Family Doctor
A JOURNAL OF THE
NEW YORK STATE ACADEMY
OF FAMILY PHYSICIANS

FEATURE ARTICLES:

CME & POST-TESTs
The Manageable Challenge Weight Loss Program

also:
- Exercise Prescription
- Mold and Healthy Living
- HRCOMP-SOAP – A new model for the primary care visit

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Cover art (plus ça change, plus c’est la même chose): Thanks to Rucker Archive, Mark Rucker and Alison Moore, for images from their collection for our cover. www.TheRuckerArchive.com
This issue of *Family Doctor* addresses several topics that impact significantly upon healthy living.

The effects of obesity on our public health have been detailed in many venues, in medical literature and everywhere in the public news media. It has become omnipresent in discussions of public health policy. Dr. Kernan does an excellent job of summarizing the impact of obesity on our public health in his article *Exercise Prescription*. His focus on counseling patients regarding the health impact of obesity and the benefits of exercise highlights one approach to the issue which family physicians should certainly include in their practice.

The Academy’s Public Health Commission has developed the Manageable Challenge program to provide another resource for family physicians to use in treating obese patients. The concept of reducing the patient’s challenge to one meaningful thing; i.e., reducing the volume of calories consumed, is a reflection of the great difficulty inherent in helping obese patients cope with the health and life threatening aspects of obesity. The combination of diet and exercise is simply too much to expect for many patients and the Manageable Challenge model can help by focusing the patient on one behavior modification: reducing the volume of calories consumed.

*Mold and Healthy Living* offers a unique insight into a major public health threat emanating from disasters. The consequences of mold damage and the threat to human health thereby are expertly reviewed in this article. The recent spate of natural disasters has raised awareness of the danger to first responders, health care workers, clean-up personnel and residents of areas damaged by storms from mold and other toxic substances that invariably appear in the aftermath of water damage.

Grace Charles’ piece on her personal experience with stress and fatigue from the rigorous schedule of a medical student addresses the importance of maintaining health for clinicians. Her suggestions for incorporating exercise, meditation and breathing exercises into a busy schedule are worth serious consideration.

Dr. Bayer’s article on the use of HRCOMP and SOAP in conjunction as part of a medical team approach to practice illustrates how coordination of the team in a medical home environment can improve efficiency and enhance comprehensiveness. He adroitly outlines the elements of the HRCOMP process of preparing for the patient interview and presents the process in terms of “lean” practice wherein each member of the clinical team is responsible for only those functions that are appropriate for his/her skills. Achieving greater efficiency and closer coordination have become the standards for effective practice and Dr. Bayer’s article helps place these objectives and the utility of combining the HRCOMP and SOAP processes into perspective.

We hope, as always, that you will enjoy and benefit from this issue of *Family Doctor*. We look forward to hearing from you about this issue and any thoughts you may have for future themes.

Vito Grasso, MPA, CAE, is the Executive Vice President of the New York State Academy of Family Physicians.

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Fellow Family Physicians:

The current overhauling of healthcare delivery in this country is unprecedented. Not only is the delivery system changing, but so are the treatment regimes we use in the exam room. The standards of medical care, previously thought to be ‘sacred cows’, are being reexamined, re-tooled or just simply thrown out. Medications thought to be contraindicated for certain medical conditions during my medical training are now used as quality-of-care indicators.

We have learned over the last few years that public health dilemmas cannot be solved simply by throwing money at the problem. The United States spends more healthcare dollars per capita than any other nation in the world by far. However, morbidity and mortality statistics show the health of our population doesn’t even make it into the top ten. So the pressure is on, not only to provide good comprehensive medical treatment, but also to provide economically responsible treatment.

Our competency as physicians is being measured by surrogate statistical markers and misleading outcome data. In order to survive in this statistical quagmire, we are told we must embrace the computerized management of our charts and business, not as an option, but as a mandate.

So now as private practice physicians we also need to be businessmen, informational technologists, statisticians, economists and politicians. Somewhere in the middle of all this we are supposed to stay current with the medical literature and practice medicine.

So much for the bad news, now for the good news. The good news is that we are family physicians. No other specialty is better trained to handle whatever walks in the front door. There is more good news. Even though we have been doing this for years, society and the politicians are finally starting to realize the leading role that primary care needs to take in order to have an effective healthcare delivery system. There are many examples of this around the world in countries that document a healthier population.

Can you handle one more piece of good news? As family physicians you are not alone. Your state and national academy are willing and able to help you through this maze. The academy is our loudest advocate, our closest ally and our most trustworthy source of information and services.

It is truly an honor to be entrusted with the responsibility of leading our academy as president over the upcoming year. I am optimistically looking forward to the challenges that await us during my term. My goal is to try to ease the growing pains of change that have enveloped us all in medicine.

Raymond L. Ebarb, M.D., FAAFP is the President of the New York State Academy of Family Physicians for 2013-2014.

...The U.S. spends more healthcare dollars per capita than any other nation in the world by far. However, morbidity and mortality statistics show the health of our population doesn’t even make it into the top ten...
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Superstorm Sandy’s ‘second wave’ has already hit many. The media are calling it the “Sandy Cough.” There is a growing concern of adverse health reactions and illnesses encountered in re-occupancy of moldy indoor environments. In particular, the cleaning and restoration of salvaged homes and businesses, and the challenges posed by mold contaminated personal items and building materials may expose unprotected workers and homeowners. What do you throw away and what can you safely restore? Moldy wallboards, carpeting and HVAC system and insulation can be replaced, but if it’s not done right, possible damaged pulmonary, immunologic or even neurologic systems may result.

In response to this urgent need and growing health concerns, the Fungal Research Group Foundation had recently invited an international group of experts to speak to the health care providers and remediation specialists of the storm-ravaged Tri-State Area (New York, New Jersey and Connecticut), and others (www.dampnessmold.com). We have summarized some of the key points from this international group of experts for health care providers:

- What are the health concerns? What have we learned from past floods and public health investigations?
- Exposure assessment: Under what circumstances is testing needed?
- Remediation: The basics of cleanup and remediation—the pros and cons of biocides; review of professional guidelines.
- Public health response and initiatives: emergency response, education, legal issues.
- Special requirements for health care and institutional facilities.

Background: Mold and Fungi

Fungi, often called “mold”, are a heterogeneous group of organisms including true fungi, lichens, yeast, slime and water molds. Ordinarily beneficial in outdoor nature, most “naturally” occurring fungi found growing indoors may be considered a danger to the health of animals or humans depending on concentration and route of exposures. There may be 150 species found airborne indoors to over 600 different species from bulk to dust samples collected...
in water damaged indoor environments. The commonly listed fungi in environmental reports include: Penicillin spp, Aspergillus spp, Cladosporium spp, Rhizopus, Paecilomyces, Aureobasidium, Chaetomium, Stachybotrys chartarum, Trichoderma, etc.) Damp building materials, particularly cellulose-containing substrates, are prone to fungal growth and amplification.

With fungal growth and development, spores are released into the air. Humans maybe exposed to fungi, its fragments or by-products (i.e., allergens, glucans, mycotoxins) by inhalation and to a lesser degree by skin contact or ingestion. Fungi have been associated with allergy and respiratory health such as rhino-sinusitis and asthma, but also with irritant or toxic effects such as skin irritation and other health disorders. Mycotoxins are well known in veterinary medicine and food safety and are regulated in many countries regarding consumption and food content. These mycotoxins have also been explored as a possible risk factor in buildings with mold problems based on non-allergic clinical presentations of sick-building type health complaints\(^1\)\(^-\)\(^3\). Patients describing a “mildew smell” are indicating the presence of microbial volatile organic compounds (MVOCs) that are produced by actively growing fungi. However, the concentrations of MVOC typically found in buildings are not believed to be at directly harmful levels.

Fungi and health

Fungi are known in medicine to be a cause of infections, allergies and irritant-toxic disorders. Symptoms reported by patients are often non-specific and may relate to reactions of the air-ways, skin, mucous membranes or internal organs. Expert reviews of the scientific literature concluded that dampness related fungi are highly associated with allergies, respiratory symptoms or diseases such as asthma and changes of the immunological system\(^4\)\(^\text{-}^6\). There are clinical studies and case reports of adverse health reactions that include non-allergic adverse effects to the lungs: sarcoidosis, infant hemorrhagic lung disease; allergic alveolitis (Hypersensitivity Pneumonitis), neurological system (headaches and cognitive dysfunction), endocrine and reproductive organs (throid hormonal changes and menstrual disorders in women), and rheumatological disorders (joint pain). An increased risk of cancer from fungal exposures has been explored.

Some of the fungi produce chemicals that are known genotoxins and carcinogens, and include (1-3)-β-D-glucan, mycotoxins, and microbial volatile organic compounds (MVOCs) \(^7\)\(^-\)\(^9\)\(^;\)\(^10\)\(^;\)\(^11\)\(^;\)\(^12\)\(^;\)\(^13\)\(^;\)\(^14\)\(^;\)\(^15\)\(^;\)\(^16\). However, these case studies are difficult to document and validate in epidemiological or experimental studies and have therefore been considered debatable by some and further evidence needs to be researched. Also liability and disability claims and special interests of the insurance industry have influenced the debate about causation and attributable risk.

Besides encountering indoor mold conditions in situation like Superstorms Sandy and Katrina, many patients spend up to 90% of their time indoors, where contaminants often are at higher levels than they are in the ambient air due to chronic moisture and leaks. Many buildings in the U.S. and Western Europe have severe dampness problems that result in significant fungal contamination in the indoor environments. Typical health complaints of patients living in moldy indoor environments or workers coming in contact with excessive fungal exposure are listed below.

Typical health complaints after intense mold exposures

- headaches (various types)
- nausea (vomiting)
- severe fatigue and exhaustion (physical and mental)
- burning, irritation and watery eyes
- sore throat and hoarseness
- sneezing or irritant-dry (rarely productive) cough, chest tightness, wheezing
- unusual epistaxis and hemoptysis (rare)
- chest pain and burning, dyspnea
- skin and mucous membrane irritation (hair loss ?)
- congestion or rhinorrhea, epistaxis
- dizziness, concentration and memory problems
- feversish – flu-like reactions

In most cases adverse health reactions are normally of short duration and reversible, provided the exposure has been stopped. However, in some cases the adverse health consequences may be more serious or may be irreversible requiring symptomatic treatment and careful avoidance of microbial triggers. Recognized mold related medical conditions are described below in more detail.

Graph 1: Exposure agents and health outcomes
Supposedly, “acceptable threshold levels” or “normal limits” to indoor mold have been reported, but variations in sampling strategies and methodological limitations make these very unreliable in practical settings. Therefore, the consensus among experts is that acceptable and safe threshold limits for fungal indoor exposure cannot be established and it is generally recommended to avoid or minimize unnecessary fungal indoor exposures.

Infections

Infections caused by fungi are called mycoses and are categorized as endemic or opportunistic. Opportunistic fungal pathogens have public health importance, especially in patients with an altered or weakened immune system, with human immunodeficiency virus (HIV) and those receiving organ transplants. Chronic rhino-sinusitis with eosinophilic inflammation of the airways has been linked to dampness related fungi from indoor environments and maybe related to the development of asthma. Endemic mycoses are related to the geographical distribution of certain fungal pathogens. These types of infection are caused by the inhalation of airborne spores or conidia found in certain regions.

Allergy and respiratory diseases

Fungi are a known cause of allergic and respiratory disease, and have been identified as one of the major indoor allergens. Regrettably, extracts that are available for allergy testing in medical offices often correspond poorly to the fungi found in indoor surveys. Long duration or intense indoor exposure to fungi can result in acute hypersensitivity reaction and chronic diseases. Most people usually tolerate fungi types and levels comparable to outside background conditions. However, as mold species and concentrations that are “atypical” in the indoor environment increase because of water leaks and dampness, the incidence of allergy and respiratory problems also tend to rise with typical allergic symptoms, cough, dyspnea and wheezing.

