Dr. Adrian Wilson installed as 2018 DAFP President

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*NOTE: Material in articles and advertisements does not necessarily express the opinion of the Delaware Academy of Family Physicians. Official policy is formulated by the DAFP Board of Directors and Membership.*
Recently I had the opportunity to represent DAFP at the National Conference of Constituency Leaders in Kansas City, MO. I truly love NCCL (formerly NCSC). NCCL was where I realized that I could have a voice and make an impact within our Academy. In that space, I don't feel out of place. I feel included.

During my time as DAFP President I had to switch from attending NCCL to attend the parallel leadership meeting for state chapter leaders known as the ACLF. For me the difference between the two meetings was striking. No longer was I surrounded with folks who look like me (which is probably an issue in and of itself), but many of the conversations reminded me quickly that my voice, experience, my life as a young minority woman in medicine simply isn't being represented in that room. Perhaps even more striking is that within the homogenous group no one seemed all that bothered about it. Reminded me of the first time I visited our AAFP board room at headquarters and realized there was a whole wall of past presidents and yet not one looked like me. It's true. We have never had a black female president of the AAFP. There has been one black president (Warren Jones 2001), three female doctors (Mary Frank (2004), Lori Heim (2009) and Wanda Filer (2015)) but not one black female president.

I know we envision AAFP (and ourselves) as forward thinking, bold champions of all things including diversity and inclusion. Yet we have members who continue to question the value and utility of the newly formed Center for Diversity and Inclusion and challenge the existence of NCCL. If you need to see it for yourself, check out the stunningly insensitive and unproductive comments our fellow members posted below the news stories about this year's NCCL.

In my opinion the experience of inclusion within in the AAFP depends a lot on your vantage point. For me there are true pockets within our Academy where I truly feel inclusion as the action or state of including or of being included within a group or structure. At other times I feel less included and more like an inclusion. An inclusion is a body or particle recognizably distinct from the substance in which it is embedded (think the flaw in the diamond). Unlike the diamond, I believe our “inclusions” add significant and irreplaceable value. Embracing and supporting one another as an organization will open access to our single greatest source of strength: our diversity.

The majority of this issue of DelFamDoc is dedicated to celebrating our 2018 DAFP Annual Assembly. It was an outstanding day highlighting the variety, breadth and depth of our Delaware Family Physician family. Check out summary articles from a few of the didactics (including a summary of the highly rated Osteopathic Manual Medicine lecture) and there are photos and announcements of the awards winners and newly installed officers and board of directors. Check out the AAFP Resources article to learn more about The EveryONE Project, Physician Health First and MACRA Ready resources.

Enjoy this issue of DelFamDoc. And if you are looking for an opportunity to have your voice heard, we are looking for a few great folks to join the editorial board of DelFamDoc— contact me for more information.
During an acute stroke, every passing second represents brain cells lost – up to 1.9 million every minute.

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This year at the National Conference of Constituency Leaders (NCCL) I heard a number of members expressing frustration about AAFP programs, projects and resources that are available. Below are a few highlights of some key resources available to you!

https://www.aafp.org/patient-care/social-determinants-of-health/everyone-project.html

The vision of the American Academy of Family Physicians (AAFP) is to transform health care to achieve optimal health for everyone. To achieve this, the AAFP is taking a leadership role in addressing diversity and the social determinants of health as they impact individuals, families and communities. To help realize this vision, the AAFP launched The EveryONE Project to help family physicians take action and confront health disparities head on. The EveryONE Project focuses on providing family physicians and their practice teams with education and resources, advocating for health equity, promoting workforce diversity, and collaborating with other disciplines and organizations to advance health equity.


Caring for your patients starts with caring for yourself. Discover the family physician ecosystem, and learn how we are working to improve physician well-being and reverse the trend toward burnout. From the website you can complete a self-check using the Maslach Burnout Inventory, being planning your path to well-being and even register for the Family Physician Health and Well-being Conference Jun 5-8, 2019 in Phoenix, Arizona.


The future of health care is quality and value-based payment. Two payment tracks make up the Quality Payment Program (QPP): the Merit-based Incentive Payment System (MIPS) and the Advanced Alternative Payment Model (APM). Most physicians will start in MIPS. MIPS payment adjustments will apply to all physicians—even employed physicians. Use the AAFP website and resources to learn why and access the top questions to ask your employer so you can understand how your performance will be measured. You can also get answers to the most frequently asked questions, informative video modules explaining the MIPS and APM payment tracks, and a list of the acronyms and definitions associated with MACRA.
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Dr. Savoy announces AAFP Board of Directors run in 2019

The AAFP will return to the City of Brotherly Love and Sisterly Affection in 2019, and when they do, Margot Savoy, MD, MPH, FAAFP will be campaigning for a position on the AAFP Board of Directors. Dr. Savoy is looking forward to the challenge saying “I am so excited for this opportunity to volunteer to serve. I look forward to following in Dr. Jaffe’s footsteps by bringing our voices to the Academy in my own unique way!”
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2018 Annual Assembly

On April 7, 2018 DAFP members gathered at the Chase Center on the Waterfront in Wilmington, DE for the Annual Scientific Assembly. A few of the presentations are summarized in this issue of DelFamDoc, but you can find the slides on the website at http://delfamdoc.org/2018-scientific-assembly/2018-scientific-assembly-handouts/.

During the meeting there were several awards presented and our 2018 officers were installed.

Dr. Megan Warner (right) named 2018 Family Physician of the Year.

Dr. Seema Dattani (left) received the 2018 Presidents Award.

Dr. Margot Savoy (left) was named the 2018 Friend of the DAFP.

Omowunmi Praise Akinruli, MD, FAFP (right) received her AAFP Fellowship.

