wellness, many are exploring the link between gratitude and resilience, happiness and overall wellness. To be clear the gratitude we are talking about here isn't the forced niceties which occur because you are checking off a box on the “how to improve your patient satisfaction scores” checklist. For our purposes, let's define gratitude as “appreciation of what is valuable and meaningful to oneself; it is a general state of thankfulness and/or appreciation.”<sup>1</sup> Two useful mental models for how to think about gratitude include: “treat 'em like dogs” and “3:1.”

## 3:1 Ratio for Success

Dr. Barbara Fredrickson discovered that experiencing positive emotions in a 3-to-1 ratio with negative ones leads people to a tipping point beyond which they naturally become more resilient to adversity and effortlessly achieve what they once could only imagine.<sup>2</sup> This is important when thinking about

*Gratitude: appreciation of what is valuable and meaningful to oneself; it is a general state of thankfulness and/or appreciation*

creating a culture of gratitude because if you are regularly acknowledging the positive and good in your team when adverse events or challenging moments arise you will have enough positive emotional credit to weather the storm.

## “Treat 'em Like Dogs!”

Dr. Dike Drummond shocks audiences during his highly rated Quadruple Aim Physician Leadership workshops by telling leaders to treat their teams like dogs. He goes on to explain that we shower affection and praise on our dogs without necessarily waiting for them to do something extraordinary. And we are quick to forgive our dogs when they make a mistake. Imagine if you could extend that level of grace to your co-workers.

## No Time Like the Present

You don't need to wait for

something big to express or reflect on your gratitude. Pick someone in your office today, look them in the eye and share a very specific reason why working with them today was a joy and a pleasure. Don't shortchange her with a quick “Ebony, thank you for your help today.” as you rush off to your next meeting. Instead be deliberate, specific and boldly transparent with your thanks. Stop walking. Look her in the eye and say “Ebony, thank you for your help today. I was really getting behind this morning and your cheerful attitude when rooming the patients and willingness to keep them informed about how long I was going to be really helped a lot. Thank you.” And when you get home from work take 15 minutes to reflect on the day looking for what went well instead of dwelling on what could have gone better. Consider writing these thoughts

Ways to Cultivate Your Attitude of Gratitude

Personal

- Be present. You can't see what good things are happening if your mind is always somewhere else.
- Say Thank You. Even when it feels strange because the other person was doing their job. Them giving you their best effort (even while expected) can still be genuinely appreciated.
- Send them a handwritten note.
- Put it on your calendar.
- Build it into your daily rituals.
- Practice how to receive a compliment or words of gratitude.
- Offer to mentor or teach others.

Organizational

- Be a champion of gratitude.
- Make a gratitude wall.
- Encourage others by catching them doing great things.
- Celebrate and recognize one another. Celebrate individual and team successes- both big and small
- Intentions matter- be careful with words.
- Communicate openly and honestly to break a negativity cycle.
- Practice how to give and receive compliments and words of gratitude.
- Participate in volunteer/service activities

down in a gratitude journal. Or even consider sharing these thoughts with your significant other. Instead of a “how was your day?” which may lend itself to a ranting list of all that went wrong, try asking one another “what was the best part of your day?” and ferreting out the details about why that such a rewarding experience. No matter which gratitude practice you choose to start, don't delay. There is no time like the present! ■

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## Testimony in Support of SB 199

The following testimony was submitted May 9 2018 to the Delaware Senate Health, Children & Social Services Committee on behalf of the Delaware Academy of Family Physicians.

The Delaware Academy of Family Physicians applauds Senators Townsend, Hansen Henry and McDowell along with Representatives Bentz, Baumbach and Brady on the introduction of SB 199 which proposes to ensure that the percentage of medical expenses allocated to primary care services is at least 12 percent by 2025. The Academy is pleased that Delaware legislative leaders recognize the value that a strong primary care infrastructure brings to the healthcare system. As you may be aware, this commitment to primary care has paid dividends in Rhode Island, and we expect similar results in Oregon after the passage of legislation last year. Further, this commitment is being proposed in current legislation in both Colorado and California, and we expect that similar legislation will be considered in a number of other states in the coming months.