The reported percentages of the population allergic to molds may vary from 2% to 18%. A high rate of asthmatics is reported to be allergic to molds. Notably, about a third of newly diagnosed asthma was attributable to workplace mold exposure. Patients can be tested for specific mold allergy using skin or serological tests (IgE-RAST, IgG or IgM-antibodies) to study immunological responses. However, due to the low sensitivity of some of the commercially available mold extract tests, false negative results are not uncommon.

Hypersensitivity pneumonitis (HP) and organic dust toxic syndrome (ODTS)

Hypersensitivity pneumonitis (HP), also called extrinsic allergic alveolitis, is a well-recognized occupational disease and fungi are one of the agents causing such interstitial lung disease. The clinical features, biochemistry and patho-physiology of allergic or inflammatory-toxic reactions to airborne microbial exposure are difficult to separate. HP can be caused by fungal exposure at work and indoors. Organic dust toxic syndrome (ODTS), also called toxic pneumonitis, is a non-allergic, non-infectious form of an acute inflammatory lung reaction to high fungal dust exposure. The differences between HP and ODTS may be difficult to distinguish.

Preventive measures have been recommended for occupations primarily in the organic dust industry but also for mold remediation workers by governmental agencies (i.e., the National Institute for Occupational Safety and Health (NIOSH)). Although HP/ODTS is more likely to occur in settings where large amounts of organic dust are present, they may also happen in office and domestic environments during flood and mold remediation. While rare in indoor environments, clinicians should have a high suspicion of HP if respiratory symptoms persist after exposure cessation, with persistent dyspnea and breathings tests suggestive of restrictive airway disease. Abnormal chest x-ray findings with ground-glass appearance and hilar node enlargement have a low sensitivity early on and typically show well into the disease process and development of interstitial lung disease. High resolution chest CT and bronchoscopy with lavage are more sensitive and specific for a HP diagnosis.

Mycotoxins

So-called “black mold” or “toxic mold” is a great concern for many patients. Primary care providers should be aware that there are currently no good and validated laboratory tests available to routinely “test” or measure “toxic mold” in the environment or in a patient’s blood or urine. In spite of this, some laboratories in the US now promote such still meaningless and expensive tests to anxious patients, but among experts these tests are considered unreliable and misleading.
What you should know, briefly: Some fungi produce mycotoxins that may be harmful to animals and humans when ingested, inhaled, or in contact with the skin. Mycotoxin production is fungi specific. Toxigenic fungi found in indoor environments are, for example: certain species of Penicillium and Aspergillus (A. versicolor, A. ochraceus,) Fusarium, Trichoderma, Cephalosporium, Chaetomium, and Stachybotrys. Then again, the actual toxin production (in-vivo) depends on factors such as available nutrients, favorable environmental conditions, the life cycle and the competitive behavior with other fungi present. These environmental conditions are not always present when these molds are identified in environmental reports brought by patients to the doctor's office.

Note: The finding of toxigenic fungi is not an indicator of “toxicity” by itself. Toxic effects in humans have been mostly described and researched in relationship with food borne diseases affecting animals or regional human disease outbreaks. Mycotoxins are important because they have been found to have genotoxic, mutagenic, cytotoxic, carcinogenic, nephrotoxic, pseudo-estrogenic, immuno-suppressive, protein synthesis inhibitor or other toxic properties.

There has been a debate regarding the public health importance of “toxic mold” in enclosed indoor environments and its impact on the occupants’ health. What is clear is that many of the typical health complaints and clinical findings in patients living or working in wet and moldy buildings cannot be explained by allergy alone. Mycotoxins have ciliostatic effects in the respiratory tract, causing diminished mucociliary clearing and local inflammatory effects in the airways and sinuses. In the context of investigating infant hemorrhagic lung diseases with indoor toxigenic Stachybotrys chartarum exposure, experimental research confirmed toxic cell effects that may have clinical implications. Mycotoxins can induce abortions and reproductive abnormalities in animals. Human cases of “mycotoxicosis” appear to be rare. In the medical literature these are mostly related to ingestion of contaminated food/feed products in some geographical areas. However, occupational or environmental inhalation exposures have been described in recent studies. Environmental sentinel investigations in water damaged buildings have shown detectable levels of airborne mycotoxins from Stachybotrys chartarum and others that may be of concern. The potential risk of nasal airway injury and neurotoxicity caused by exposure to water-damaged building and mycotoxins has been recently demonstrated in experimental research with monkeys.

The health care provider should be aware of characteristic symptoms and signs such as extreme fatigue, constant sore throat or skin irritation, headaches, neuromuscular or neuro-cognitive dysfunction, bleeding disorders of the lung in infants, irregular menses, diarrhea, dermatitis and irritation of skin, and impaired immune function. The knowledge of the adverse health effects in animal and human health has led internationally to regulatory efforts to protect humans from excess exposure in food and agricultural products based in many cases on a “precautionary principle”, in part because the data are still limited and definite dose response models have not yet been established for these agents (see also http://www.fao.org/docrep/005/y1390e/y1390e00.htm).

Remediation

It is important to address any moisture or water intrusion immediately since significant mold growth can occur within 48 hours. Drying efforts of water damaged areas should be started as soon as possible. It is advisable to follow current professional guidelines for the identification and remediation of indoor molds. In general, environmental testing for mold is not necessary if visible growth is present. The indoor use of any chemicals (i.e., biocides) is not recommend for the control of fungal growth. Systematic source removal of fungal growth, cleaning with soap and water, followed by HEPA vacuuming should suffice in most cases. For any larger scale projects, remediation workers should be medically cleared and use proper respiratory, skin and eye protection. Several references are available online (from New York City Dept Health, American Industrial Hygiene Association, American Conference of Governmental Industrial Hygienist (AGGHI), EPA http://www.epa.gov/iedmold1/cleanupguidelines.html, IICRC (http://iicrc.org/standards/iicrc-s500/) and NIOSH (DHHS (NIOSH) Publication Number 2013-102).

Conclusion

Indoor fungi (“mold”) are important in public health and worker health prevention. There is consensus among experts that fungi associated with dampness leads to preventable health problems, primarily of the respiratory organs and allergy. Anyone involved in “mold clean-up” should be educated about mold hazards and proper personal protective equipment. Clean-up workers may need to be evaluated and “cleared” for larger scale mold remediation work. In general, the adverse effects of fungal inhalation are related to duration and intensity of exposure and adverse respiratory and allergy reactions.

Human susceptibility and intolerance to fungi vary based on host factors, age and co-morbidity. In most cases diligent exposure cessation and control leads to symptoms reversal and health improvement. In some cases symptomatic treatments with medications are required to control symptoms. Early recognition, preventive building engineering, hygiene and public health interventions can reduce fungal diseases, especially in the institutional or health care facilities. If needed, health care providers should consult with industrial hygienists and remediation experts to improve environmental control and healthy living.
References


Exercise prescription has long been an essential component of the physician's armamentarium to ensure good health. The early Greek physician Hippocrates stated, “eating alone will not keep a man well; he must also take exercise. For food and exercise...work together to produce health.” As more evidence accrued in the 20th century showing a correlation between physical inactivity and many chronic conditions, organizations such as the NIH and CDC began to examine more closely the effects of exercise as medicine. With more and more evidence showing the efficacy of exercise in treating a wide range of conditions, ranging from childhood obesity to fractures in the elderly, exercise prescription is becoming more prevalent.

Obesity has become increasingly prevalent in the US. As of 2010, more than 17% of children in the US were classified as being obese, up from 5% in 1976. In adults, this percentage is even higher, with over one-third of the adult population being obese. The economic costs of obesity are staggering, estimated to be roughly 157 billion dollars in 2008.

Obese children are more likely to suffer from a variety of medical conditions, including metabolic syndrome, cardiovascular disease, joint problems, low self-esteem, and social stigmas, among others. Metabolic syndrome, a constellation of risk factors including insulin resistance, dyslipidemia, hyperglycemia, and hypertension, can lead to diabetes mellitus type 2, cardiovascular disease (CVD), and eventual mortality and morbidity from CVD complications. Children who suffer from metabolic syndrome walk more slowly and take fewer steps during the day. Furthermore, they require more
cardiorespiratory effort to move their body mass.7
To counteract this, exercise has been shown to be helpful in treating obesity.5,6,8 Exercise can promote an increase in HDL, a reduction in glucose and triglyceride levels, and can increase cardiorespiratory endurance. It has also been shown to promote the development of self-esteem in young children in the short-term.9 Exercise may be beneficial in the treatment of anxiety and depression as well.10 Schools have long promoted physical exercise in the form of physical education classes, with positive effects on lifestyle behaviors and physical health status measures, such as decreases in television viewing and increases in physical activity duration.11 Unfortunately, the rise in obesity has been accompanied by a decrease in physical education attendance in the US. The rates of high school students who attended physical education (PE) classes in school decreased from 42% in 1991 to 31% in 2011.12 When stratified into grades, the percentage of students who attend PE classes daily dropped from 41% in 9th grade to only 24% in 12th grade in 2011.12 In elementary school children, less than 4 out of 10 children met activity and screen-time recommendations and older children have been found to be more sedentary.13 This correlates with a higher level of obesity.

With these alarming statistics, increasing recognition has been placed on exercise as a treatment modality in addition to medications and other interventions.

In 2008, the US Health Department issued for the first time physical exercise guidelines for Americans.14 One part focuses on children and adolescents, with the key guidelines as follows:

Children and adolescents should do 60 minutes (1 hour) or more of physical activity daily.

Aerobic: Most of the 60 or more minutes a day should be either moderate- or vigorous-intensity aerobic physical activity, and should include vigorous-intensity physical activity at least 3 days a week.

Muscle-strengthening: As part of their 60 or more minutes of daily physical activity, children and adolescents should include muscle-strengthening physical activity on at least 3 days of the week.

Bone-strengthening: As part of their 60 or more minutes of daily physical activity, children and adolescents should include bone-strengthening physical activity on at least 3 days of the week.

It is important to encourage young people to participate in physical activities that are appropriate for their age, that are enjoyable, and that offer variety.

Other organizations have also issued similar guidelines. In 2011, the American College of Sports Medicine (ACSM) issued a revision of its Position Stand on exercise, which provided updated recommendations for adults, recommending that all healthy adults engage in physical exercise that include cardiorespiratory, resistance, flexibility and neuromotor components.15 A basic exercise prescription can be issued for all children following these guidelines. Further tailoring can be done to address each child’s need and desire for exercise, with age-appropriate and enjoyable activities. One method for codifying exercise prescriptions is to apply the FITT-PRO, which is defined as Frequency, Intensity, Time, Type, and Progression of exercise that patients are to perform (AAFP 2006, ACSM 2011). As there is a wide range of various forms of exercise activity, specific prescriptions can be tailored easily.

The physician must be proactive as patients are more likely to engage in exercise if specifically recommended by physicians (AAFP 2006). Exercise prescriptions are only beneficial if patients choose to participate in them and successful exercise prescription often requires a multi-disciplinary approach, involving collaborations between physicians, patients, and health fitness professionals.15,16,17 Follow up is recommended as with any other medical prescription.18
With fewer than one out of three patients even receiving advice to exercise from their physicians, much less a prescription, the onus is on primary care physicians to add exercise prescription more frequently.17,18 To combat the rising tide of obesity in adolescents then, a simple prescription is often a good first step in helping children avoid the long-term health complications from obesity.