2018 DAFP Board of directors was installed by AAFP President Dr. Michael Munger.

Dr. Adrian Wilson was installed as 2018 President of the DAFP.
Throughout the day we heard from local family physicians what they love about family medicine and being a family physician.

And we had an excellent day of continuing medical education- both lectures and hands-on!
Quality Insights of Delaware

Quality Insights is the Quality Innovation Network—Quality Improvement Organization (QIN-QIO) for New Jersey, Delaware, Pennsylvania, West Virginia and Louisiana. They are committed to collaborating with physicians to reach the Centers for Medicare & Medicaid Services’ goals of better care, smarter spending, and healthier people.

As a QIN-QIO, Quality Insights focuses exclusively on quality improvement and technical assistance in our five-state Network.

Quality Insights collaborates with patients, providers and stakeholders on multiple, data-driven quality initiatives to improve patient safety, reduce harm, and improve clinical care locally and across the network. They offer skills and assistance in:

- Transforming practice
- Employing lean methodologies
- Assisting with value based purchasing programs
- Developing innovative approaches to quality improvement

Quality Insights offers free learning and networking opportunities, technical assistance and best practice tools and resources in support of data-driven quality initiatives designed to improve patient safety, reduce harm, and positively impact clinical care locally and across the network.

Many of Quality Insights services come in the form of Learning and Action Networks (LAN), peer groups where participants hear from experts and each other, share successes and lessons learned and have access to customized data reports, showing their performance compared to the Network, national averages and more.

Quality Insights has formed LANs to improve cardiac care, diabetes care, and adult vaccination rates and to lower incidences of healthcare acquired conditions, such as pressure ulcers, and inappropriate antibiotic use.

Quality Insights is also offering LANs related to the use of health care technology and quality reporting, and they have formed community coalitions to improve effective communication and coordination of care.

Finally Quality Insights is offering special projects focused on topics such as improving appropriate prescribing and usage of opioids, helping more people take advantage of Medicare’s Annual Wellness Visit, and improving palliative care for patients with heart failure.

For more information about Quality Insights visit their website at https://www.qualityinsights-qin.org/Home.aspx.

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<tr>
<td>Cathy Browning</td>
</tr>
<tr>
<td>RN Project Coordinator</td>
</tr>
<tr>
<td><a href="mailto:cbrowning@qualityinsights.org">cbrowning@qualityinsights.org</a></td>
</tr>
<tr>
<td>800.642.8686, ext 4256</td>
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<tr>
<td><strong>MACRA/MIPS Quality Payment Program</strong></td>
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<td>800.642.8686, ext 4256</td>
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<td><strong>Nursing Home HAC</strong></td>
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<tr>
<td>Elsie Josiah</td>
</tr>
<tr>
<td>RN Project Coordinator</td>
</tr>
<tr>
<td><a href="mailto:ejosiah@qualityinsights.org">ejosiah@qualityinsights.org</a></td>
</tr>
<tr>
<td>877.987.4687, ext 117</td>
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<tr>
<td><strong>Quality Reporting</strong></td>
</tr>
<tr>
<td>Jan Lennon</td>
</tr>
<tr>
<td>Delaware Program Director</td>
</tr>
<tr>
<td><a href="mailto:jlennon@qualityinsights.org">jlennon@qualityinsights.org</a></td>
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<td>877.987.4687, ext 7806</td>
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Andrew Taylor Still, MD, DO founded the American School of Osteopathy now A.T. Still University in Kirksville, Missouri in 1892. Today there are 34 accredited colleges of osteopathic medicine in the United States delivering instruction at 51 teaching locations in 32 states. Osteopathic colleges educate nearly 29,000 future physicians annually. To put that in perspective, that is more than 20 percent of all U.S. medical students. Six of the colleges are public and 28 are private institutions.

There are 4 key tenets in osteopathic medicine philosophy.

1. The body is a unit; the person is a unit of body, mind, and spirit.

2. The body is capable of self-regulation, self-healing, and health maintenance.

3. Structure and function are reciprocally interrelated.

4. Rational treatment is based upon an understanding of the basic principles of body unity, self-regulation, and the interrelationship of structure and function.

Because the curriculum is rooted in a holistic, whole-person approach to medicine it is no surprise that 56 percent of all DOs choose to practice in the primary care disciplines of family practice, general internal medicine, and pediatrics.

Osteopathic Vocabulary for the Allopath

There are five models used in discussion of osteopathic patient care including 1) respiratory-circulatory, 2) biomechanical-structural, 3) metabolic-nutritional, 4) neurological and 5) behavioral-biopsychosocial.

Osteopathic manipulative treatment (OMT) or Osteopathic manual medicine (OMM) refer to comprehensive systems of diagnosis and treatment. These systems can include a wide range of techniques that are classified as being direct, indirect or combined depending on whether force is being applied toward or away from the restrictive barrier. Table 1 explains more detail about barriers to motion.