As you know, primary care has a **public purpose**. Primary care is the essential foundation of a successful, sustainable health care system. Research continues to show that primary care is critical to the health of individuals and improves health outcomes. Primary care helps prevent illness and death and is associated with a more equitable distribution of health in populations.<sup>i</sup> A study found that patients who identified primary care physicians as their usual sources of care had lower five-year mortality rates than patients identifying a specialist physician as their usual source of care.<sup>ii</sup> Internationally, a study reported that the populations of countries with higher ratings of “primary care orientation” experience better health outcomes and incur lower health care costs than the populations of countries with lower degrees of primary care orientation.<sup>iii</sup>

Primary care treatment can not only improve the health of patients but it is also a highly effective use of health care dollars. It is estimated that almost 40 percent of emergency department visits and roughly 10 percent to 17 percent of inpatient

hospitalization costs are preventable.<sup>iv</sup> Primary care includes health promotion, disease prevention, health maintenance, counseling, patient education, diagnosis and treatment of acute and chronic illnesses in a variety of health care settings. Primary care can help save money on these preventable visits. Additionally, studies have found that states with more general practitioners use more effective care and have lower spend than those states with a higher number of specialists<sup>v</sup>. Similarly, within the United States, health care markets with a larger percentage of primary care physicians have lower spending and higher quality of care.<sup>vi</sup> One study found that increasing family physician comprehensiveness of care, calculated by claims measures, found a decrease in Medicare costs and hospitalizations.<sup>vii</sup>

Unfortunately, a Commonwealth Fund analysis identified underinvestment in primary care as one of four fundamental reasons that the U.S. health system ranks last among high-income countries.<sup>viii</sup>

Primary care is important to the health of individuals and can help bend the cost curve. Yet, we don’t know how much we are spending on primary care. The work done in Rhode Island and Oregon show us that primary care spending generally accounts for a small portion of total spending. In fact, some studies have suggested that U.S. primary care spending accounts for only 5 to 8 percent of overall health care costs<sup>ix</sup>. Although primary care only accounts for a small amount, the decisions made in this setting have consequential results on the rest of a patient’s medical care. It’s time we know what we’re investing in primary care.

Rhode Island was the first to state to mandate spending on primary care and their success began in 2009 when it established

*continued on page 28*



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*continued from page 26*

affordability standards to lower costs and improve quality in its health insurance market. The standards required health plans to increase the percentage of their medical expenses spent on primary care by five percentage points from 2010 to 2014. In 2011, total primary care spending for commercial members increased by 23 percent while total medical spending fell by 18 percent.<sup>x</sup> In their 2012 and 2014 report, this trend continued. Annual primary care spending rose by \$18 million from 2008 to 2012 while annual total medical spending dropped \$115 million at the same time.<sup>xi</sup> Because of this success, Rhode Island has updated its affordability standards and now requires insurers to spend at least 9.7 percent of annual total health expenditures on direct primary care and at least 1 percent on indirect primary care (for a total of 10.7 percent). Rhode Island defines direct primary care payment as that which directly benefits primary care practices and providers. Indirect primary care payment is defined as those payments which help primary care practices function as patient centered medical homes.

A fundamental change in the health care system to prioritize a primary care based system is essential to improvements in access, quality and cost. For these reasons we are highly supportive of the initiative proposed by SB 199, however we would like to ask the members of the committee to consider the potential for unintended consequences of the following provision:

No group or blanket policy or contract issued or delivered by an Insurer may reimburse for Primary Care at a rate less than Medicare reimbursement for comparable services.

(i) This shall include payment for care coordination services such as “chronic care management”, which also should not be subject to patient deductibles and copayments.

While we understand and agree with the premise and recognize that many family physicians and other primary care clinicians are paid at rates below Medicare, sometimes significantly lower, we are concerned that this language, intended to be a floor, could become a ceiling. We'd encourage the sponsors and members of the committee to consider language that not only guarantees a Medicare “floor” but also encourages payers to embrace value-based payment models that move away from the flawed fee-for-service payment model. Further, while we share the intention that patients are protected from cost-shifting measures currently becoming more prevalent in high-deductible plans, we believe that the bill should be specific that these payments, which are not subject to deductible or copayment, must not result in decreased reimbursement to the physician.

Once again, on behalf of the more than 300 family physicians in Delaware who make up the foundation of our state's primary care infrastructure, thank you for your commitment to primary care. We look forward to working with you to ensure that this legislation lives up to the intention of its sponsors. ■

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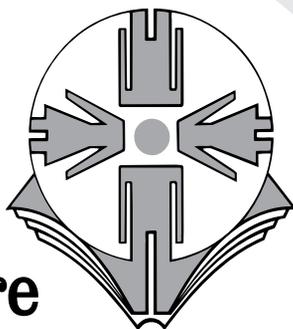
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