References
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Hyperlipidemia is a major modifiable risk factor for cardiovascular disease. Among young adults, ages 12 to 19 years, 20.3% have abnormal lipids; boys are more likely than girls to have at least one lipid abnormality (24.3% vs. 15.9%, respectively). In this column, I will review new guidelines on screening and management of pediatric hyperlipidemia established by the Expert Panel on Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents, National Heart Lung and Blood Institute, NIH (October 2012).

Hyperlipidemia refers to an elevated concentration of one or more of the measured serum lipid components (total cholesterol [TC], low-density lipid [LDL], high-density lipoprotein [HDL], and triglycerides [TGs]). Lipoproteins are complexes of lipids and proteins essential for transporting cholesterol, TGs, and fat-soluble vitamins.

**Etiology:**
Elevated levels can result from genetically based derangement of lipid metabolism. Primary lipid disorders most commonly seen in children and adolescents are familial combined hyperlipidemia and familial hypercholesterolemia (heterozygous). Secondary causes include obesity, metabolic syndrome, hypothyroidism, diabetes mellitus (type 1 and type 2), polycystic ovary syndrome, juvenile rheumatoid arthritis, chronic renal disease, Kawasaki disease, and hepatitis.

**Risk Factors/High Risk Conditions**
High risk factors and high risk conditions to consider for treatment decisions in children with hyperlipidemia include:
- **Positive family history** of myocardial infarction; angina; coronary artery bypass graft/stent; angioplasty; sudden cardiac death in parent, grandparent, aunt, or uncle (if male at age <55 years and female at age <65 years).

**Laboratory testing**

**Acceptable, Borderline, and High Plasma Lipid, Lipoprotein Concentrations (mg/dL) for Children and Adolescents**

<table>
<thead>
<tr>
<th>Category</th>
<th>Acceptable</th>
<th>Borderline High</th>
<th>High+</th>
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<tbody>
<tr>
<td>TC</td>
<td>&lt;170</td>
<td>170-199</td>
<td>≥200</td>
</tr>
<tr>
<td>LDL-C</td>
<td>&lt;110</td>
<td>110-129</td>
<td>≥130</td>
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<tr>
<td>Non-HDL-C</td>
<td>&lt;120</td>
<td>120-144</td>
<td>≥145</td>
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<tr>
<td>Apo B</td>
<td>&lt;90</td>
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<td>&lt;75</td>
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<td>≥100</td>
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<td>10-19 years</td>
<td>&lt;90</td>
<td>90-129</td>
<td>≥130</td>
</tr>
<tr>
<td>HDL-C</td>
<td>&gt;45</td>
<td>40-45</td>
<td>&lt;40</td>
</tr>
<tr>
<td>ApoA-1</td>
<td>&gt;120</td>
<td>115-120</td>
<td>&lt;115</td>
</tr>
</tbody>
</table>

*Values for plasma lipid and lipoproteins levels are from the National Cholesterol Education Program (NCEP) Expert Panel on Cholesterol Levels in Children. Non-HDL-C values from the Bogalusa Heart Study are equivalent to the NCEP Pediatric Panel cut points for LDL-C. Values for plasma ApoB and ApoA-I are from the National Health and Nutrition Examination Survey III. The cut points for high and borderline represent approximately the 95th and 75th percentiles, respectively. Low cut points for HDL-C represent approximately the 10th percentile.*
• Moderate risk conditions including Kawasaki disease with regressed coronary aneurysms, chronic inflammatory disease (e.g., systemic lupus erythematosus, juvenile rheumatoid arthritis), nephrotic syndrome, and human immunodeficiency virus infection).

Screening
Screening recommendations are provided by the Expert Panel.7

• Birth to 2 years: No lipid screening. (SOR C)
• 2 to 8 years: No routine lipid screening. (SOR B) Measure fasting lipid profile twice, if the family history is positive for elevated cardiovascular risk or the child has a high level risk factor or condition.
• 9 to 11 years: Universal screening with non-fasting lipid profile and calculate non-HDL-C (TC-HDL-C). (SOR B) If non-HDL-C is ≥145 mg/dL and HDL <40 mg/dL, repeat fasting lipid profile twice and obtain average level.
• 12 to 16 years: No routine screening. (SOR B) If new knowledge of positive family history, new risk factor or new high risk condition is identified in the patient, obtain fasting lipid panel (twice and average).
• 17 years to 21 years: Universal screening once in this time period, obtain non-fasting lipid profile and calculate non-HDL–C; if non-HDL–C ≥145 mg/dL, HDL–C <40 mg/dL, obtain fasting lipid panel (twice and average). (SOR B)

Management:

Diet
For children with elevated lipids, diet is recommended as first-line treatment. AAP recommends that all children engage in moderate-to-vigorous physical activity for 1 hour/day and <2 hours/day of sedentary screen time. The Expert Panel accepts the 2010 Dietary Guidelines for Americans (2010 DGA) as appropriate recommendations for diet and nutrition in children 2 years of age and older.

CHILD 1: The Cardiovascular Health Integrated Lifestyle Diet (CHILD 1) is the first stage in dietary change for children with identified dyslipidemia, children with a risk factor/ high-risk medical condition, and children with a positive family history of early cardiovascular disease.

Dietary components: Primary beverage: fat-free unflavored milk; limit/avoid sugar sweetened beverages, encourage water; fat content: Total fat 25-30% of daily kcal/EER; saturated fat 8-10% of daily kcal/EER; avoid trans fat as much as possible; monounsaturated and polyunsaturated fat up to 20% of daily kcal/EER; cholesterol <300 mg/dL; encourage high dietary fiber intake from foods.

CHILD 2-LDL (for high LDL). Dietary components: 25-30% of calories from fat, ≤7% from saturated fat, 10% from monounsaturated fat, <200 mg/day of cholesterol and avoid trans fat as much as possible, plant sterol esters and/or plant stanol esters up to 2 g/day as replacement for usual fat sources can be used after age 2 years in children with FH.

CHILD 2-TG (for high triglycerides) [average fasting levels of TG ≥ 500mg/dL or any single measurement ≥1,000 mg/dL related to a primary hypertriglyceridemia].). Dietary components: 25-30% of calories from fat, ≤7% from saturated fat, 10% from monounsaturated fat; <200 mg/d of cholesterol, avoid trans fat, decrease sugar intake (e.g., no sugar-sweetened beverages), increase dietary fish to increase omega-3 fatty acids.

Medication
Expert Panel recommends decisions regarding the need for medication therapy should be based on the average of results from at least two fasting lipid profiles obtained at least 2 weeks but no more than 12 weeks apart. (SOR C). The goal of LDL-lowering therapy in childhood and adolescence is a LDL–C below the 95th percentile (≤130 mg/dL).

Children Younger Than Age 10 Years
Children < age 10 years should not be treated with a medication unless they have a severe primary hyperlipidemia or a high-risk condition that is associated with serious medical morbidity (homozygous hypercholesterolemia/LDL-C ≥ 400 mg/dL; primary hypertriglyceridemia with TG ≥ 500 mg/dL; positive family history. (Grade C)

Children Ages 10–21 Years
Children with average LDL-C ≥ 250 mg/dL or average TG ≥ 500 mg/dL should be referred directly to a lipid specialist. (Grade B).

Children with lipid abnormalities (other than LDL-C ≥ 250 mg/dL or TG > 500 mg/dL) should be initially managed for 3-6 months, with diet changes (CHILD 1, CHILD 2-LDL or CHILD 2-TG based on specific lipid profile findings). If BMI is ≥ 85th percentile, add increased physical activity, reduced screen time, and calorie restriction. Children at high risk should be considered for initiation of medication. (Grade C)

Treatment for children with severe elevation of LDL-C:
Based on assessment of lipid levels and associated risk factors or risk conditions:

• Children with average LDL-C ≥ 250 mg/dL should be referred directly to a lipid specialist. (Grade B)
• If LDL-C remains ≥ 190 mg/dL after a 6-month trial of lifestyle/diet management (CHILD 1→CHILD 2-LDL) for children ages 10 years and older, statin therapy should be considered. (Grade A)
• If LDL-C remains ≥ 130 mg/dL to < 190 mg/dL in a child age 10 years or older with a negative family history and no high-level or moderate-level risk factor or risk condition, management should continue to focus on diet changes (CHILD 2-LDL) plus weight management if BMI ≥ 85th percentile. Pharmacologic therapy is not generally indicated, but treatment with bile acid sequestrants might be considered, in consultation with a lipid specialist. (Grade B)
• If LDL-C remains ≥ 160 to 189 mg/dL after a trial of lifestyle/diet management (CHILD 1 → CHILD 2- LDL) in a child age 10 years or older with a positive family or at least one high-level risk factor or risk condition or at least two moderate-level risk factors or risk conditions then statin therapy should be considered. (Grade B)

If LDL-C remains ≥ 130 to 159 mg/dL after a trial of lifestyle/diet management (CHILD 1 → CHILD 2- LDL) in a child age 10 years or older with at least two high-level risk factors or risk conditions or at least one high-level risk factor or condition together with at least two moderate-level risk factors or risk conditions then statin therapy should be considered (Grade C).

• For children ages 8 and 9 years with LDL-C persistently ≥ 190 mg/dL after a trial of lifestyle/diet management (CHILD 1 → CHILD 2- LDL), together with positive family history or the presence of at least one high-level risk factor or condition or the presence of at least two moderate-level risk factors or conditions statin therapy might be considered. (Grade B).

Children with elevated TG or elevated non-HDL-C:

• Children with average fasting levels of TG ≥ 500 mg/dL or any single measurement ≥ 1,000 mg/dL related to a primary hypertriglyceridemia should be treated in conjunction with a lipid specialist; the CHILD 2-TG diet should be started and use of fish oil, fibrate, or niacin to prevent pancreatitis should be considered. (Grade D)

• Children with fasting levels of TG ≥ 200 to 499 mg/dL after a trial of lifestyle/diet management with CHILD 1 → CHILD 2-TG, should have non-HDL recalculated and be managed to a goal of < 145 mg/dL. (Grade D)

• Children with fasting levels of TG ≥ 200 to 499 mg/dL, non-HDL > 145 mg/dL, after a trial of lifestyle/diet management with CHILD 1 → CHILD 2-TG and increased fish intake, may be considered for fish oil supplementation. (Grade D)

• Children ≥ 10 years with non-HDL-C levels ≥ 145 mg/dL after the LDL-C goal is achieved may be considered for further intensification of statin therapy or additional therapy with a fibrate or niacin, in conjunction with referral to a lipid specialist. (Grade D).

Statin therapy is recommended as the initial medication for treating children with elevated LDL–C or non-HDL–C levels.

Bile acid sequestrants were the first-line medications recommended in the original NCEP Pediatric Guidelines. The primary adverse effects of the bile acid sequestrants are gastrointestinal including bloating, nausea, diarrhea, and constipation; these significantly affect adherence. NCEP recommends reassessing LDL approximately every 6 weeks until the LDL goal is met, then every 6 to 12 months.

Resource For Providers:


Alia Chauhan, MD, FAAP, is an Assistant Professor at Hofstra North Shore-LIJ School of Medicine and a member of the Faculty of the Family Medicine Residency Program North Shore-LIJ- Southside Hospital.

References

6 Kavey RE, Allada V, Daniels SR, et al; American Heart Association Expert Panel on Population and Prevention Science; American Heart Association Council on Cardiovascular Disease in the Young; American Heart Association Council on Epidemiology and Prevention; American Heart Association Council on Nutrition, Physical Activity and Metabolism; American Heart Association Council on High Blood Pressure Research; American Heart Association Council on Cardiovascular Nursing; American Heart Association Council on the Kidney in Heart Disease; Interdisciplinary Working Group on Quality of Care and Outcomes Research. Cardiovascular risk reduction in high-risk pediatric patients: a scientific statement from the American Heart Association Expert Panel on Population and Prevention Science; the Councils on Cardiovascular Disease in the Young, Epidemiology and Prevention, Nutrition, Physical Activity and Metabolism, High Blood Pressure Research, Cardiovascular Nursing, and the Kidney in Heart Disease; and the Interdisciplinary Working Group on Quality of Care and Outcomes Research: endorsed by the American Academy of Pediatrics. Circulation. 2006;114(24):2710-2738.
New York State is losing the war against obesity because our strategy is weak and unimaginative. It is time to attack this costly and disabling public health threat in more creative and aggressive ways.