There are seven care modalities or treatment systems in osteopathic manual medicine including 1) counterstrain, 2) high velocity, low amplitude (HVLA), 3) lymphatic, 4) muscle energy (ME), 5) myofascial release, 6) osteopathy in the cranial field, and 7) soft tissue. Table 2 lists some common examples of OMM modalities. Techniques are those methods used within a particular treatment system and include examples such as lumbar rolls, rib-raising, etc.
Table 2. Examples of Common OMM Modalities

<table>
<thead>
<tr>
<th>Counterstrain</th>
<th>Identification of tender points</th>
</tr>
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<tbody>
<tr>
<td>Muscle Energy</td>
<td>• Restricted range of motion</td>
</tr>
<tr>
<td></td>
<td>• Toning</td>
</tr>
<tr>
<td>Balanced Ligamentous</td>
<td>• Usually involving joints and</td>
</tr>
<tr>
<td>Tension</td>
<td>the disruption of the balance</td>
</tr>
<tr>
<td></td>
<td>of ligaments surrounding them</td>
</tr>
<tr>
<td>High Velocity Low</td>
<td>• Engage a restrictive barrier</td>
</tr>
<tr>
<td>Amplitude</td>
<td>and move through it</td>
</tr>
<tr>
<td>Myofascial Release</td>
<td>• Release of tension through the</td>
</tr>
<tr>
<td></td>
<td>fascial layer</td>
</tr>
<tr>
<td>Soft Tissue</td>
<td>• Increase range of motion</td>
</tr>
<tr>
<td></td>
<td>• Increase mobility</td>
</tr>
<tr>
<td>Lymphatic Drainage</td>
<td>• Increase lymphatic flow and</td>
</tr>
<tr>
<td></td>
<td>drainage</td>
</tr>
<tr>
<td></td>
<td>• Vulnerable to fascial disruptions</td>
</tr>
<tr>
<td>Cranial Osteopathy</td>
<td>• Working through dysfunction</td>
</tr>
<tr>
<td></td>
<td>through the cranium</td>
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Beyond the Back

One key take home from Dr. Rapacciuolo presentation was that while OMM/OMT are wonderful for the management and treatment of back pain, there are a wide range of other issues often overlooked by referring allopaths. Some examples included Sinusitis/URI/Otitis Media, GERD, Headaches, TMJ Dysfunction, COPD, Asthma, CHF and Constipation.

References


Joint pain is a common complaint to family physician offices accounting for approximately 2.5% of all visits to family physicians for acute sprains and strains and 1.8% of visits for degenerative joint disease. As you approach the patient with joint pain there are three initial considerations which can help guide your work-up.

1. Is this a mechanical injury or an inflammatory reaction?
2. Is this a joint issue or a non-articular soft tissue syndrome?
3. Is there a single or multiple joints involved?

**Acute Monoarthritis**

Typically acute monoarthritis is an inflammation in one joint indicated by swelling, tenderness and warmth. Occasionally polyarticular diseases like rheumatoid arthritis, sarcoid, viral, enteropathic and psoriatic arthritis) can present with a single joint and later progress to resemble a more traditional presentation. The most critical diagnoses to consider and rule out is an acute infection. A summary of the differential diagnoses for monoarticular disease is presented in table 1.

### Table 1. Monoarticular Differential Diagnosis

<table>
<thead>
<tr>
<th>Common</th>
<th>Less Common</th>
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<tr>
<td>Osteoarthritis</td>
<td>Rheumatologic</td>
</tr>
<tr>
<td>Crystals (Gout)</td>
<td>Ankylosing spondylitis</td>
</tr>
<tr>
<td>Trauma</td>
<td>JRA</td>
</tr>
<tr>
<td>Infectious</td>
<td>Psoriatic arthritis</td>
</tr>
<tr>
<td>Septic</td>
<td>Reactive arthritis</td>
</tr>
<tr>
<td>Viral</td>
<td>Sarcoidosis</td>
</tr>
<tr>
<td>Neoplastic</td>
<td>SLE</td>
</tr>
<tr>
<td>Overuse</td>
<td>Hemoglobinopathies</td>
</tr>
</tbody>
</table>

**Symmetric Polyarthritis**

There are a number of symmetric polyarthritides as shown in table 2.

### Table 2. Symmetric Polyarthritis Differential Diagnosis

- Rheumatoid Arthritis
- Lupus
- Psoriatic Osteoarthritis
- Scleroderma
- PMR
- Lyme Disease
- CPPD (pseudogout)
- Sarcoid
- Spondyloarthropathy

### Table 3. Extra-Articular Manifestations of RA

- Neuropathy
- Pleural effusion
- Interstitial lung disease
- Pulmonary nodules
- Rheumatoid nodules
- Vasculitis
- *Accelerated CAD*
- Pericarditis
- Scleritis
- Keratoconjunctivitis
- Ulcerative keratitis
- Amyloidosis
- Splenomegaly

Diagnosing rheumatoid arthritis is mainly a clinical diagnosis supported by appropriate lab studies. The criteria are fairly straightforward and based on a point system. Every patient with six or more points is unequivocally positive for RA. You could also diagnose a patient who have symptoms in one or more joint with clinical synovitis not explained by another diagnosis. The four areas considered in RA diagnosis include the number of affected joints, serology, acute phase reactants and duration of symptoms lasting six or more weeks. Rheumatoid joint erosions are most specific to RA diagnosis but the patient may also have a high ESR, positive ANA and positive rheumatoid factor.

Disease modifying anti-rheumatic drugs are the main treatment for RA, and they should be use early in the diagnosis. DMARDS
Osteoarthritis

Osteoarthritis is a chronic joint disorder in which there is progressive softening and disintegration of articular cartilage accompanied by new growth of cartilage and bone at the joint margins (osteoophytes) and capsular fibrosis. It can be primary (idiopathic) or secondary to some other condition (eg. Postraumatic, childhood anatomic abnormality, metabolic, neuropathic, endocrinopathy, Paget’s, gout, septic arthritis). Osteoarthritis is often noted for its lack of systemic findings including only minimal articular inflammation. Typically patients will describe an insidious onset of an aching or burning sensation with transient stiffness in the hands and large weight-bearing joints. In the hands usually the DIP and PIP joints will be affected often sparing the wrist and MCP. On x-ray you will find joint space narrowing, subchondral sclerosis, osteophytes and occasionally cysts.

Medical management of osteoarthritis is multimodal including medications (NSAIDS, acetaminophen), walking aides (canes, walkers), weight loss, physiotherapy (especially aquatherapy) and possibly local injections like steroids or hylanuronic acid.