Obesity is a pervasive, expensive problem. Sixty percent of New Yorkers are either obese or overweight, and the condition affects all age and ethnic groups. The health care cost of obesity was estimated at $185 billion nationally in 2012, which means New York State could be expending as much as $15 billion per year, and lost productivity could be another $15 billion. Obesity matches and may surpass tobacco in terms of its negative impact on health and consumption of health care dollars. One of the fundamental requirements for control of health care costs in the near future is to lower obesity rates.

Our response to obesity in New York has been neither bold nor effective, nothing like our all-out frontal assault against tobacco. New York State government has expended hundreds of millions of dollars over the past several years on tobacco cessation and prevention programs. It has conducted an aggressive anti-tobacco media campaign. New York has enacted the nation’s highest tax on tobacco. State laws greatly restrict the sites where people can use tobacco. Doctors are reimbursed for helping their Medicaid patients quit. As a result, New York State has one of the lowest tobacco use rates in the nation. But, in contrast, State government has expended much less to fight obesity and enacted few significant legislative actions.

The NYS Academy of Family Physicians advocates a statewide campaign to address obesity that matches the budgetary and legislative scope and magnitude of the anti-tobacco campaign. This campaign must create and use multiple strategies to help our patients reach healthier weights. It must change our culture and promote awareness that achieving healthy weight is a blend of personal responsibility and outside help. We have no choice but to invest money in this enterprise in order to protect health and reduce costs in the future.

What should some of these statewide strategies and investments look like? Consider aggressive media and social marketing techniques, effective weight loss programs that are financially accessible to all who need them, low-calorie meals at schools and restaurants, calorie posting, smaller portions, a statewide ban or limitation on trans fats, reimbursement for doctors to help patients lose weight, provision of affordable medications where indicated, and creation of local advocacy coalitions. An effective tax policy would also be helpful, even though it would be difficult to accomplish.

There are innumerable possibilities for intervention, but more importantly our State needs a coordinated campaign of this magnitude and scope if we are to have a chance at combating obesity. We are facing a scary future of increasing illness and increasing cost. This is no time to be timid.

The Academy actively advocates many of the aforementioned strategies. One of the more effective resources for helping people to lose weight is you, the physician. Thus, one of the most powerful actions you can take to help end the obesity epidemic is to help your patients lose weight. The Academy has created a weight-loss program called Manageable Challenge which is described here and we urge you to incorporate it into your practice.

William Klepack, MD is a family physician in Dryden, NY and was Chair of the NYSAFP Public Health Commission. Ron Rouse is a health care consultant and staff representative on the NYSAFP’s Public Health Commission.
As physicians, we know that most of our adult patients are obese or overweight as are an estimated 60% of New Yorkers. Obesity is one of the deadliest, costliest, and most intractable health problems facing our patients. Many of them want to lose weight, yet most either try and fail or simply never try. We want to help them be successful but often we find what we are doing is not effective. Family doctors are looking for some help.

The standard, conventional approach to losing weight often fails because people who for decades have consumed too much, eaten the wrong foods, and not moved are told they now have to eat less, drop their favorite foods, and start exercising. This “triple challenge” becomes overwhelming and thus people end up doing nothing or failing within a brief period of time. We have come to realize that an entirely different approach is needed if we are to effectively address the obesity epidemic among our patients. We must focus weight loss initially on one, single challenge — consuming fewer calories. Hence, the name “Manageable Challenge.”

**A Single, Manageable Challenge**

Our approach is based on a “calorie deficit” – burning more calories than the number consumed. The body burns some calories for basal metabolism and additional calories to accomplish the work of simple activities (moving about one’s home or office, shopping and doing other easy activities). When people eat fewer calories than what their body needs for these and other purposes, they lose weight. Focusing on helping patients achieve a calorie deficit is less intimidating for the patient than facing the “triple challenge.”

Manageable Challenge does not rely nor insist upon daily exercise or eating all the “right” foods. For many people who want to lose weight this approach is a welcome and refreshing change. Although eating healthy and exercising are laudable lifestyles to adopt, and they do facilitate weight loss, they are not needed to lose weight. Eating “healthy foods” can reduce one’s health risks but can be a very challenging adjustment. Exercise, while beneficial for cardiovascular health, overall well-being, and maintaining weight loss, is not a very efficient way to achieve weight loss. However, we believe that once patients start losing weight by consuming less, their success will motivate them to eat healthier foods and become active, and we will encourage them to do so when the timing is right.

**Set A Realistic Weight-Loss Goal**

Manageable Challenge aims to help patients reach a healthier weight, not necessarily a “perfect” weight, so losing even some weight is great success. In fact, a 5%-10% weight loss will still make patients feel healthier because they will be healthier. Therefore, direct your patients to set goals that are reasonable. Patients should aim to lose 1-2 pounds per week and avoid improbable goals such as losing 10 pounds in 20 days. Discourage your patients from basing their weight-loss goal on some unrealistic beauty goal or what they weighed when they got married or graduated from school. Also, encourage them to be flexible; if, after dieting, they think they cut back too much on their eating, then encourage them to cut back a little less if they are losing weight.

**A Critical Step: Finding One’s Daily Calorie Cap**

A critical step in Manageable Challenge is for patients to start with an estimate of the maximum amount of calories they can consume and still lose 1-2 pounds per week. A person’s calorie cap is a function of age, gender, weight, height, and activity level. For example, with every increase in age by 10 years for males, one’s daily calorie needs decrease by about 100; for females it is about 70. Gender plays a role. Depending on one’s weight and age, females require anywhere from 600 to 1,000 fewer calories than males of the same age and weight.

A heavier person burns more calories for daily activity than a less heavy person; for instance, a 230 pound female needs about 400 fewer calories per day than a 330 pound female. Thus, doctors should continually remind their dieting patients as they lose weight that eventually their calorie expenditure will decrease to where it now equals their reduced calorie intake (what many patients call “getting stuck”). At that new balance point the doctor must explain that the patient’s intake should be tweaked further and the patient must now consume fewer calories; otherwise patients, having reached a plateau in their attempts to lose weight, will become frustrated and possibly give up. Warning patients about this phenomenon before they experience it will help preserve your credibility and avoid patient frustration and premature quitting.

We recommend that males consume no fewer than 1,500 calories per day and no fewer than 1,200 for females. The calorie caps used in Manageable Challenge are based on a widely used formula developed by the National Academy of Science’s Institute of Medicine (see partial Table below; to see full Table, go to http://www.nysafp.org/weightloss/AFP-MC-Patient-Packet.pdf.)

The formula is also used by the US Department of Agriculture and the US Department of Health and Human Services. This formula takes into account gender, age, weight, and height and therefore offers calorie caps that are tailor-made for and recognize individual characteristics, unlike some programs that simply recommend the same or similar caloric intake regardless of patients’ varying characteristics. But no method of estimating calorie caps is
foolproof. The wise physician will take out some verbal “insurance” with his/her patients and tell them that the estimate is just that and will likely need tweaking depending on whether the compliant patient is actually losing weight.

The sample table is based on a widely-used formula developed by the National Academy of Science’s Institute of Medicine. The formula is used by the US Department of Agriculture and the US Department of Health & Human Services.

The Institute of Medicine defines the estimated number of calories a person needs to simply maintain his/her weight as one’s Estimated Energy Requirement (EER). Other terms that have similar meaning include Resting Energy Expenditure or Resting Metabolic Rate. If patients want to lose 1 pound per week they have to consume 3,500 fewer calories each week than their EER. Thus, each day they have to consume an average of 500 fewer calories; if patients want to lose 2 pounds per week, then 7,000 fewer calories per week and an average of 1,000 fewer calories per day. For example, if a person burns 2,700 calories daily to maintain her/his weight – the point at which s/he neither gains nor loses weight – then s/he cannot consume more than 2,200 calories per day to lose one pound per week and 1,700 per day to lose 2 pounds per week.

### Banking Calories

One of the more appealing aspects for helping patients cope with the emotional ordeal of consuming less is the concept of “banking” calories. This tactic enables patients to exceed their Daily Calorie Cap for a special occasion and still lose weight as long as they go below their Daily Calorie Cap on the other days. For example, if a person consumes 150 calories below her/his Calorie Cap for six days, then that person has “banked” an additional 900 calories (6 x 150) that s/he then can consume at the upcoming event and still meet the goal of losing 1 or 2 pounds per week. Similarly, if a patient wants to save up for a special dinner that same night, s/he can eat less during the day. Further, if patients go over their Daily Calorie Cap, they can cut back the next week. The Calorie Log will help patients keep track of their calorie “banking” efforts. While this tactic can be very successful, warn patients about the risky habit of drawing on their credit without replenishing their “account”!

### A Lapse Now and Then

Losing weight is extremely difficult so anticipate that most of your patients occasionally will lapse by exceeding their Daily Calorie Caps. Relapse occurs when several lapses string together. Occasional lapses or a relapse may lead the person to give up and quit the program. Forewarn your patients there is a good chance they will lapse but they should not become discouraged, nor should you as their physician. Instead, you and your patients should realize one of the biggest reasons people do not lose weight is that they consistently undercount the number of calories they consume. A log helps to prevent that. Smart phone apps are very helpful for selected patients.

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### Daily Calorie Cap Chart (for men)

<table>
<thead>
<tr>
<th>STEP 1- My Weight is Closest to:</th>
<th>STEP 2 - Each Week I Want to Lose:</th>
<th>STEP 3- My age is closest to:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 pound</td>
<td>20 25 30 35 40 45 50 55 60 65</td>
</tr>
<tr>
<td>150</td>
<td>1905</td>
<td>1760 1715 1665 1620 1570</td>
</tr>
<tr>
<td></td>
<td>1980</td>
<td>** ** ** ** ** ** ** **</td>
</tr>
<tr>
<td></td>
<td>1905</td>
<td>** ** ** ** ** ** ** **</td>
</tr>
<tr>
<td>160</td>
<td>2050</td>
<td>1880 1835 1785 1740 1690 1645</td>
</tr>
<tr>
<td></td>
<td>**</td>
<td>** ** ** ** ** ** ** **</td>
</tr>
<tr>
<td>170</td>
<td>2100</td>
<td>1810 1765 1715 1670 1625 1580</td>
</tr>
<tr>
<td></td>
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<td>** ** ** ** ** ** ** **</td>
</tr>
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<td>1860 1815 1770 1720 1675 1630</td>
</tr>
<tr>
<td></td>
<td>**</td>
<td>** ** ** ** ** ** ** **</td>
</tr>
<tr>
<td>190</td>
<td>2200</td>
<td>1910 1865 1820 1775 1730 1690</td>
</tr>
<tr>
<td></td>
<td>**</td>
<td>** ** ** ** ** ** ** **</td>
</tr>
<tr>
<td>200</td>
<td>2250</td>
<td>1960 1915 1870 1830 1790 1750</td>
</tr>
<tr>
<td></td>
<td>**</td>
<td>** ** ** ** ** ** ** **</td>
</tr>
</tbody>
</table>
everyone makes mistakes and be prepared to respond positively by “picking oneself up” and re-starting the weight-loss program.