Spondyloarthropathies

Spondyloarthropathies are chronic inflammatory rheumatic diseases that cause arthritis and involve the sites where ligaments and tendons attach to bones called “entheses.” There are two major presentations including inflammation causing pain and stiffness, most often of the spine and bone destruction causing deformities of the spine and poor function of the shoulders and hips. The major spondyloarthropathies include Ankylosing spondylitis, Reactive arthritis (formerly known as Reiter’s syndrome), Psoriatic arthritis, Inflammatory bowel disease-associated spondyloarthropathy and Undifferentiated spondyloarthropathy. Some key clinical recommendations for managing patients include:

- Use clinical criteria supported by laboratory tests, synovial fluid analysis, and radiographs help to establish the presence of spondyloarthropathies.
- Initial management begins with NSAIDs.
- Sulfasalazine (Azulfidine) may be an effective second-line agent that provides short-term relief.
- DMARDs such as etanercept (Enbrel) and infliximab (Remicade) are effective in treating inflammatory symptoms.
- Despite the possibility of a bacterial etiology in reactive arthritis, antibiotic therapy has been ineffective.
- Second-line treatment of psoriatic arthritis (after NSAIDs) includes systemic corticosteroids, methotrexate, sulfasalazine, cyclosporine, and tumor necrosis factor-α inhibitors.

References

3 year old female presents to the emergency room with a swollen right second digit and limping due to pain in her right leg. Two weeks prior, she was diagnosed with Group A streptococcal pharyngitis (confirmed rapid strep test), and treated with 10 days of amoxicillin. Parents report that the patient has difficulty running around and getting on and off of the couch because of pain. In the Emergency room, the patient is afebrile and basic laboratory studies including CBC and BMP are within normal limits. Exam reveals a tender, non-erythematous effusion of the right knee and a uniformly swollen second digit.

A swollen joint in a child may not be a common occurrence in your office. This office visit may cause some anxiety as you attempt to remember a broad differential. We highlight this case to review the 4 most common causes of swollen joints in children. We hope that the next time this case presents your office, you feel more confident with your evaluation and diagnosis.

The first thing to think about when evaluating a child with a swollen joint is the clinical history. If the subjective information includes history of recent sore-throat or viral illness, start to consider either reactive arthritis or acute rheumatic fever (ARF). Reactive arthritis can occur after any viral illness, whereas ARF will occur after Group A Streptococcal (GAS) infection. Joint swelling in reactive arthritis can occur days to weeks after an infection. ARF commonly takes 2-4 weeks to present. Another clinical scenario to consider is one that involves exposure to ticks. If a patient has been in an area with woods or tall grass, Lyme Disease should be on the differential. Finally, with Juvenile Idiopathic Arthritis (JIA), the history may not include a recent illness or insect exposure, and the swollen joint(s) may be described as “coming up out of the blue.” A family history of polyarthritis may or may not be present in JIA. The age of onset peaks from 1-3, with a smaller peak from age 8-10 in the case of juvenile rheumatoid arthritis. Other specific types of JIA have slight variation in age of presentation.

The physical exam of the child may or may not be helpful when determining the etiology of the swollen joint. Lyme disease will usually present with mono- or oligoarticular arthritis, but the knee will typically be involved. JIA can involve various joints based on subtype. ARF is distinguished by a presentation with migratory arthritis. Reactive Arthritis may present in multiple joints, however, swelling typically occurs in the lower extremities.
In terms of testing, the diagnosis of ARF can be supported by a positive GAS rapid test at the time of initial illness. Anti-strep antibodies can also be helpful. Lyme disease can be suspected with positive Lyme titers. The false-positive rate can be quite high with this test, and therefore, a confirmatory western blot should be obtained. Finally, ESR/CRP can be helpful in the diagnosis of reactive arthritis or JIA. In these cases, clinical context is crucial.

The differential diagnosis of the swollen joint in a child can be broad. A thorough history and physical exam can be very helpful in narrowing the list of possibilities, and can lead to the proper treatment and care of the patient.

*JIA is a composite term that includes Juvenile Rheumatoid Arthritis (former term), as well as several other types of juvenile arthritis: Systemic arthritis, Polyarthritis, Oligoarthritis (persistent and extended), Enthesitis-related arthritis, Psoriatic arthritis. See the International League of Associations for Rheumatology (ILAR) guidelines for more information. [6]

**References:**


Malignant Bowel Obstruction

Victoria Atchinson, PA & John J. Goodill, M.D., FACP, FCCP
Christiana Care Pain and Palliative Care Section

Case presentation

JS is a 55 yr old male who presented with 1 week of intractable nausea and vomiting. He had a history of a proctocolectomy for ulcerative colitis in the past. He subsequently had a small bowel obstruction thought to be due to crohn’s disease leading to an ileostomy. Last year he was found to have large volume acites and abdominal carcinomatosis due to advanced stage Gastric or colon cancer. He had been undergoing chemotherapy with TPN support. He also had recently been treated for a RLQ abscess with pigtail catheter drainage and antibiotics. He complained of abdominal pain and shortness of breath. On exam he appeared chronically ill, thin. His abdomen was distended and he had a catheter coming from his RLQ and an ileostomy in his LLQ. CT of his abdomen showed partial SBO with extensive peritoneal metastases. The patient refused an NG tube. He was started on dexamethasone, Zofran and morphine. Reglan was also added. He had only occasional vomiting with this regimen. IV fluids were given for slightly elevated BUN/cr.