**Recommendations on Billing for Weight-loss Counseling**

Given that, with rare exception, there are no reimbursable codes for obesity counseling and prevention, it is necessary to use an ICD diagnosis code for one of the many obesity related morbidities. Then, an appropriate E/M code (e.g., 99214, 25-minute counseling) should be selected which takes into account the time factors in counseling and coordinating the patient’s care. Meanwhile, the Academy is actively advocating for the creation of unique reimbursement codes for weight-loss counseling and it appears that the Federal Affordable Care Act requires such codes beginning in 2014 for many insurance policies.

**Your Comments on Manageable Challenge**

We are constantly in the process of refining the program. We welcome your suggestions and experiences and ask that you email them to rrouse2272@aol.com.

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**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.

1) **What are the three parts of the typical triple challenge to losing weight?**
   a) Eating healthy  
   b) Banking calories  
   c) Maintaining a Daily Calorie Log  
   d) Exercising  
   e) Consuming less food

2) **The initial focus of Manageable Challenge is to**
   a) Exercise  
   b) Consume less food  
   c) Identify the correct billing code for weight-loss counseling  
   d) Eat healthy

3) **As a realistic goal, how many pounds should a patient lose per week?**
   a) 1-2 pounds per week  
   b) About a pound per day  
   c) About a pound every 2 days  
   d) 1 pound every 2 weeks

4) **If a patient wants to lose one pound per week, then each day the patient should consume how many fewer calories than their Estimated Energy Requirement?**
   a) 200  
   b) 300  
   c) 400  
   d) 500

5) **One of the biggest reasons patients fail to lose weight is they…**
   a) Do not exercise regularly  
   b) Consistently undercount the number of calories they consume  
   c) Do not eat less than 1,200 calories per day  
   d) Use the wrong Daily Calorie Cap

6) **True or False. A person’s daily caloric needs …..**
   a) are not affected by age  
   b) are the same for males and females  
   c) decrease as a person loses weight  
   d) remain the same as they lose weight

7) **True or False. Exercise …**
   a) is a must for losing weight  
   b) is not a very efficient method for losing weight  
   c) aids in maintaining weight loss and improves cardiovascular health

---

To complete the test, go to: nysafp.org>education+events
MANAGEABLE CHALLENGE
DESCRIPTION OF PROGRAM ELEMENTS

The two main components of Manageable Challenge are the Patient Schedule for Office Visits & Telephone Calls and the Patient Packet.

Patient Schedule

We have developed a suggested structure and timeframe for office visits and phone calls to the patient. This document is meant to serve only as a guide. As the practitioner, you may use it as you see fit. Some practitioners will want to conduct several office visits and phone calls while others will want to combine them. Similarly, some practitioners will want to provide individual visits whereas others will prefer group visits. Download the Patient Schedule at http://www.nysafp.org/weightloss/AFP-MC-Patient-Schedule.pdf.

The first office visit focuses on introducing Manageable Challenge to your patient, assessing the nature and extent of her/his weight problem, discussing prior weight loss attempts, and evaluating the patient’s readiness to lose weight. If the patient is prepared to lose weight, the second office visit, which some doctors may choose to combine with the first, focuses on developing a personalized weight-loss plan for the patient. The personalized plan includes setting a weight loss goal, deciding the number of pounds to be lost per week, determining the patient’s Daily Calorie Cap, and explaining how to use various weight-loss tools to ensure success. Subsequent office visits and telephone calls are to determine patient progress, revise the personalized plan if needed, provide encouragement, and choose a new start date if the patient has terminated the plan.

Patient Packet

The Packet explains the program to your patients, but obviously you or your staff will need to answer questions they may have. Some patients will require more time than others to fully understand the program. The Patient Packet also contains tools that will help your patients remain below their Daily Calorie Caps.

First, patients need to know their Estimated Energy Expenditure Requirement (EER). To lose two pounds, they must consume 1,000 fewer calories than their EER. The Patient Packet contains a table that enables patients to find their estimated calorie cap or they can go to the NYSAFP web site to use an automatic calculator http://www.nysafp.org/caloriecap. Again, the table and the automatic calculator provide estimates for their calorie caps. Some people will need more or fewer calories than the number presented. Both the table and the automatic calculator are based on a widely-used formula developed by the National Academy of Science’s Institute of Medicine.

Help In Meeting One’s Daily Calorie Cap

At this point, patients know what their Daily Calorie Cap is. One of the biggest frustrations in losing weight is that people consume more calories than they think. Manageable Challenge provides some tools on how to avoid this mistake.

Calorie Counter Wheel. It is distributed by the NYS Department of Health. It gives people the number of calories for many different foods and snacks. The wheel offers only an “idea” of how many calories are in food items. The actual number of calories may vary, especially if a food item has lots of sauces and dressings. You can ask for up to 10 free wheels by sending an email to our Academy office at Bobbi@nysafp.org or you can directly order several dozen free wheels from the NYS Department of Health at http://www.health.ny.gov/publications/4208 and ask for Item #1225 (Food & Fitness Wheel).

The Visual Portion Guide helps people to more accurately estimate the portion sizes of the food they eat by comparing those portions to common items such as a baseball or a deck of cards.

“Learning to Read Food Labels” teaches people the importance of determining how many calories are in one serving of the particular item they are consuming and the number of servings in the container or carton. This knowledge will help them become sensitive to the fact that eating only one serving may equal 250 calories but eating all three servings contained in the carton means consuming 750 calories.

Daily Calorie Log. Patients must not only use the above tools to count calories but, just as importantly, they need to add up all those calories so they do not go over their daily and weekly calorie caps. Patients only need to keep a log for a while -- perhaps for four weeks -- until they learn to accurately estimate their daily caloric consumption.

Remember: one of the big problems in weight loss is that people eat a lot more than they think so they become frustrated because they are not losing weight. The Daily Calorie Log will keep them on track.

“Banking” Calories. As described in the previous article, “banking” is a tactic that enables patients to exceed their Daily Calorie Caps for a special occasion and still lose weight as long as they go below their Daily Calorie Caps on the other days. The Calorie Log will help patients keep track of their calorie “banking” efforts.

Helpful Tips. The Patient Packet contains over 30 tips to help your patients cope with the daily rigors of dieting and to facilitate their efforts to consume less food.
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ENERGY PLUS
Many forces are coming together to change the way we organize primary care visits. The Patient Centered Medical Home (PCMH) model stresses collaborative team care with an emphasis on care coordination and motivational interviewing through care plans. Studies have analyzed the tasks of primary care physicians (PCP’s), and calculated that 18 hours per day are needed to complete routine preventive and chronic care tasks for an average PCP patient load (1,2). Finally, taking the lead from industry, medical programs have incorporated “Lean” practices, as originally implemented by Toyota manufacturing. One of the tenets of Lean practice is having each worker complete the tasks which are most appropriate to his or her skill level. In the context of medicine, this would mean freeing the physician of duties which another team member could handle more efficiently, thus allowing for “heijunka”, or production of care at an even rate.

In our office we are seeing the team care concept evolve on various fronts, which include daily team huddles and intensive care coordination. With the PCMH as a framework, we employ a part time care coordinator who “preps” the office visits for care discrepancies and gaps in care plans. The care coordinator also prints the hospital census for each of our four local hospitals and sends patient summaries to the hospitals.

Our nurse care manager handles transition issues for hospital discharges, does population management for targeted diseases, and coaches high risk patients. The high risk patients are selected on the basis of recent hospitalizations, gaps in care targets (such as HbA1c), and provider choice.

In addition, we have expanded the role of the medical assistant (MA) to include collection of data, health coaching, patient interviewing, medicine reconciliation, and preventive care assessment.

This work allows the provider to have a rich array of information with which to start an effective interview. The preparatory work falls under the pneumatic of HRCOMP, as described below. After HRCOMP is completed the provider is then able to perform an interview using the traditional SOAP format.

The pneumatic HRCOMP lays out the essential elements which need to be collected for each patient encounter, as follows:

H-Hospital record retrieval.
R-ROS-a mini ROS to assess depression and cardio-respiratory status.
C-Care plan review, as per PCMH standards.
O-Outstanding referrals, labs, imaging.
M-Medicine reconciliation.
P- Preventive care update, including immunizations.

The MA is in charge of ensuring all this information is up to date before the provider starts the interview process. The nurse care manager, or other staff, usually will have already tracked down hospital and referral notes, but the MA will need to confirm they are all up to date. I will flesh out below the components of the HRCOMP visit.

H-Hospital record retrieval. In an ideal world pertinent hospital information would download directly to the medical record, but alas this is often not the case! Our nurse care manager usually procures this information within 60 hours of discharge, so that the MA only has to confirm the retrieval.

R-ROS. We perform a basic ROS on each patient, which screens for depression and cardio-respiratory problems. Any red flags can be followed up with further testing such as a PHQ-9, pulse oximetry, or EKG, all done per protocol before the provider enters the room.

C-Care plans. Care plans are an essential feature of the PCMH. The nurse care manager reviews the need for care plans before each visit, and the MA updates the care plans as needed.

O-Outstanding referrals, labs, and imaging. Outstanding referrals and orders are generally managed by a care manager, but the MA may need to track down further information based on patient responses to our intake form (Figure 1). Incomplete referral, lab, and imaging orders are generally reprinted by our care manager prior to the patient visit.

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M-Medicine reconciliation. Patients do most of this work by bringing their medicines to each visit and reviewing a printed medication list (Figure 2) in the reception or exam areas. The MA then reviews the results as needed, marking discrepancies and highlighting meds that need refills.

P-Preventive care. Preventive care needs, including immunizations, are highlighted in advance by the care manager. Flu shots are administered by the LPN, per office protocol.

In our office the HRCOMP protocol is performed for every scheduled visit, with an attempt to complete most elements for acute visits as well. The “Hub” for this activity is the patient intake form (Figure 1). The care manager generates the intake form which goes through the following iterations;
1. Initially generated by the EHR, with pertinent lab values and overdue preventive care items automatically generated.
2. Reviewed by our care manager, to highlight care gaps and the need for care plans.
3. Continued by the patient on arrival to the office.
4. Completed by the MA when rooming the patient.
5. Reviewed and signed by the main provider of care before entering the exam room.

The main provider thus has an educated patient as well as a comprehensive data base before starting the patient interview process using traditional SOAP methodology.

The HRCOMP-SOAP interview process involves a much more comprehensive medical visit with a great deal more resource utilization than the traditional visit format of 10 or 20 years ago. The process is congruent, however, with team concepts and patient involvement outlined by the PCMH model. It also allows the main provider to conduct the medical interview with greater efficiency, per Lean guidelines.

Regarding resource utilization, the process for one main provider requires about 2 hours per day of care management time and one MA is needed for each provider. On the other hand, having the vital information supplied by the HRCOMP format streamlines the main provider visit. Many of these visits will be billed at a higher level of care than traditional visits. Finally, most certified medical homes receive compensation in various ways for providing more comprehensive care.

In summary, this paper outlines a new approach to medical office visits, using the HRCOMP-SOAP format. This new model ensures a comprehensive, thorough approach to care, using a team model with patient interaction. The team, consisting of a care manager, MA, and provider interact through the use of a patient intake sheet which ensures completeness of care for each medical visit, and allows each team member to participate as is appropriate to his or her training.

References

William Bayer, MD, has been a private family practitioner for over 20 years in downtown Rochester, NY. He attended Harvard Medical School and interned at Highland Family Medicine in Rochester. Currently, he is a Clinical Associate Professor of Family Medicine at URMC which has had NCQA Level III Patient Centered Medical Home status since 2010.
My Personal Exploration into Mind-Body Medicine

By Grace M. Charles, MD

As a recent medical school graduate with a physician for a mother, I had the opportunity to appreciate many of the advances my generation experienced in medical education: recorded lectures, patient simulators, online testing, electronic medical records, and a deeper knowledge of molecular medicine amongst them. One thing that continues to lag, unfortunately, is the support and training of medical students in caring for themselves. It was my own struggle with this, and my mother’s confirmation of the same difficulty during her training, that prompted my exploration of ways to prevent stress and maintain overall health during my years of limited sleep, difficult work, and living in that nebulous state of being a student doctor.

Below I report on some practices I discovered that benefited me during medical school in particular. These practices tend to be included under the umbrella of mind-body medicine, defined by the National Center for Complementary and Alternative Medicine as practices that focus on the interactions among the brain, mind, body, and behavior, with the intent to use the mind to affect physical functioning and promote health. I’ve found them to be useful, and I hope you will, too.

Be Mindful

In the book Search Inside Yourself, based on author Chade-Meng Tan’s mindfulness course he teaches at Google, Tan explains that mindfulness is simply the practice of paying attention moment-to-moment without judging. Thus, he says, it is inherent within us and easy to learn; the difficulty lies in developing it to the point that one can encounter difficult moments with calm and thoughtfulness as well. He recommends two ways of practicing mindfulness: the Easy Way and the Easier Way. In the Easy Way, the practitioner focuses his attention on the breath; if his mind wanders, he gently brings it back to the breath. The Easier Way lacks any agenda; there is no doing, only being, whatever that may mean to the individual practitioner. Tan suggests beginners institute a practice of two minutes of mindfulness each day, so that is what I did. Regular mindfulness practice, as Tan explains, “deepens the inherent calmness and clarity in the mind. It opens up the possibility of fully appreciating each moment in life, every one of which is precious. It is for many people, including myself, a life-changing practice. Imagine—something as simple as learning to just be can change your life.”

I was searching for a practice that would keep me grounded in the moment so I could better appreciate and take advantage of the valuable time I spent with my patients, peers, and teachers. And so my practice of mindfulness began. Every morning, I sat down, set a timer for two minutes, closed my eyes, and would simply “be” until the timer chimed. Starting my day in this way had several personal benefits. For one, it put the day before me into perspective, enabling me to see the many items on my to-do list in the larger context of what I actually was accomplishing with my life. Second of all, it gave me a mental anchoring point. When I found my mind growing tired and restless as the day wore on, I reminded myself of how only hours before I sat and was present in the moment for those two minutes. This enabled me to more easily return to that familiar state of mind no matter what I was doing in the present moment, be it a patient interaction or written exam. Thirdly, since undertaking a regular mindfulness practice, I have observed an increasing emotional maturity that I believe to be largely related to making the effort to be purposefully present in the moment. In particular, during some difficult patient interactions, I have noted the presence of the emotion while maintaining the mental calm to figure out how to best handle the situation at hand.

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Exercise

We all know exercise is good for our bodies. It took a disruption in my normal exercise routine to teach me the extent of what it does for my mind-body wellness. Having practiced yoga and been a gym regular for years, I didn’t have much experience living life without exercise. I learned my lesson the hard way: as my hours of sleep dwindled and exams loomed, I stopped making time for exercise. To give my education my all, I decided to spend all of my time on it. It was to the hospital, home to study, rinse and repeat. This was, in fact, incorrect; devoting all of my time to my medical education ultimately detracted from it. Without exercise, I found my thoughts more scattered, my mood more labile, and my body less strong and in shape, resulting in my feeling more mentally vulnerable as well. In addition, my mind was restless when it came time to study, resulting in less efficient study sessions. I realized that physical activity is a necessary part of my day. At some point continuing to work your mind without giving your body the opportunity to exercise too reaches a point of diminishing returns.

Yoga in particular is a form of exercise I enjoy and recommend. The word yoga is Sanskrit for yoke or union, specifically referring to the integration of the mind and body. The standard practice requires strength, flexibility, and balance, while encouraging students to be present in the moment, to keep the mind clear of unrelated thoughts, and to have an open heart full of wishes for peace, happiness, and liberty for all beings. Yoga also offers practitioners the opportunity to set an intention for their practice or to dedicate it to a specific individual or group of individuals. I often find myself thinking of my clinical duties and how, by learning to have a more open heart through my intentions, I can become better at empathizing with and caring for my patients. Ultimately, my yogic intentions infuse into my approach to everyday life, reminding me to be positive in my dealings with others and to appreciate and be grateful for opportunities to share with, learn from, and care for them. If you are interested in trying yoga or increasing your practice, consider taking a class designed for your skill level at a local studio or getting a DVD so you can practice at your convenience.

Meditate

I used to lose a lot of valuable time in the transition period between arriving home from the hospital and getting anything of significance done at home. I wanted to rest and play but needed to get work done. I found my solution in the form of meditation. The Chopra Center occasionally releases free 21-day meditation challenges. A friend of mine forwarded me an invitation to one such challenge, and I found the 15 minute guided meditations—an inspiring lesson held within each—to give me the opportunity for rest, relaxation, and refocus after returning home from a long day. After that short respite, I felt an improved outlook and was able to get back to work with vigor and positivity. Especially after spending the day working hard in a bright and noisy hospital, I have found it particularly effective to meditate sitting or lying down in the dark and quiet. In addition to the Chopra Center challenges, other sites, including YouTube, offer access to free guided meditations. There are many forms of meditation, including imagery, mantras, walking meditation, body scans, and so on. Experiment and choose what works best for you.

Breathe

Deep breathing has played an important role in all three of my practices mentioned above. In yoga, the breath is synchronized with movement so as to support both the mind and physical body through the flow of poses. A deep inhalation can summon strength for both the mind and body to inspire oneself to hold a difficult pose; a deep exhalation encourages relaxation of the thoughts as well as of tight muscles. In meditation and mindfulness practices, prolonged deep breaths may be the primary focus of the mind or may be used to support the slowing of the whirl of one’s thoughts. In recognition of these benefits, I expanded deep breathing to other areas of my life. Particularly as we know that the breath tends to become more rapid and shallow when times get hectic, slow deep breathing is a great way to counter the body’s excitement and to encourage a return to a state of calm. Therefore, I like to check in with myself every now and then while at work, observing my thoughts and emotions, where I feel tension body, and the quality of my breathing. Then I take a deep breath in and out of my nose: with the inhalation I feel the sequential expansion of my abdomen and then my thorax and with the exhalation their slow release in the opposite direction. This purposeful breathing helps to quiet my mind and release physical tension throughout my body. Check in with yourself periodically throughout the day. If you need a reminder, consider aiming to observe your breathing every hour on the hour and to practice one deep breath at that time, noting how the state of your mind and body changes after the breath.

I encourage you to try each technique and modify them as you like to find what resonates with you. Then you can incorporate into your life the practices that best serve you and share them with your friends, family, patients, and students.
Mindful Practice: Enhancing Quality of Care, Quality of Caring and Resilience

Two separate 4-day workshops designed to improve the quality of care that clinicians provide while improving their own resilience and well-being. For medical practitioners (physicians, NPs, PAs) and others involved in medical practice and education.

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Session I: for those who have not previously attended a mindful practice workshop.

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Course directors: Ronald Epstein MD and Mick Krasner MD
Location/Accommodations: Chapin Mill Retreat Center, Batavia, NY
For Information & Registration: Please call 585-275-4392 or visit the session sites below:
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Maximizing Mental Health Care by Pairing Primary Care Physicians with Mental Health Providers

By Kurt R. Bravata, MD; Christopher Leggett PhD PsyNP; Amir Levine, PhD, LCSW, CASAC; Jose A. Lopez, MD, MPH; Michael McNett, MD; Doug Reich, MD; Jose Tiburcio, MD

Abstract:

General practitioners (GPs) are often the first health care professionals consulted when mentally ill patients seek help. This important role uniquely positions GPs as gatekeepers or points-of-access to the mental health services their patients receive. Because of this, close collaboration between mental health providers and primary care physicians is absolutely essential in order to maximize the scope of mental health care available to patients. This is not to say that primary care physicians should ever abdicate their role in providing mental health care. However, a close marriage between a patient’s primary doctor and mental health provider often results in better outcomes. Still, studies have shown that family practitioners frequently under-use community mental health resources. This may be simply due to a stylistic approach to medical practice or a result of barriers to integrated care. In urban communities it is particularly true that obstacles such as differing cultural values, skewed perceptions, and frustrating language barriers can complicate the ability of a single provider to provide quality mental health care on a comprehensive level. Because of this, it is important for general practitioners and mental health providers to collaborate in order to create a broad safety net of mental health resources for these vulnerable patients.

Editorial

I am a family medicine resident currently in my senior year of residency at Bronx-Lebanon Hospital Center in Bronx, New York. I treat patients with mental health disorders every day. A large percentage of my patients carry diagnoses of bipolar disorder or some other psychiatric malady. However, I would be hard pressed to think of a scenario where I did not rely to some extent on the support of a psychiatrist or other mental health worker to assist in the care of my patients with emotional and psychiatric disorders. The complicated medical management of my patient’s myriad comorbidities is a formidable task by itself without adding to it the responsibility of carrying out the full duties of a psychiatrist. On the other hand, I am sure that my experience is not that much different from many other general practitioners in that I often find myself falling into the role of adjunct behavioral health specialist or counselor.

I believe that one has to be psycho-socially astute to be a good primary care physician. Patients come in a package that includes a body, mind, and yes, spirit, which is a discussion we can save for another day. I take the point of view that true primary care must encompass or at the very least attempt to recognize the integral importance of all three components that make up a human being. However, as a primary care provider, I also understand the need to know the boundaries of my area of expertise. It is one thing to be capable of providing a service, but being proficient in its delivery is another thing altogether. That is why, when it comes to administering psychiatric medication, I often defer to my colleagues who are formally trained in the field of psychiatry.
Primary care is an art as well as a science. It naturally follows that the art of practicing medicine is one that is perfected over time. Because of this, it is perfectly reasonable to assume that a physician who once deferred the bulk of his mental health cases to psychiatrists might with time gradually take on more of that responsibility as his comfort level grew. However, it is my opinion that regardless of the mental health expertise of the general practitioner, it is important to maximize the breath of the safety net of mental health resources available in order to optimize outcomes.

Kurt R. Bravata, M.D.
Resident Physician, Bronx-Lebanon Hospital
AAFP-AMA Resident Fellow Section Delegate
AMA-RFS Sectional Alternate Delegate

"The cornerstone of family medicine is the ability to treat the whole person. Our values and knowledge base are fueled by the biopsychosocial perspective which takes into account the interaction of biological, social, psychological and emotional factors as they interact to form a very unique picture of illness in every patient. Currently, primary care providers are the gate-keepers of patient care and are already the first line of treatment for most patients struggling with mental health conditions. Throughout my years of clinical experience as a behavioral medicine educator and provider I have witnessed time again the way in which family physicians provide compassionate and effective mental health care to the most vulnerable patients struggling with multiple medical and psychological co-morbidities.

It is my clinical opinion that family physicians are perfectly positioned and equipped to diagnose and treat mental health conditions. Furthermore, family physicians cannot afford to "outsource" mental health care as many patients prefer and feel comfortable being treated by their primary care provider. I am hoping that in the future we will ask how to create behavioral health training programs so that family physicians feel empowered to continue to manage mental health care in the most effective ways possible, rather than ask whether primary care physicians should treat mental health conditions. This is the way of the future and we should embrace it."

Amir Levine, Ph.D., LCSW, CASAC

Although a substantial number of patients with mental illness are treated by their primary care providers, often the FP serves as a point of access for specialty mental health services; nevertheless, significant barriers to referrals exist at the patient as well as provider levels. Patient demographics, social stigma, lack of knowledge, and patient and physician

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attitudes influence a person’s chance of accessing adequate mental health care.