Epidemiology: Malignant bowel obstruction (MBO) is a fairly common oncologic complication, with a global prevalence estimated to range from 3% to 15% of cancer patients. MBO is most commonly seen in ovarian cancer, reaching 20-50% of patients, and 10-29% of patients with colon cancer.1 MBO also occurs with other abdominal cancer (gastric and pancreatic) as well as non-abdominal malignancies.2 There is a predominance of MBO in relation to gender, with an estimation that 64% of patients are female due to the high incidence of this complication in ovarian cancers. The mean age of patients who present with this diagnosis is 61 years of age, and the average time from the initial diagnosis of cancer to a MBO complication is approximately 14 months.3 This complication may be handled through invasive treatment options or medical management, although about 36% of patients with inoperable MBO have spontaneous resolution. However, the rate of recurrent obstruction in this group of patients is higher than 60%, and for patients with inoperable MBO, the mean rate of survival is 4-5 weeks. The six month life expectancy is approximately 50% in patients who undergo surgery, and is 8% in patients with inoperable MBO.1 When this complication is diagnosed at an earlier stage of the disease, palliative surgery is still an option in most cases and may offer a better survival for patients.

Clinical Manifestations: The etiology of a malignant bowel obstruction can be varied; it may be due to intraluminal or extraluminal tumor growth related to the cancer itself, the cancer treatment, such as radiation enteritis, or benign etiologies such as adhesions or internal hernias.2 The most common symptoms associated with this complication include nausea, vomiting, and colicky abdominal pain. Symptomatology will vary based on the level of the obstruction, small bowel versus distal colon, and may also vary based on whether there is a partial or a complete obstruction. A complete obstruction may present with symptoms of obstipation, an inability to defecate or pass flatus whereas a partial obstruction may present with diarrhea and fecal incontinence.3 With a gastric or proximal small bowel obstruction, a patient may present with intermittent, periumbilical pain, anorexia, and bilious or watery large volume emesis. For a more distal small bowel or large bowel obstruction, clinical presentation is often characterized by the presence of abdominal distension, small volume and foul smelling emesis, a complete lack of emesis, and deep, crampy visceral pain.4
**Diagnostic Evaluation:** The physical exam findings consistent with a MBO include a distended, tender abdomen with or without a palpable mass. For patients with a history of known cancer, the diagnostic workup is performed to confirm the diagnosis and level of obstruction, but also to “assess tumor burden, which may influence the goals of care,” for depending upon the extent of disease spread, many patients will not be candidates for aggressive surgical treatments. The initial study of choice due to its wide availability and low cost is a plain abdominal radiography, with supine and nondependent films. This study has a high sensitivity for small bowel obstructions, which is characterized by bowel distension and at least two air fluid levels. A large bowel obstruction is characterized by the presence of a dilated colon proximal and no air distal to the obstruction. An abdominopelvic computed tomography (CT) can provide more clinically relevant information that may impact management, for it can more readily localize the site of the obstruction, the degree of obstruction, and identify the presence of a closed-loop obstruction as well as ischemia or perforation of the involved bowel. Overall, a CT scan is considered the best diagnostic modality for determining which patients may benefit from immediate surgical intervention versus conservative management. A CT of a partial obstruction of the small bowel may demonstrate a delay in the passage of contrast, whereas a complete obstruction is diagnosed when there is no passage of contrast beyond the point of obstruction. A large bowel obstruction is characterized by a dilated large bowel proximal to a transition point with decompressed bowel distal to the obstruction. While a CT scan is performed more quickly, an abdominopelvic magnetic resonance imaging (MRI) may be of benefit to make a diagnosis in select patients, and can more readily detect peritoneal and hepatic disease. Aside from radiographic studies, it is important to also obtain laboratory evaluations to determine the presence of metabolic derangements, such as acidosis or renal injury. The presence of extreme leukocytosis or lactic acidosis may suggest bowel ischemia. In patients with ovarian and colorectal cancer, there may be some benefit in checking serum tumor markers such as cancer antigen 125 for ovarian cancer and carcinoembryonic antigen for colorectal cancer to help clarify tumor burden.

**Management:** Once the diagnosis of MBO has been confirmed, management may include palliative care as well as medical or surgical management. Invasive surgical approaches may be considered in all patients except those who are actively dying. Medical management has a lower short-term mortality and may be associated with incomplete resolution or recurrence of the obstruction. The goals of treatment overall should include the relieving of nausea and vomiting, allowing for oral intake, alleviating pain, and permitting the patient to return to their chosen care setting. Even in the case of surgical emergencies, a nonoperative approach may be preferred if the patient’s overall disease prognosis or goals of care are inconsistent with aggressive measures.

**Medical management of MBO:** For patients who are not candidates for surgery, options include placement of a self-expanding colorectal stent, decompression using a nasogastric (NG) or endoscopically placed gastrostomy tube. In the short term, a self-expanding stent is successful in over 90% in the short term, and is predominantly used for left sided lesions. The indications for stent placement in patients with malignant colonic obstructions include: palliation of a surgically incurable colorectal cancer, to serve as a bridge to surgery to allow for clinical improvement, and management of patients with extracolonic pelvic tumors such as ovarian cancer, which are causing extrinsic compression. Patients with stent placement had a lower 30-day mortality rate, however, potential risks include perforation, stent migration, or re-occlusion. For temporary decompression, an NG tube can help remove large amounts of secretions and reduce nausea, vomiting, and pain. However, this is not to be considered for long term drainage due to the risks of nasal cartilage erosion, otitis media, aspiration pneumonia, esophagitis, and bleeding. A percutaneous endoscopic gastrostomy (PEG) tube placement may aid in managing the symptoms of nausea and vomiting, especially in patients with upper gastrointestinal obstructions. This option may be considered in the setting of patient preferences to allow for the possibility of intermittent oral intake, the availability and cost of drugs, or unacceptable side effects from pharmacologic management.