Studies have demonstrated that ethnic minorities traditionally receive less care for depression than do white populations. For example, a survey of patients found that immigrants were 60% more likely to have undiagnosed anxiety disorders than natives. Specifically, African-Americans and Hispanics have been found to utilize mental health resources significantly less than non-Hispanic whites, even when accounting for insurance coverage, income, geographic location, employment status and level of education. A number of theories have been suggested to explain this disparity, among them mistrust and suspicion of medical authorities along with perceptions of discrimination. Recent immigrants may be particularly susceptible to emotional imbalances as they are subject to additional psychological strains as a result of their relocation. These new members of society tend to rely primarily on community health centers and public hospitals. Hence primary care facilities end up serving as a health care safety net and, as a result, inner-city populations are much more likely to receive mental health care through primary care providers. Conversely, immigrants are much less likely than natives to use any type of mental health service, including alternative sources such as community leaders, religious groups or alternative medicine practitioners.

Studies have indicated that racial and ethnic minorities tend to have a considerably strong attitude of mistrust towards the medical establishment. Various reasons for this disposition exist, including significantly lower insurance coverage, cultural beliefs surrounding mental health and coping, fear of undocumented status, and unfamiliarity with existing mental health resources.

A long history of stigmatization and rejection of individuals with mental illness plays significantly into how patients view their own mental health. A 2001 report by the Surgeon General on mental health proclaimed stigma as the “most formidable obstacle to future progress in the arena of mental illness and health.” In one study, black women, particularly immigrants, were found to have much higher stigma concerns than their U.S.-born counterparts.

Large-scale epidemiological studies have shown that women are more likely than men to use mental health treatment services. Studies of women seeking treatment for substance abuse have documented increased economic barriers compared to men, resulting in a lower likelihood of seeking treatment.

An analysis of data from the 2005 National Health Interview Survey found that among respondents experiencing significant mental distress, those older than 65 years of age had less contact with a mental health provider and were more likely to report not affording mental health care. Yet, roughly 22% of older adults meet criteria for psychiatric disorders, a prevalence rate similar to that in people younger than 65. The data suggests that despite poor health outcomes and increased health care costs associated with psychiatric disorders in older adults, mental health services are underutilized, and access to assessment and treatment by specialty mental health providers is poor. Fewer than 3% of older adults report seeing a mental health professional for treatment, a rate lower than that of any other adult age group. Instead, older adults tend to seek mental health treatment in primary care.

An investigation by Borowsky, et al., found that mental health disorders were less frequently diagnosed in younger male patients. This may be partly due to parental resistance related to stigmatic misconceptions about mental health care. The unfortunate reality is that studies using structured clinical interviews and parent-completed behavioral rating scales have shown that 11% to 20% of school-age children attending primary care pediatric clinics evidence one or more DSM diagnosable mental health problem.

The quality of primary mental health care seems to vary considerably from one region to another. This may be related to some of the above-mentioned factors, such as social stigma, lack of adequate insurance coverage, and under-diagnosis by PCPs. However, little is known about challenges PCPs face arranging mental health referrals and hospitalizations. Although a variety of community, educational, recreational and voluntary sector resources may be available for patients with psychosocial problems, GPs often under-refer to these programs because of lack of knowledge and time.

Perceived need for care may also influence a patient’s readiness for treatment and utilization of mental health services. Multiple investigations cite patient beliefs that their “problem can be handled without medical intervention”, “treatment is a waste of time”, and a “lack of need” as reasons for...
not seeking mental health services or not showing up to appointments. The result is that patient resistance to referral presents a major barrier to treatment and has been correlated with high rates of missed referral appointments, according to several surveys of PCPs.

Another barrier to successful treatment of mental health disorders is the ability and desire of patients to adhere to the prescribed regimen. Studies have shown that in certain cases the phenomenon of noncompliance may be related to marital status. In general, married patients are less likely to adhere to treatment as well as to receive referrals to specialty care from a PCP.

The high prevalence of psychiatric morbidity in primary care, the growing perception of the need for specialized help by the least severe patients, and the lack of accuracy in referrals, contribute to the increasing overload in mental health services. Patients are much more likely to prefer counseling to medication, yet PCPs' schedules may predispose them towards the latter treatment. Multiple surveys of PCPs have suggested that the reason for this is the lack of time needed for consultation and referral. The extra workload induced by patients with mental health problems may sometimes cause GPs to be reluctant to become involved in a patient's mental health care.

According to some surveys, PCPs have cited perceived inadequacy of training as a barrier to providing appropriate mental health care. It has been proposed that cross-cultural training may be as important as medical expertise in the diagnosis and treatment of psychiatric problems. This lack of capacity to treat mental health disorders, physicians' attitudes towards mental health, failure of communication, and lack of resources impede a patient's ability to receive adequate treatment. The result is a flawed system in which physicians fail to detect mental disorders in approximately half of those patients who present with one.

Physicians who feel burdened by mental health patients, who view their patients as non-compliant, or not ready for psychiatric treatment, are less likely to provide adequate mental health care. The same is true of physicians who lack interest in participating in psychiatric care, believe that treatment of the mentally ill is not part of their job, have low comfort levels with psychiatric illness, or have the perception that medical problems are competing with psychiatric issues. Financial considerations may sway PCPs as well, with inadequate reimbursement of mental health services discouraging physicians from initiating treatment. Studies have also evidenced higher rates of referrals for patients who are viewed as suitable for specialty care and for patients who evoke negative emotional responses in their general provider.

Physical environment may have a profound effect on whether mental illness is properly identified. For example, studies have shown that women living in public housing face a lower likelihood of appropriate diagnosis. This may be primarily related to a number of factors stemming from socio-economic status. Similarly, patient income has been shown to significantly the outcome of patient treatment, as indicated by a national survey in which 54% of respondents reported they were unable to afford psychiatric medications. The availability of transportation and the ability to physically reach clinics or providers have also been cited as significant barriers to care.

Hence, co-location of both primary care and mental health services has been cited as means to improve primary care-mental health collaboration and patient care. The availability of co-location of both primary care and mental health services has been cited as means to improve primary care-mental health collaboration and patient care.

Physician demographics and practice characteristics have also been proposed as factors related to quality of mental health care. For example, studies have documented more frequent referrals by physicians that are males, Caucasians, and more recent medical school graduates. Whereas, pediatricians, solo/small group practices, and private practices are more likely to encounter difficulties in mental health referrals.

The role of the PCP in addressing mental health is important in urban communities plagued by limited resources and a high disease burden. In such communities, poverty and unemployment negatively impact mental health. Poor communication between the referring physician and the specialist is one of the most prominent barriers to mental health care in primary practice, according to several surveys of PCPs. Several surveys point to low satisfaction with mental health providers as a barrier to psychiatric specialty services.

The results of an Ontario study showed that FPs believed their role in delivering mental health services would improve if support were more accessible to them. Bringing providers together in primary care settings is one way to assist FPs in caring for their patients' mental health.

Conclusion

GPs, as the term implies, treat a broad range of comorbidities. In fact, the majority of GPs manage patients with mental health disorders on a daily basis. This dynamic adds complication to the already formidable task of managing medical issues often coinciding within the same patient. Despite this fact, many GPs find themselves taking on the role of adjunct behavioral health specialist or counselor. Others feel perfectly comfortable prescribing psychotropic medications and therefore are less likely to refer their patients to psychiatrists.

At the center of this debate over practice styles is the patient who has taken a leap of faith to put his or her welfare into the hands of the GP. Because of this, there is an ethical imperative to assure that each patient receive comprehensive broad-based care that involves a multidisciplinary team to optimize outcomes. Therefore, GPs should develop healthy streamlined working relationships with their local mental health professionals and should be comfortable calling consults or making referrals to them on a routine basis.
As gatekeepers to the world of medical specialists and mental health services, GPs must be aware of the existing obstacles that may be implicated in preventing patients from receiving adequate mental health care. This starts with the patient-physician relationship which must be based on good communication. One must be careful not to allow personal convenience or stylistic preference to limit the ability of patients to obtain access to the full spectrum of mental health resources available in the community.

In urban communities obstacles such as differing cultural values, skewed perceptions, and frustrating language barriers can complicate the ability of a single provider to provide quality mental health care on a comprehensive level. Because of this, it is important for GPs and mental health providers to collaborate in order to create a broad safety net of mental health resources for these vulnerable patients.

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Michael McNett, MD, is a Primary Care Provider at Bronx-Lebanon Hospital. He is board-certified in Family Medicine and has special expertise in HIV/AIDS and integrative/Chinese medicine. He also subspecializes in transgender medicine and pain management. Doug Reich, MD, is the Chairman of the Bronx-Lebanon Hospital Department of Family Medicine. Jose Tiburcio, MD, is the Residency Director at Bronx-Lebanon Hospital Department of Family Medicine.
New NYSAFP Officers for 2013-2014

President – Raymond L. Ebarb, MD
Raymond L. Ebarb, MD, is a Board Certified Family Physician in private practice for 25 years. He is on the faculty of both SUNY Stony Brook and Hofstra Medical School. He is the Medical Director of the Association of Help for Retarded Children for last 25 years in Bohemia, NY and has served as the Chair of the Family Medicine Department of Southside Hospital in Bay Shore, NY. Dr. Ebarb has been an active member of the NYS Academy for over 20 years. His priorities in the upcoming years will be focusing on the participation of new physicians with the Academy and recruiting medical students to the specialty of Family Medicine.

Dr. Ebarb has special interest in Disaster and Wilderness Medicine. He made two trips to New Orleans for hurricane relief and to Haiti for earthquake relief, attended numerous Western U.S. conferences of the WMS, and enjoys adventure vacations with his wife, Therese and sons Theo and Ray.

President-Elect – Mark Josefski, MD
Mark Josefski, M.D., is a Board Certified Family Physician at the Institute for Family Health, practicing at the Family Health Center of Kingston, in Kingston, NY. He is the former director of the Mid-Hudson Family Residency Program, where he remains as a senior faculty member. He is on the Board of Directors of the Health Alliance of the Hudson Valley in Kingston, where he is Vice President of the Medical Staff. Dr. Josefski has been active with the AAFP, NYSAFP and STFM since 1989; he currently serves on the Operations Commission and Executive Committee.

Dr. Josefski is Clinical Assistant Professor at Albert Einstein College of Medicine and the New York College of Osteopathic Medicine, and serves on the Board of Directors of NYCOMEC. He enjoys playing competitive baseball in the Capital District Men’s Senior Baseball League, and performs with Ars Choralis, a community singing group in Woodstock, N. Y.

Vice President – Tochi Iroku-Malize, MD
Tochi Iroku-Malize MD, MPH, is the Chair of the newly created Family Medicine Department at the Hofstra-North Shore LIJ School of Medicine and the NSLIJ Health System. She is also the Program Director for their Family Medicine Residency Program at Southside Hospital. Dr. Iroku-Malize received her medical education at the University of Nigeria. After completing her residency at Southside Hospital, she obtained an MPH from Columbia University and is board certified in Family Medicine as well as Hospice and Palliative Medicine.

As a hospitalist at Southside Hospital, Dr. Iroku-Malize helped develop the “Hospitalist 101” course for the NSLIJ Health System and she remained an active faculty member in the Family Medicine Residency Program, eventually becoming Associate Director of the program. She obtained a White Belt in Six-Sigma and Core Management Certification in 2008.

Dr. Iroku-Malize was instrumental in revising the AAFP Recommended Curriculum Guidelines for FM Residents. She has presented on numerous topics locally, nationally and internationally.