**Pharmacologic Management:** For most patients with inoperable MBO, treatment with opioids and anti-emetics, usually a dopamine antagonist such as Haloperidol, may aid in relieving symptoms of nausea and vomiting. Another option is the use of somatostatin analogs, such as Octreotide, which inhibit the secretion of GH, TSH, ACTH, and prolactin, decrease the release of gastrin, CCK, insulin, glucagon, gastric acid, and pancreatic enzymes. They also may inhibit neurotransmission in the peripheral nerves of the GI tract and can aid in decreasing peristalsis and splanchnic blood flow.
In patients with an incomplete and early MBO, a combination of drugs with different mechanisms may aid in alleviating gastrointestinal symptoms and reverse malignant bowel obstruction, including metoclopramide, octreotide, and dexamethasone.\(^7\)

**Surgical Candidates:** After an initial surgical evaluation, it is estimated that between 6-50% of cancer patients with a MBO are considered inoperable. For patients with imaging evidence of residual primary or recurrent tumor, peritoneal disease (carcinomatosis), multiple sites of disease, ascites, hypoalbuminemia, age greater than 65 years old, and poor performance status are considered to be poor surgical candidates. The most frequent reasons why many patients are deemed inoperable include extensive tumor spread, multiple partial obstructions, and inability to correct obstructions surgically.

**Surgical techniques:** In general, a bowel resection with anastomosis or internal bypass is preferred over a diverting ileostomy due to the fact that the latter may be associated with high volume output, dehydration, and electrolyte imbalance due to a proximal location. If a complete surgical resection of the tumor with negative margins is possible, then this is the more desirable option, however, a debulking of a tumor has been shown to have limited benefit since it is likely to grow back. However, an exception is in ovarian cancer, where initial cytoreductive surgery has demonstrated a survival benefit when combined with chemotherapy.\(^7\) A bowel resection offers patients a better overall survival and fewer complications when compared to intestinal bypass, although these outcomes may be skewed by the burden and location of disease.

If there is healthy bowel both proximal and distal to the site of obstruction, a side-to-side intestinal bypass may be performed to restore bowel continuity and allow the patient to resume oral nutrition. Patients undergoing bypass treatment were more likely to have peritoneal carcinomatosis or extensive intraabdominal disease with multiple levels of obstruction, which may contribute to a poor prognosis and higher rates of mortality and morbidity.

In the case of an unresectable small bowel obstruction, an ileostomy may be created from the most distal unaffected segment of bowel to relieve the obstruction, maintaining a minimum of 100 cm of small intestine in order to allow for adequate nutrient absorption. However, a proximal ileostomy may be associated with high outputs, and can result in dehydration and electrolyte imbalance.

In some cancer patients whom have had previous abdominal surgery, they may experience bowel obstructions due to benign etiologies such as adhesions. In these patients, the obstruction may be relieved by adhesiolysis without any bowel resection, bypass, or diversion.\(^3\)

In the case of patients who present acutely with a cancer-related colorectal obstruction, a temporary diverting colostomy may serve as a bridge to definitive surgery. Another alternative may be a self-expanding metallic stent to relieve the obstruction and permit definitive surgery once the patient has been optimized.\(^3\)

**Followup on case/outcome**

Follow up:

Goals of care were discussed with pt and his family. The nausea/vomiting were identified as the most distressing thing. They agreed to a DNR/DNI and
also were willing to consider a PEG tube for decompression and stomach drainage to relieve vomiting. The plan was to transition to hospice after placement of the tube. PEG tube was placed by IR under MAC anesthesia. Unfortunately the patient had an aspiration event post op after which he developed agitation/desaturation. An RRT was called. He was treated with IV Haldol for the agitation and subsequently started on a morphine drip. He was transitioned to hospice and became more unresponsive and went on to die comfortably within the next 24 hours.

References:
Quadruple Aim FAIL Diary: How to Sabotage Your Physician Wellness Program From the Start

Dike Drummond MD | CEO TheHappyMD.com

Healthcare’s new Quadruple Aim recognizes happy, healthy patients can only come from happy healthy doctors. Quadruple Aim leaders understand that taking better care of your doctors is mandatory for successful organizations in the future.

If you are a quadruple aim leader and step up to the plate to launch a wellness intervention of any kind -- BE VERY CAREFUL ABOUT YOUR NEXT DECISION!

90% of physician leaders fall into a blind spot our leadership skill set and sabotage their wellness programs from the start. Don’t let this be you.

Even the best of intentions will fail if you don’t understand this physician-specific blind spot before you launch your project.

In this article – let me show you three key learning points critical to the success of any physician wellness project.

• This physician leadership blind spot
• The decision that will sabotage even your best intentions – and how to avoid it
• A case study of a Mindfulness Program FAIL that illustrates this concept perfectly

The Invisible Fork in the Road

When you and your leadership team finally make the decision to do something about burnout – you will be standing at the most important decision point for the whole project. Unfortunately this decision point is rendered invisible to almost all physicians because of the programming of our medical education.

Here’s that choice: Do it TO the physicians OR Do it WITH the physicians.

If you make the wrong choice ... even a Mindfulness Program can blow up on you. I will give you an example of just such a FAIL at the end of this post.

First, let me show you your programming

Realize that physicians make naturally lousy leaders when it comes to running projects - like your wellness program - for a simple reason. Our default leadership style doesn’t work in this arena.

You must recognize and change your leadership style for success in your Quadruple Aim efforts.

Physician Leadership 101

• We are taught to Diagnose and Treat
• Once we think we have the Diagnosis, we Give Orders
• We expect the Team to Obey
• and the Patients to Comply

That is appropriate if you are the undisputed expert, with the single “right answer” and the smarts to coordinate the implementation of that solution. You are not that person when you are leading a wellness project.

When it comes to preventing physician burnout, there is only one way to understand what to do ...

• ASK YOUR PEOPLE WHAT THEY NEED
• AND GIVE IT TO THEM

BEWARE:

Any wellness program that is not specifically requested by the front line physicians will struggle -- and most will fail.

Outline of a Wellness Program FAIL

• Leadership says, “We need to do something about burnout.”
• A committee is formed and charged with figuring out what to do
• The members of the committee use their physician programming to Diagnose and Treat

continued on page 26

Vascular Specialist, Fellowship-Trained in Venous Disease

Sean P. Ryan, MD
Vascular Surgeon
Board Certified
Fellowship, Thomas Jefferson University Hospital, Philadelphia, PA
General Surgery Residency, Christiana Care Health System, DE
Robert Wood Johnson Medical School, NJ
• They perform a literature review
• From within the committee meetings, they name what they see as the problem
• In the same meetings, they come to consensus on a solution – “This is what we need to do to/for the doctors”
• The program is launched onto the physicians
• The Wellness Committee sits back, expects the program to work and the physicians to be thankful
• and it all blows up for a very simple reason...

It was done TO the physicians - not WITH them
Your project is just one more thing for the physicians to squeeze into their already overloaded day. They didn’t ask for it. For a number of them, your program will be the last straw that tips them over the edge into burnout.

It can be very confusing to see your program go down in flames, especially since you know your heart is in the right place.

You really do want to help. Your physician leadership blind spot just blew up your project. You didn’t see it coming. And now burnout is worse rather than better.

YIKES!!
The even bigger tragedy...
The leadership team can quickly give up on being able to do anything about burnout and moves on to more pressing financial issues.

Don’t make this classic physician leadership mistake
Always work with the physicians in the front lines to design your wellness interventions.

If you ask them, they will tell you exactly where to focus your efforts.
1) Ask Questions about their sources of stress
2) Make a list and help them choose just ONE to address
3) Work with them to implement a positive change
4) Repeat

Simple, right? Step outside of your Diagnose and Treat programming and become a Servant Leader instead. Let THEM tell you what to do.

Working WITH your physicians provides several huge benefits
• It is less work for you as the leader
• The projects are always targeted on key stressors

• Your project is much more likely to have a meaningful impact on your doctor’s quality of life
• Your physicians are bought in and participating from the start
• There is a cascading effect where success builds on success and the culture begins to shift
• Listening to the doctors is a powerful way to show you care about them and understand the true meaning of the Quadruple Aim

Remember, Always Launch Wellness Programs WITH Your Physicians

• Ask what is stressing them
• Listen
• Address their concerns
• Make participation voluntary

And watch the difference it makes.
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AAFP Publishes Position Paper on the Prevention of Gun Violence

In February, 2018 the AAFP, American Academy of Pediatrics, American College of Obstetricians and Gynecologists, American College of Physicians, and American Psychiatric Association laid out three concrete steps for the president and Congress to take:

- Label violence caused by the use of guns as a national public health epidemic.
- Fund appropriate research at the CDC as part of the 2018 federal budget.
- Establish constitutionally appropriate restrictions on the manufacturing and sale, for civilian use, of large-capacity magazines and firearms with features designed to increase their rapid and extended killing capacity.

In March, the AAFP Board of Directors requested the Commission on Health of the Public and Science to research and draft and evidence-based position paper on the prevention of gun violence to serve as the foundation to the on-going advocacy efforts moving forward. The position paper was released in May, 2018 and can be found on the AAFP website at https://www.aafp.org/about/policies/all/gun-violence.html.

An excerpt from the position paper:

Gun violence is a national public health epidemic that exacts a substantial toll on the U.S. society. Gun violence includes homicide, violent crime, attempted suicide, suicide, and unintentional death and injury. According to the Centers for Disease Control and Prevention (CDC), more than 38,000 deaths from firearms (including suicides) occurred in the United States in 2016,1 and nearly 85,000 injuries from firearms occurred in 2015.2 That’s an average of 105 deaths and more than 230 injuries from firearms each day.1,2

In addition to the thousands killed or injured, myriad families must also cope with the consequences of this violence. In terms of the financial toll, although the estimates vary, it’s generally held that gun violence expenses—medical charges, loss of income, daily care/support, and criminal justice expenditures—cost the U.S. economy approximately $229 billion annually.3

Gun violence should be considered a public health issue, not a political one—an epidemic that needs to be addressed with research and evidence-based strategies that can reduce morbidity and mortality. Gun violence affects people of all ages and races. Family physicians care for victims of gun violence and their families every day. These physicians, who witness the substantial impact firearm-related violence has on the health of their patients, families, and communities, have the power to help improve the safety and wellbeing of those groups.

The complexity and frequency of firearm violence, combined with its impact on the health and safety of Americans, suggest that a public health approach should be a key strategy used to prevent future harm and injuries. This approach focuses on three elements: scientific methodology to identify risk and patterns, preventive measures, and multidisciplinary collaboration.4 The AAFP encourages this public health approach and supports research that identifies which policies and interventions effectively reduce morbidity and mortality, while also respecting the Constitutional right to bear arms.
QUALITY INSIGHTS & YOU:
Improving Health Care Quality in the First State

Quality Insights has long been a go-to resource for Delaware providers and stakeholders seeking to improve health care quality. We are excited to introduce two new initiatives and encourage your practice to join us in this work. Your participation creates a foundation for your quality improvement efforts, as well as prepares your practice for future value-based payment models.