She has been an active member of the NYSAFP, serving on several commissions including Public Health, Leadership and Education, and as 2008-2009 Chair of the Board of the NYSAFP. Dr. Iroku-Malize has been a representative to the AAFP National Conference of Special Constituencies and is currently a member of the AAFP Commission on Continuing Professional Development.
Treasurer – James Mumford, MD

James M. Mumford, MD, FAAFP, is a board certified Family Physician serving as Vice-Chair and Inpatient Director of the Beth Israel Department of Family Medicine in New York City. Dr. Mumford has been active with the NYSAFP since 2005 and currently serves as NYSAFP Secretary and Chair of the Leadership Commission. Annually Dr. Mumford focuses on developing leadership curriculum for our NY resident members as well as our seasoned members. In addition, he works with his commission to identify the talented NYSAFP up-and-comers to represent NY on the national stage at the National Conference of Special Constituencies. Dr. Mumford is Assistant Professor of the Department of Family and Social Medicine, Albert Einstein College of Medicine. Dr. Mumford sees the integrated use of technology in both the inpatient and outpatient settings as a key factor in health care transformation. He believes Family Physicians are uniquely positioned to navigate these new developments to lead our patients and communities successfully to better health and care delivery.

Secretary – Robert J. Ostrander, MD

Robert J. Ostrander, M.D., FAAFP is a family physician in private practice in rural Yates County in the Finger Lakes since 1986. In addition to his primary work caring for patients, he is an Assistant Professor in the Department of Family Medicine at SUNY Upstate Medical University in Syracuse, where he is part of the University’s Rural Scholars Program and whose students he teaches in a longitudinal program in his practice. 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, and is a member of the ACTion Sheet Workgroup for the American College of Medical Genetics. He also serves on the Governor’s Rural Health Council for the New York State Department of Health. He graduated in 1983 from SUNY Upstate Medical College in Syracuse and completed his Residency in Family Practice at St. Joseph’s Hospital and Health Center in 1986. He enjoys primitive canoe camping and making maple syrup.
## IN THE SPOTLIGHT

### 25 YEAR MEMBERS

<table>
<thead>
<tr>
<th>Name</th>
<th>Location</th>
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<tbody>
<tr>
<td>Sharon A. Alger-Mayer, MD</td>
<td>Latham, NY</td>
</tr>
<tr>
<td>Carmen Adriana Alvarez, MD</td>
<td>Buffalo, NY</td>
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<tr>
<td>Joseph P. Augustine, MD</td>
<td>East Syracuse, NY</td>
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<tr>
<td>Richard J. Bebirian, DO</td>
<td>Massapequa, NY</td>
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<tr>
<td>Allan A. Berger, MD</td>
<td>Great Neck, NY</td>
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<tr>
<td>Holly Bienenstock, DO</td>
<td>Port Washington, NY</td>
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<tr>
<td>Meera S. Boppana, MD</td>
<td>Ozone Park, NY</td>
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<tr>
<td>Randall L. Burchell, MD</td>
<td>Stillwater, NY</td>
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<tr>
<td>Yuk-Wah Ng Chan, MD</td>
<td>Poughkeepsie, NY</td>
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<tr>
<td>Peter J. Christiano, MD</td>
<td>Baldwinsville, NY</td>
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<tr>
<td>Debra Clark, MD</td>
<td>Keesville, NY</td>
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<tr>
<td>Mark Costanza, MD</td>
<td>Amherst, NY</td>
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<tr>
<td>Laurel Ann Dallmeyer, MD</td>
<td>Canandaigua, NY</td>
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<tr>
<td>George F. Davis, MD</td>
<td>Copake, NY</td>
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<tr>
<td>Anthony DiGiovanna, MD</td>
<td>Cortland, NY</td>
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<tr>
<td>Arthur DiNapoli, MD</td>
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<td>Joseph George DiSalvo, MD</td>
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<td>Joseph Dic, DO</td>
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<td>Joan L. Donoghue, MD</td>
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<tr>
<td>Mary D. Driesch, MD</td>
<td>Penn Yan, NY</td>
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<td>Brooke D. Durland, MD</td>
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<td>Bruce Robert Elwell, DO</td>
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<td>Richard L. Farrell, MD</td>
<td>Saratoga Springs, NY</td>
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<tr>
<td>Shawn Fazio, MD</td>
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<td>J. Keith Festa, MD</td>
<td>Marlboro, NY</td>
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<td>Robert Basil Hayes, MD</td>
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<td>Avraham Henoch, MD</td>
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<td>Thomas Hughes, MD</td>
<td>Lockport, NY</td>
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<td>Marc Immerman, MD</td>
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<td>Brian James Izzo, MD</td>
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<td>Raja A. Jaber, MD</td>
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<td>Shelley E. Justa, MD</td>
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<td>Michael Alan Ladinsky, DO</td>
<td>West Islip, NY</td>
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<td>Tat Sum Lee, MD</td>
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<td>Peter M. Liljeberg, MD</td>
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<td>Federica A. Manetti, MD</td>
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<td>Richard E. Mittereder, MD</td>
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<td>Thomas Gyorgy Molnar, MD</td>
<td>Manhasset, NY</td>
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<td>Mark Montera, MD</td>
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<td>John O’Bryan, MD</td>
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<td>Kevin C. Oeffinger, MD</td>
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<td>Frank C. Pedevillano, DO</td>
<td>Poughkeepsie, NY</td>
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<td>Anthony Petracca, MD</td>
<td>Queensbury, NY</td>
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<td>David Frank Pfalzer, MD</td>
<td>Kenmore, NY</td>
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<tr>
<td>Diane W. Piela, DO</td>
<td>Sun City, CA</td>
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<tr>
<td>Gurumukh Singh Raince, MD</td>
<td>Greenlawn, NY</td>
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<tr>
<td>Nancy Colon Sapio, MD</td>
<td>Clifton Park, NY</td>
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<td>Vishnudat Seodat, MD</td>
<td>Aquebogue, NY</td>
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<tr>
<td>Virginia T. Shephard, MD</td>
<td>Hornell, NY</td>
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<tr>
<td>James Ritchie Simcoe, MD</td>
<td>Norwich, NY</td>
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<tr>
<td>Bruce Soloway, MD</td>
<td>New Rochelle, NY</td>
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<tr>
<td>Elizabeth N. Sousa, MD</td>
<td>Pleasantville, NY</td>
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<tr>
<td>Ann Carey Tobin, MD</td>
<td>Delmar, NY</td>
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<tr>
<td>Miriam Therese Vincent, MD, PhD, JD</td>
<td>Valley Stream, NY</td>
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<tr>
<td>Anna Marie Ward, MD</td>
<td>Norwich, NY</td>
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<tr>
<td>George G. Weis, DO</td>
<td>Amsterdam, NY</td>
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<tr>
<td>Ruth Willner, MD</td>
<td>New York, NY</td>
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## 50 YEAR MEMBERS

<table>
<thead>
<tr>
<th>Name</th>
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<tbody>
<tr>
<td>Gerard J. Diesfeld, MD</td>
<td>Arcade, NY</td>
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<tr>
<td>Elio Joseph Ippolito, MD</td>
<td>Tarrytown, NY</td>
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## H. S. SCHOLARSHIP AWARDS

<table>
<thead>
<tr>
<th>Name</th>
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<tbody>
<tr>
<td>Arielle J. Flowers</td>
<td>Gasport, NY</td>
</tr>
<tr>
<td>Rachael Utech</td>
<td>Williamsville, NY</td>
</tr>
</tbody>
</table>

The Student Externship Matching Grant Awards from the AAFP/Foundation and the NYSAFP/Foundation are:

- Lindsey Anne Fuller, a student at Albert Einstein College of Medicine—Mentoring Family Physician is William B. Jordan, Bronx, NY
- Danielle Schenone, a student at SUNY Upstate Medical University—Mentoring Family Physician is Megan Westervelt, DO, Big Flats, NY
The “ups” and “downs” of a staircase recovery often highlight the irregularity of its momentum. In short, three dynamics are playing out:

**Three Primary Reasons:**

1. Stock markets have been choppy and displaying more volatility than earlier in the year with the result being some short-term fade in prices of both value and growth names, including blue chip stocks. The Dow, S&P 500, and NASDAQ as the broader barometers have retreated about 7-10% from recent highs and even the go-to stocks like Johnson & Johnson, IBM, Disney, Proctor & Gamble, and National Grid have pared back. Short-term adjustments are a necessary and normal part of the ebb and flow we have historically experienced in bull runs. Because “straight up” runs can be dangerous, we have found this kind of “back and fill” consolidation to be constructive and healthy… though a little concerning when going through it.

2. With the QE-3 taper talk being a bit abstract and inconclusive, we have seen bond prices pull back too. Some of this is in anticipation of higher interest rates to come and some of this reflects the greater flow of money into stocks. Investor trends have been pro-stocks both for yield and growth and that money has come from money market cash and fixed income sources. Risk is “on” and fewer investors want to stay in cash or bond funds, despite the good yields in the latter. The price retreat in fixed assets corresponds to the emotional pullback we experienced around year end 2012 when the fiscal drama (an unknown) was playing out. Eventual changes to the country’s monetary policy are behind some of the anxiety.

Until the next global shock hits, these assets are looking to level off and stabilize … but the flight to safety will eventually cause prices to come back some as investors who want steady income yield choose to buy them. Some will slightly change allocation and stay put with minor adjustments. Others may make a bigger switch in asset allocation and tolerate more stock risk, but wait on dips to do new buys. All in all, the bull run is still in place but a little more pullback is possible. The bond fund fade is a little disconcerting too but this phenomenon has occurred before and will iron itself out. Nevertheless, even more recently a revised GDP growth figure of 1.8% (down from 2.4%) has called into question the actual strength of the recovery. Although the signals are mixed, we will be here to keep you on a straight path.

3. Global Factors still playing a key role in investor sentiment. A lot to elaborate on here, so I’ll suffice it to say that the dynamics from the Eurozone and Asia are still with us and influencing the outlooks of investors. This anxiety has tended to be fleeting and the intensity seems tied to the severity of the headline news itself.

I certainly don’t want to oversimplify the situation either so feel free to call me at any time. I recognize that generalizations can be helpful summaries but I also like to personalize plans/approaches to your situation. As many of you know this is one of my hallmark beliefs … let’s review the risks and objectives to your satisfaction and react or be prepared to adjust as necessary. This is a “touch base” write-up designed to explain the recent market gyrations and I welcome your questions and feedback.

*co-written with Brendan Callanan

This is one of our typical e-mails to clients (distributed 2-3 times per week). If you would like to talk or consider our investment advisor services please call me at 518-581-0500. We have been in downtown Saratoga Springs for the past 18 years.

Colley Asset Management, Inc.

It is vital to check the economy’s pulse…
Fall In Love with Dairy Again

Do you love the taste of dairy foods, but sometimes feel gassy or bloated after having milk, cheese or yogurt? If so, there are a variety of tips that may help you to enjoy the recommended 3 servings of low-fat or fat-free dairy foods every day – without experiencing pain or embarrassment.

Enjoy Dairy Again with These Tips:

**Sip it.**
Start with a small amount of milk daily and increase slowly over several days or weeks to build your tolerance.

![8oz.](image)

**Try it.**
Opt for low-lactose or lactose-free milk and milk products. They are real milk products--just with lower amounts or zero lactose--provide the same nutrients as regular dairy foods, and they taste great.

![Lactaid Milk](image)

**Stir it.**
Mix milk with other foods, such as soups and cereal; blend with fruit or drink milk with meals. Solid foods help slow digestion and allow the body more time to digest lactose.

![Cereal](image)

**Slice it.**
Top sandwiches or crackers with natural cheeses such as Cheddar, Colby, Monterey Jack, mozzarella and Swiss. These cheeses are low in lactose.

![Cheese](image)

**Spoon it.**
Enjoy easy-to-digest yogurt. The live and active cultures in yogurt help to digest lactose.

![Yogurt](image)


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