Working Together to Improve HPV Vaccine Rates in Delaware

As Benjamin Franklin once said, “An ounce of prevention is worth a pound of cure.” This is especially true when discussing cancer prevention. Quality Insights is spearheading a new training program for medical providers to increase Human Papilloma Virus (HPV) vaccination rates in Delaware.

Benefits of Participation:
- Assistance with collecting baseline data associated with the project
- Resources including slides, handouts, and e-newsletters provided at no cost to your practice

Requirements:
- Actively participate in a staff training supported by Quality Insights (lunch provided)
- Serve pediatric/adolescent patients (under 21) as a non-Vaccine for Children (VFC) provider

For more information, please contact Lisa Gruss at lgruss@qualityinsights.org or call 302.299.7284.

Pediatric Nutrition, Physical Activity & Body Mass Index Pilot Project

According to the CDC, the percentage of U.S. children and adolescents affected by obesity has more than tripled since the 1970s. Join Quality Insights in our efforts to reduce pediatric obesity in Delaware. This project will focus on pediatric nutrition, physical activity and Body Mass Index (BMI).

Join Us to Make a Healthy Delaware.

Benefits of Participation:
- Participants will help to shape future resources and programming for Pediatric Obesity in Delaware.
- Receive assistance in pulling the practices NQF 0024 measure (Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents)

Requirements:
- Must be a pediatric site or a primary care site with a pediatric population
- Participate in a workflow analysis regarding current nutrition, physical activity counseling and BMI practices

For additional details, please contact Ryan Williamson at rwilliamson@qualityinsights.org.

These projects are in collaboration with the Division of Public Health (DPH) – Comprehensive Cancer Control Program, Immunization and Vaccines for Children, Centers for Disease Control and Prevention (CDC), DPH - Physical Activity, Nutrition & Obesity Prevention Program (PANP) and Delaware Cancer Consortium (DCC). Publication number DELPH-GEN-050218.
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What’s in your glass?

Choices are great, but they can be overwhelming. This at-a-glance chart can help you understand what’s in your 8-ounce glass of milk.

### Calories and Nutrients (% Daily Value)

<table>
<thead>
<tr>
<th></th>
<th>Low-Fat Cow’s Milk</th>
<th>SOY</th>
<th>Almond</th>
<th>Coconut</th>
<th>Rice</th>
</tr>
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<tbody>
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<td>Calories</td>
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<td>110</td>
<td>60</td>
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<td>120</td>
</tr>
<tr>
<td>Protein</td>
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<td>8g</td>
<td>1g</td>
<td>&lt;1g</td>
<td>1g</td>
</tr>
<tr>
<td>Fat</td>
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<td>4.5g</td>
<td>2.5g</td>
<td>5g</td>
<td>2.5g</td>
</tr>
<tr>
<td>Carbohydrates</td>
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<td>9g</td>
<td>8g</td>
<td>7g</td>
<td>23g</td>
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### Vitamins and Minerals (% Daily Value)

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<th>Coconut</th>
<th>Rice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calcium</td>
<td>30%</td>
<td>45%</td>
<td>45%</td>
<td>45%</td>
<td>30%</td>
</tr>
<tr>
<td>Phosphorus</td>
<td>25%</td>
<td>25%</td>
<td>N/A</td>
<td>N/A</td>
<td>15%</td>
</tr>
<tr>
<td>Potassium</td>
<td>10%</td>
<td>10%</td>
<td>1%</td>
<td>1%</td>
<td>N/A</td>
</tr>
<tr>
<td>Riboflavin</td>
<td>25%</td>
<td>30%</td>
<td>30%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Vitamin B-12</td>
<td>20%</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
<td>25%</td>
</tr>
<tr>
<td>Vitamin A</td>
<td>10%</td>
<td>10%</td>
<td>10%</td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td>Vitamin D</td>
<td>25%</td>
<td>30%</td>
<td>25%</td>
<td>25%</td>
<td>25%</td>
</tr>
</tbody>
</table>

**Naturally Occurring**

**Good Source = 10% – 19% DV**

**Excellent Source = 20%+ DV**

### Price

<table>
<thead>
<tr>
<th></th>
<th>Low-Fat Cow’s Milk</th>
<th>SOY</th>
<th>Almond</th>
<th>Coconut</th>
<th>Rice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per ½ Gallon</td>
<td>$2.05</td>
<td>$5.37</td>
<td>$5.32</td>
<td>$4.99</td>
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</tr>
<tr>
<td>Per 8oz. Serving</td>
<td>$0.26</td>
<td>$0.42</td>
<td>$0.41</td>
<td>$0.62</td>
<td>$0.43</td>
</tr>
</tbody>
</table>
Help Your Patients

Lung Cancer

Improving Preventive Screening Rates

Quality Insights invites you to be part of a new and important Preventive Lung Cancer Screening (PLCS) quality improvement effort. We are enrolling a limited number of new practices, so act now.

Benefits of Participation:
- Become an industry leader for PLCS quality improvement efforts
- Gain eligibility to receive a $1,000 stipend for actively participating in the project
- Receive on-site support to improve lung cancer screening rates
- Secure the opportunity to be highlighted as a Delaware success story to both the Delaware Division of Public Health and the Centers for Disease Control and Prevention (CDC)

Participation is Easy:
- Designate an individual to act as the primary contact with Quality Insights
- Learn how to identify patients eligible for lung cancer screening and refer them for screening
- Complete a workflow analysis regarding your current preventive lung cancer screening processes and help close the identified gaps

Get started today. For more information and a copy of our project agreement, email Sarah Toborowski at stoborowski@qualityinsights.org.

Your participation in this work creates a foundation for your practice’s quality improvement efforts, as well as prepares your practice for future value-based payment models.

Quality Insights requires completion of our Memorandum of Understanding and Business Associate Agreement.